STATE OF ILLINOIS)
) SS.
COUNTY OF)
WILLIAMSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Robert McKnight, Jr.,
Petitioner,

vs.

NO: 15WC 11670

The American Coal Company,
Respondent.

19IWCC0179

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 disease, 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 31, 2018, is hereby affirmed and adopted.

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

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

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

DATED: APR 3 - 2019
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MJB/jrc
052

Michael J. Brennan

19IWCC0179

SPECIAL CONCURRING OPINION

This case was scheduled for Oral Arguments on February 5, 2019, before a three-member panel of the Commission including members Michael J. Brennan, Kevin Lamborn, and Thomas J. Tyrrell, at which time Oral Arguments were either heard, waived or denied. Subsequent to Oral Arguments and prior to the departure of Kevin Lamborn, a majority of the panel members had reached agreement as to the results set forth in this decision and opinion, as evidenced by the internal Decision worksheet initialed by the entire three-member panel, but no formal written decision was signed and issued prior to Commissioner Lamborn's departure.

Although I was not a member of the panel in question at the time Oral Arguments were heard, waived or denied, and I did not participate in the agreement reached by the majority in this case, I have reviewed the Decision worksheet showing how Commissioner Lamborn voted in this case, as well as the provisions of the Supreme Court in *Zeigler v. Industrial Commission*, 51 Ill.2d 137, 281 N.E.2d 342 (1972), which authorizes signature of a Decision by a member of the Commission who did not participate in the Decision. Accordingly, I am signing this Decision in order that it may issue.

Deborah L. Simpson
Deborah Simpson

DISSENT

I respectfully dissent from the opinion of the majority and would reverse the Arbitrator's Decision. After considering the totality of the evidence, I believe Petitioner met his burden of proving that he sustained an occupational disease arising out of and in the course of his employment as an underground coal miner with Respondent. I believe the evidence supports a finding that Petitioner has coal workers' pneumoconiosis ("CWP") and that his current condition of ill-being is causally related to his sustained exposure to coal dust and other proven irritants. After reviewing the evidence, I believe Petitioner sustained a loss of 10% of the person as a whole due to his occupational injury.

Respondent does not dispute that Petitioner worked for over 37 years as a coal miner. During those almost four decades, he worked underground and was continuously exposed to irritants such as coal dust, silica dust, roof bolting glue fumes, and diesel fumes. Petitioner testified that he first noticed breathing problems during his final year of work. He testified that he began coughing more and the mucus when he blew his nose was black. He also noticed that it became harder for him to get around. Petitioner testified that he becomes short of breath after walking approximately 25 feet.

The majority places great weight on the opinions of Respondent's experts and Petitioner's lack of treatment and documented respiratory complaints. I interpret the evidence much differently than the majority. Here, Petitioner's two experts opined that Petitioner developed coal workers' pneumoconiosis due to his exposure to coal dust and other irritants. Dr.

Smith, a board-certified radiologist and B-reader interpreted the November 2015 chest x-ray as positive for pneumoconiosis. Dr. Paul, a specialist in allergy and pulmonary disease, also diagnosed pneumoconiosis based on the chest x-ray findings of fibronodular lesions in both lower lung areas. However, both of Respondent's experts testified that Petitioner does not have CWP. However, the testimony of Respondent's experts shines a critical light on the development of CWP and the reliability of seemingly normal x-rays. The experts agree that Petitioner worked in the underground coal mining industry for enough time to develop CWP. Dr. Castle, Respondent's expert, testified that the records he reviewed would not automatically rule out the existence of CWP. Dr. Castle admitted that even with a negative chest x-ray, a person could have CWP. Dr. Meyer, Respondent's expert, testified that the "gold standard" for determining the existence of lung disease is a pathologic review of the tissue, not radiologic studies. Dr. Castle testified that studies have shown that as many as 50% of long-term coal miners have pathological CWP that was not seen on radiographic studies. Dr. Meyer even admitted that an old study shows a high incidence of finding coal macules in coal workers that aren't yet severe enough to be seen on an x-ray and are only detectable through a pathologic review. Likewise, the fact that Petitioner's CWP is not yet severe enough to require medication should not be determinative of whether Petitioner suffers from CWP. The experts acknowledge that CWP is a progressive disease.

Respondent's experts admit to so many caveats regarding the accuracy of ruling out the presence of CWP solely based on one's interpretation of a chest x-ray that the majority's reliance on those very interpretations is baffling. After considering the totality of the expert opinions and testimony, it is clear that two experts definitively confirm the diagnosis of CWP while the remaining two experts are unable to definitively rule out the presence of CWP. When considered along with Petitioner's credible testimony and work history, Petitioner unquestionably met the burden of proving an injury pursuant to §1(d)-(f) of the Occupational Diseases Act.

For the forgoing reasons, I would reverse the Arbitrator's Decision in its entirety.

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

McKNIGHT JR, ROBERT
Employee/Petitioner

Case# 15WC011670

THE AMERICAN COAL COMPANY
Employer/Respondent

19IWCC0179

On 5/31/2018, 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:

0755 CULLEY & WISSORE
KIRK CAPONI
300 SMALL ST SUITE 3
HARRISBURG, IL 62946

1662 CRAIG & CRAIG LLC
KENNETH F WERTS
115 N 7TH ST PO BOX 1545
MT VERNON, IL 62864

STATE OF ILLINOIS)
)SS.
COUNTY OF Williamson)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Robert McKnight, Jr.
Employee/Petitioner

v.

The American Coal Company
Employer/Respondent

Case # 15 WC 11670

Consolidated cases: _____

19IWCC0179

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Herrin, on April 12, 2018. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ Other Sections 1(d)-(f) of the Occupational Diseases Act

FINDINGS

On August 15, 2014, Respondent was operating under and subject to the provisions of the Act.

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

On this date, Petitioner did 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 $n/a; the average weekly wage was $734.69.

On the date of accident, Petitioner was 61 years of age, married 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 under Section 8(j) of the Act.

ORDER

Based upon the Conclusions 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

May 18, 2018
Date

MAY 31 2018

Petitioner filed an Application for Adjustment of Claim which alleged he sustained an occupational disease to his lungs, heart, pulmonary system and respiratory tracts. The Application alleged a date of last exposure of August 15, 2014, and that Petitioner sustained the occupational disease as a result of inhalation of coal mine dust, rock dust, fumes and vapors for a period in excess of 37 years (Arbitrator's Exhibit 2).

At the time of trial, Petitioner was 65 years old. Petitioner has a high school education. He does not have any post high school education. Petitioner worked in the coal mines for 37 years with all of those years being underground. In addition to coal dust, Petitioner was regularly exposed to and breathed silica dust, roof bolting glue fumes and diesel fumes.

Petitioner last worked in the coal mines on August 15, 2014, the alleged date of last exposure, for Respondent at its New Future Mine. He was 61 years old on that date. His job classification was shoveling on the belt. Petitioner testified that he was exposed to coal dust on that day. Petitioner left the mine at that time because he was retiring. That was the last day that he worked in any coal mine. Petitioner did not work anywhere after he left the mines.

Petitioner started working in the coal mines in 1977 for Inland Steel. He was hired as a shuttle car operator and started working on the miner shortly after that. The shuttle car operator drives the shuttle car that takes the coal from the face of the mine where it is cut out to the belts to be removed from the mine. The miner operator is the one who actually runs the continuous miner machine that cuts the coal out of the face of the mine. Petitioner ran a continuous miner off and on for over 30 years. Petitioner worked for Inland Steel for 26 years. Petitioner went to work for Respondent in January, 2003, as a miner operator. While working for Respondent he occasionally ran a ram car. His last job for Respondent was as belt shoveler. He worked in that position for six months. In that job he was shoveling coal back on the belt. He testified that a lot of dust was created when he was shoveling. He was also exposed to roof bolting glue fumes because he was working in the entry way where they were bolting. He testified that the roof bolting glue had an odor that would take his breath away.

Petitioner testified that he first noticed breathing problems in the last year that he worked in the mine. He noticed that he was coughing a lot and when he would blow his nose it would be black. He was a lot slower getting around. He testified that from the time he first noticed his breathing problems until he left the mine they got a little worse. He testified that since leaving the mine, his breathing has not gotten any better. He testified that he can walk 25 feet on level ground at a normal pace before becoming short of breath. Petitioner testified that he could climb three or four flights of stairs and then he would have to stop. Petitioner was not taking any breathing medications at the time of trial.

Petitioner testified that he cannot walk like he would like to walk without having to stop because he is breathing hard. He testified that when he gets up in the morning he is coughing and blowing his nose and sneezing. Petitioner stated he is sure it is from having black lung. Petitioner testified that he used to hunt and fish, but he does not do that anymore because he cannot walk any distance.

Petitioner testified that Dr. Oakley is his family physician. He testified that he never talked to Dr. Oakley much about his breathing problems. He testified that Dr. Oakley was aware that he worked in a coal mine. Petitioner never smoked. At the time of trial, Petitioner stated he takes medication for a thyroid problem and indigestion.

Petitioner testified that from time to time while he worked in the mines, he had an opportunity to undergo chest x-ray screening by NIOSH for black lung. He underwent such screening. He testified that they would write to him after the chest x-ray and tell him what the film revealed. He did not bring any of those letters with him to trial. Petitioner testified that he has been honest with his physicians at Logan Primary Care regarding his problems and symptoms. Petitioner testified that to occupy his time he goes to church and watches TV.

At the request of Petitioner's Counsel, Petitioner was examined by Dr. Glennon Paul. Dr. Paul was deposed on March 28, 2016, and his deposition testimony was received into evidence at trial.

Petitioner saw Dr. Glennon Paul on November 12, 2015 (Petitioner Exhibit No. 1; Deposition Exhibit No. 2). Dr. Paul is the Medical Director of St. John's Respiratory Therapy and Clinical Assistant Professor of Medicine at SIU Medical School (Petitioner's Exhibit 1; p 6). Dr. Paul is the senior physician at the Central Illinois Allergy and Respiratory Clinic. Those physicians specialize in allergy and pulmonary disease. They take care of patients with respiratory diseases, critical care, allergic diseases and some internal medicine problems (Petitioner's Exhibit 1; p 7). Dr. Paul is board certified in asthma, allergy and immunology (Petitioner's Exhibit 1; p 9). Dr. Paul testified that at the time he did his fellowship in 1970 to 1972, there were not any pulmonary fellowships developed. He testified that it was strictly in allergy, asthma and respiratory disease (Petitioner's Exhibit 1; p 10). Dr. Paul is not an A-reader or a B-reader (Petitioner's Exhibit 1; pp 14, 21). Dr. Paul is not board certified in pulmonary disease (Petitioner's Exhibit 1; p 21). Dr. Paul has seen over one hundred individuals for black lung exams at the request of Petitioner's counsel (Petitioner's Exhibit 1; p 15).

Dr. Paul testified that Petitioner had 37 years of underground coal mine employment. Petitioner was never a cigarette smoker. Dr. Paul testified that Petitioner's chest examination was normal. The pulmonary function testing performed by Dr. Paul was within normal limits (Petitioner's Exhibit 1; p 12).

Dr. Paul testified that Petitioner had coal workers' pneumoconiosis caused by the coal dust environment. In light of the diagnosis of coal workers' pneumoconiosis, Petitioner could not have any further exposure to the environment of a coal mine without endangering his health (Petitioner's Exhibit 1; p 13). Dr. Paul's diagnosis of coal workers' pneumoconiosis was based on his chest x-ray findings of fibronodular lesions in both lower lung areas (Petitioner's Exhibit 1; p 13).

Petitioner did not relate to Dr. Paul any respiratory complaints or any past history of respiratory problems. Dr. Paul did not review any medical records regarding Petitioner (Petitioner's Exhibit 1; p 15). Petitioner did not tell Dr. Paul that he left work due to a respiratory disease or that he had a problem in performing the duties of his last job. Dr. Paul testified that Petitioner had no sign of respiratory disease. Dr. Paul testified that the spirometry was normal except for Petitioner's carbon monoxide diffusing capacity adjusted was 66% of normal, which is low. Dr. Paul testified that this was secondary to the dust that Petitioner had in his lungs. Dr. Paul testified that the diffusion capacity could vary from day to day depending on how the testing was done and how Petitioner was feeling, but being low would be a permanent thing with regard to the diffusion capacity testing. Dr. Paul did not know the inspiratory time for the tracer gas. He did not know the hold time for the tracer gas. Dr. Paul testified that he does not record the inspiratory volume for the tracer gas. Dr. Paul testified that he did not think that the American Thoracic Society recommended that the inspiratory volume for the tracer gas be recorded (Petitioner's Exhibit 1; pp 15-17).

Dr. Paul testified that Petitioner's FEV1/FVC ratio was 76% of predicted which would suggest no obstruction, but it was at the lower limits of normal. The predicted for Petitioner was 75% (Petitioner's Exhibit 1; p 18). Dr. Paul testified that Petitioner's total lung capacity was normal which ruled out a restriction (Petitioner's Exhibit 1; p 20).

Dr. Paul did not know the date of the x-ray that he reviewed. Dr. Paul testified that all opacity types were present (Petitioner's Exhibit 1; p 20). Dr. Paul testified that it was a profusion 1. He testified that he did not know if it was 1/0, 1/1 or 1/2. He testified that he did not look at it that way. He testified that if it is positive for coal workers' pneumoconiosis, he calls it a 1 (Petitioner's Exhibit 1; pp 20-21).

Dr. Henry K. Smith, board certified radiologist and B-reader, interpreted chest x-ray for Petitioner dated November 12, 2015. He rated the film as quality 2 due to overexposure. Dr. Smith interpreted the film as positive for pneumoconiosis, profusion 1/1 with P/S opacities in all lung zones (Petitioner's Exhibit 2).

Dr. Cristopher Meyer reviewed a PA and lateral chest x-ray dated November 12, 2015, from Central Illinois Allergy and Respiratory (Respondent's Exhibit 1; p 41). Dr. Meyer first received a copy film which he judged to be unreadable for an ILO B-reading interpretation. Subsequently he received the original film for that date. He found the original examination to be overexposed but diagnostic. He graded it as quality 3 (Respondent's Exhibit 1; pp 41-42). Dr. Meyer testified that there was a calcified

granuloma in the left upper zone with calcified left hilar lymph nodes indicating prior granulomatous disease. He testified that there were no radiographic findings of coal workers' pneumoconiosis. Dr. Meyer testified that granulomatous disease is not a sequelae of dust exposure. It is actually a healing of a prior fungal infection or tuberculosis infection (Respondent's Exhibit 1; p 42).

Dr. Meyer has been board certified in radiology since 1992 (Respondent's Exhibit 1; p 8). Dr. Meyer has been a B-reader since 1999 (Respondent's Exhibit 1; pp 20-21). Dr. Meyer was asked to take the B-reading exam by Dr. Jerome Wiot who was part of the original committee that designed the training program which is called the B-reader program (Respondent's Exhibit 1; pp 21-22). Dr. Meyer has recently been asked to have a more active academic role in the B-reader program. Dr. Meyer is on the American College of Radiology Pneumoconiosis Task Force which is engaged in redesigning the course and exam and submitting cases for the B-reader training module and exam. Dr. Meyer testified that the faculty is typically experienced senior level B-readers (Respondent's Exhibit 1; pp 33-34). Dr. Meyer testified that radiologists have a 10% higher pass rate on the B-reading exam than other specialties. In Dr. Meyer's opinion radiologists have a better sense of what the variation of normal is. Dr. Meyer testified that one of the most important parts of the B-reader training and examination is making a distinction between a 0/1 and 1/0 film (Respondent's Exhibit 1; pp 35-36).

Dr. Meyer testified that the B-reader looks at the lungs to decide whether there are any small nodular opacities or any linear opacities and based on the size and appearance of those small opacities, they are given a letter score (Respondent's Exhibit 1; p 23). Dr. Meyer testified that specific occupational lung diseases are described by specific opacity types. Coal workers' pneumoconiosis is characteristically described by small round opacities. Diseases that cause pulmonary fibrosis, like asbestosis will be described by small linear opacities (Respondent's Exhibit 1; p 29). The distribution of the opacities is also described because different pneumoconioses are seen in different regions of the lung. Coal workers' pneumoconiosis is typically an upper zone predominant process. Idiopathic pulmonary fibrosis and asbestosis is a basilar or linear process. The last component of the interpretation is the extent of lung involvement or the so-called profusion (Respondent's Exhibit 1; p 24). Dr. Meyer testified that the profusion is basically trying to define the density of the small opacities in the lung (Respondent's Exhibit 1; p 31).

At the request of Respondent's counsel, Dr. James R. Castle reviewed medical records and a chest x-ray regarding Petitioner (Respondent's Exhibit 2; p 21). Dr. Castle was deposed on June 9, 2017, and his deposition testimony was received into evidence at trial. Dr. Castle is a pulmonologist and is board certified in internal medicine and in the subspecialty of pulmonary disease (Respondent's Exhibit 2; p 4). Board certification in pulmonary disease was first established in 1941 (Respondent's Exhibit 2; p 35). Dr. Castle practiced in Roanoke, Virginia, for 30 years. His practice was limited to pulmonary disease and chest disease, which encompassed critical care medicine (Respondent's Exhibit 2; p 7). Dr. Castle's practice included patients with occupational lung disease. He had some

patients in his practice that had coal workers' pneumoconiosis (Respondent's Exhibit 2; p 8). Dr. Castle has been certified as a B-reader since 1985 (Respondent's Exhibit 2; p 14).

Dr. Castle reviewed a chest x-ray dated November 12, 2015, from Central Illinois Allergy and Respiratory Service. He testified that in his opinion there were no parenchymal abnormalities consistent with pneumoconiosis on this film. He testified that there was evidence of a calcified granuloma (Respondent's Exhibit 2; p 30). Dr. Castle testified that for a proper reading of the chest x-ray for pneumoconiosis, one needs to note the individual's name, the date of the film needs to be present and the quality of the film needs to be noted. He testified that next one needs to identify whether or not there are any opacities, the type of opacity, the location of the opacities and then the profusion of the opacities determined by a side by side comparison with the standard ILO films. Dr. Castle testified that if there are large opacities present, that should be noted. Dr. Castle testified that there is no such thing as radiographic apparent pulmonary impairment (Respondent's Exhibit 2; p 31). Dr. Castle agreed with the American Thoracic Society's statement that an older worker with mild pneumoconiosis may be at low risk for working in currently permissible exposure levels until he reaches retirement age. Dr. Castle testified that it is very unlikely that simple pneumoconiosis will progress once the exposure ceases (Respondent's Exhibit 2; pp 31-32).

Dr. Castle testified that the pulmonary function study by Dr. Paul on November 12, 2015, revealed valid spirometry and lung volumes which were normal showing no evidence of obstruction or restriction from any cause. A diffusing capacity performed at Methodist Hospital on May 3, 2016, was also entirely normal. Dr. Castle opined that Petitioner did not have any respiratory impairment from any cause including coal workers' pneumoconiosis and coal mine dust exposure (Respondent's Exhibit 2; pp 34-35). Dr. Castle testified that the spirometry performed at Methodist Hospital on May 3, 2016, revealed no evidence of obstruction or restriction (Respondent's Exhibit 2; p 28). Dr. Castle testified that to have valid diffusion capacity testing, the test requires a less than four-second inhalation of gas from residual volume to a breathhold and exhalation of gas within four seconds. The inhalation must be at least 85% of the best vital capacity. Dr. Castle testified that he did not know whether the diffusion capacity testing by Dr. Paul was valid because there were no tracings. Dr. Castle testified that he agreed with Dr. Paul that scarring of the lung due to dust exposure is permanent and if there is a reduction in the diffusing capacity as a result of that scarring, it would be permanent (Respondent's Exhibit 2; p 29).

Dr. Castle is familiar with the *AMA Guides to the Evaluation of Permanent Impairment, Sixth Edition*. He testified that if Table 5-4 of the *AMA Guides* is applied to the results of Petitioner's pulmonary function testing as well as the valid diffusion capacity testing, he would be Class 0 impairment (Respondent's Exhibit 2; p 30). Dr. Castle testified that Petitioner did not suffer from any pulmonary disease or impairment occurring as a result of his occupational exposure to coal mine dust. He testified that Petitioner worked in or around the underground coal mining industry for a sufficient enough time to have developed coal workers' pneumoconiosis if he were a susceptible host (Respondent's

Exhibit 2; pp 32-33). Dr. Castle testified that none of the physical examinations revealed in the treatment records indicated any consistent physical findings indicating the presence of a chronic interstitial pulmonary process. Petitioner's physical examination of the lungs was normal on virtually all occasions (Respondent's Exhibit 2; p 33). Dr. Castle testified that based upon the objective testing performed on Petitioner, he was capable of heavy manual labor (Respondent's Exhibit 2; p 35).

Dr. Castle testified that the treatment records that he reviewed concerning Petitioner would not in and of themselves rule out the existence of coal workers' pneumoconiosis. He testified that one could have coal workers' pneumoconiosis notwithstanding a negative chest x-ray. It would be possible that if he had a biopsy, he could have some evidence of minimal pathologic changes (Respondent's Exhibit 2; p 37). Dr. Castle testified that there are studies that have shown that as many as 50% of long term coal miners have pathological coal workers' pneumoconiosis that was not appreciated by a radiographic study during their lives (Respondent's Exhibit 2; p 43). Dr. Castle testified that coal workers' pneumoconiosis is basically an x-ray diagnosis except for the caveat about pathology (Respondent's Exhibit 2; pp 46-47). Dr. Castle testified that coal workers' pneumoconiosis is basically trapped coal dust in the part of the lung which ends up wrapped in scar tissue (Respondent's Exhibit 2; p 47). He testified that by definition, if a person has coal workers' pneumoconiosis, he would have an impairment in the function of the lungs at the site of the scarring (Respondent's Exhibit 2; p 48).

Medical records of Logan Primary Care Services were admitted into evidence. Petitioner was seen on May 13, 2009, to establish as a new patient. He reported that he was in good general health and was not using regular medications. Physical examination of the lungs showed that they were clear to auscultation bilaterally with no wheezes, rhonchi or rales (Respondent's Exhibit 3; pp 134-135). Petitioner's lungs remained clear on August 5, 2009, and January 7, 2010 (Respondent's Exhibit 3; pp 129-133). Petitioner was seen on May 5, 2011, with upper/lower respiratory symptoms. He was experiencing runny nose, nasal congestion, post nasal drip, sore throat, headache, sinus pressure, cough, chest congestion and wheezing. Physical examination of the lungs showed that they were clear to auscultation bilaterally. There were no wheezes, rhonchi or crackles. The assessment was upper respiratory infection, cough and elevated blood pressure. Petitioner was instructed about increasing his fluids and standard cold maintenance (Respondent's Exhibit 3; pp 119-121). Petitioner was seen on June 6, 2011, in follow up from ER visit for kidney stone. Physical examination of the lungs remained clear to auscultation and percussion without wheezes, rhonchi or rales (Respondent's Exhibit 3; pp 114-116). Petitioner was seen on April 18, 2012, for URI symptoms, including sinusitis, sore throat and diarrhea. He also related some runny nose, congestion and sneezing with occasional cough. Physical examination of the lungs showed that they were clear to auscultation and percussion. Assessment was URI and acute sinusitis (Respondent's Exhibit 3; pp 110-111). On August 31, 2012, and September 7, 2012, Petitioner was seen regarding headaches. Physical examination of the lungs were normal on those dates (Respondent's Exhibit 3; pp 92-98).

On January 17, 2013, a note was issued by Dr. Parks stating that Petitioner had chronic back pain and should avoid operating heavy machinery (Respondent's No. 3; pp 89-90). Petitioner was seen on April 27, 2013, for cough, congestion and runny nose. The onset was sudden and had been present for one week. The doctor noted that he had a history of allergies and sinusitis. Physical examination of the lungs showed that they were clear to auscultation and percussion. The assessment was acute sinusitis and cough (Respondent's Exhibit 3; pp 85-87). Petitioner presented with elevated blood pressure on October 29, 2013. There was no complaint of chest pain or shortness of breath. Lungs remained clear (Respondent's Exhibit 3; pp 83-84). On June 23, 2014, Petitioner presented with lower back pain. He indicated he was feeling better and needed a work release to go back to work without restrictions (Respondent's Exhibit 3; pp 75-76). Petitioner was seen on February 6, 2017, with a three day history of runny nose, watery eyes, congestion, post nasal drip and non-productive cough. Physical examination of the chest revealed the lungs were clear to auscultation with no wheezes, rhonchi or rales. The assessment was sinusitis (Respondent's Exhibit 3; pp 19-20). Petitioner was seen on August 29, 2017, complaining that he had not had an appetite since April. He had no respiratory distress and physical examination of the chest revealed normal effort and normal breath sounds. He was diagnosed with anorexia (Respondent's Exhibit 3; pp 2-3). Petitioner was seen on October 10, 2017, for uncontrolled GERD. On examination his pulmonary effort was normal and his breath sounds were normal (Respondent's Exhibit 3; pp 3-5). Petitioner was seen on December 5, 2017. His GERD was well controlled on PPI. His review of systems respiratory was negative for apnea, cough, choking, chest tightness and shortness of breath. He had no respiratory distress, wheezes or rales (Respondent's Exhibit 3; pp 5-7).

Conclusions of Law

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

The Arbitrator concludes that Petitioner did not sustain an occupational disease arising out of and in the course of his employment with Respondent.

In support of this conclusion the Arbitrator notes the following:

The spirometry performed as part of Dr. Paul's examination on November 12, 2015, was within normal limits. Dr. Castle agreed that the pulmonary function study by Dr. Paul showed no evidence of obstruction or restriction from any cause. Dr. Castle testified that the diffusing capacity performed at Methodist Hospital on May 3, 2016, was entirely normal. Dr. Castle also testified that the spirometry performed at the Methodist Hospital on the same date revealed no evidence of obstruction or restriction. Dr. Castle further testified that Petitioner did not have any respiratory impairment from any cause including coal workers' pneumoconiosis and coal mine dust exposure. Dr. Castle testified that based upon the objective testing performed on Petitioner, he was capable of heavy manual labor.

Dr. Henry K. Smith, B-reader and board certified radiologist, noted the chest x-ray of November 12, 2015, was positive for coal workers' pneumoconiosis. Dr. Paul is not an A-reader or B-reader. Dr. Paul does not have the special training for interpreting chest x-rays for occupational lung disease that was described by Dr. Meyer. Dr. Meyer and Dr. Castle, B-readers, reviewed Petitioner's chest x-ray of November 12, 2015. Dr. Meyer testified that the film was quality 3 but diagnostic. Dr. Meyer testified that there were no radiographic findings of coal workers' pneumoconiosis. Dr. Castle testified that there were no parenchymal abnormalities consistent with pneumoconiosis on the film. Dr. Meyer and Dr. Castle both noted calcified granuloma on the film. Dr. Castle described the protocol for proper reading of a chest x-ray for pneumoconiosis. Dr. Paul did not follow this protocol.

The Arbitrator finds the opinions of Dr. Castle and Dr. Meyer to be more persuasive than those of Dr. Paul and Dr. Smith.

Although Petitioner testified that he noticed breathing problems in the last year that he worked in the mine, a review of medical records does not support his complaints. Petitioner was not taking, nor had he ever taken, breathing medications. Petitioner indicated that he last worked in the coal mines on August 15, 2014, at which time he voluntarily retired. Petitioner did not relate to Dr. Paul any respiratory complaints or any past history of respiratory problems.

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

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 Up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Carmen Rivera,

Petitioner,

vs.

NO: 15 WC 18868

Shree Dutt, Inc. d/b/a Dunkin Donuts,

19IWCC0180

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petitions for Review under §19(b) 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 Decision of the Arbitrator and finds Petitioner's current condition of ill-being is causally related to the work injury. The Commission further modifies the Decision and finds Respondent is liable for additional medical expenses. The Commission further modifies the Arbitrator's Decision and finds Petitioner is entitled to prospective medical treatment in the form of the recommended right total knee replacement. The Commission further modifies the Arbitrator's Decision and finds Petitioner is entitled to additional temporary total disability benefits. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Comm'n*, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

Findings of Fact

In the interest of efficiency, the Commission primarily relies on the Arbitrator's detailed recitation of facts. On June 1, 2015, Petitioner injured her right knee while walking on a floor sticky with caramel flavoring that continuously leaked out of its dispenser throughout the day. She visited the ER the next day and the doctor diagnosed effusion of the right knee joint and a sprain/strain of the knee. She visited Dr. Udeani Coe on June 4, 2015, with complaints of right knee pain and swelling. (PX 3). The doctor noted right knee tenderness and swelling as well as limited range of motion due to pain. Petitioner returned to the clinic two days later complaining of right knee pain. *Id.* The doctor noted moderate effusion with limited range of motion due to pain. After examining Petitioner's knee, he suspected a ligamentous injury and opined that Petitioner would likely need an MRI and possibly surgery. X-rays of the knee taken that day showed minimal

degenerative changes with no evidence of fracture or dislocation.

Dr. Murtaza examined Petitioner on June 11, 2015, with continued complaints of severe pain and swelling. (PX 4). The exam revealed a significant amount of knee effusion, tenderness to palpation over the medial and anterior joint line, some laxity of the right knee, and suprapatellar and prepatellar effusions. An MRI of the right knee performed that day had the following impression: 1) ACL tear; 2) mild extrusion of body of medial meniscus noted; 3) tear of the posterior horn of medial meniscus; 4) edema noted in the vastus medialis and lateralis muscles; 5) extensive soft tissue edema/contusion noted in the popliteal fossa and subcutaneous tissues of the knee predominantly along the lateral joint line; 6) knee joint effusion with gross distension of suprapatellar bursal space; and 7) bone cyst/erosion noted in the proximal tibia along the tibial plateau. (PX 6).

Petitioner first visited Dr. Poepping, an orthopedic surgeon, on June 12, 2015, with complaints of severe right knee pain. (PX 8). After reviewing the MRI, the doctor diagnosed an ACL rupture, medial meniscal tear, and posterolateral corner injury. On June 23, 2015, Dr. Poepping noted Petitioner still had a moderate effusion and slightly limited range of motion. (PX 4). Petitioner began PT on July 6, 2015. (PX 9). Petitioner arrived in a wheelchair wearing a leg brace from her thigh to her ankle. She complained of knee pain and swelling and stated she could not walk or stand. *Id.* Between July 19, 2015 and July 25, 2015, Petitioner visited at least three ERs with complaints of increasingly severe pain and swelling in the right knee. Petitioner also reported complaints of nausea and vomiting. Unfortunately, none of the medical providers in the various ERs properly diagnosed the reason for Petitioner's worsening condition. This delay had a detrimental impact on Petitioner's condition.

On July 28, 2015, Dr. Poepping noted a small right knee effusion as well as obvious right thigh swelling with redness medially extending up the right medial thigh. (PX 4). He diagnosed right thigh cellulitis and sent Petitioner to the ER. Petitioner was admitted to the hospital that day and was not discharged until August 17, 2015. (PX 13). The diagnoses upon discharge were right leg cellulitis, septicemia, acute respiratory failure, septic shock, necrotizing fasciitis, acute post-hemorrhagic anemia, arthritis, osteomyelitis, hypophosphatemia, and diarrhea. The ER doctor noted Petitioner's right leg was swollen, warm, and tender up to the mid-thigh, Petitioner's knee was swollen with a central yellowish area of discoloration with a central abscess looking area. *Id.* A right knee x-ray showed gas in the soft tissues, the suprapatellar region, and the region of the lower leg. The findings were concerning for a gas-forming organism seen with gas gangrene. *Id.* A July 29, 2015, MRI had the following impression:

> "large knee effusion with synovitic debris and foci of internal signal void corresponding to the gas density seen on the plain radiographs, highly suggestive of septic arthritis; abnormal marrow edema within the proximal tibia with findings highly suspicious for osteomyelitis and milder marrow signal changes seen in portions of the distal femur, favored to represent reactive edema; fluid collections with internal gas locules seen within the medial subcutaneous soft tissues and within the superficial posterior compartment leg musculature consistent with large abscesses; cellulitis of the knee, distal thigh,

> and proximal leg; tears of the medial and lateral menisci; distal anterior cruciate shows increased signal which could be due to focal partial tear vs mucoid degeneration; sprain of the fibular collateral ligament; strain of the popliteus tendon; and tendinopathy of the patellar tendon."

Id.

On July 30, 2015, Dr. Sompalli performed surgery including an incision and drainage of the right thigh and leg abscess which was around 300-400 milliliters, excisional debridement of the posterior thigh fascia and posterior leg fascia, and a fasciotomy of the right superficial and deep compartments of the right leg and medial thigh. *Id.* The postoperative diagnosis was necrotizing fasciitis with abscesses of the right leg and thigh. Dr. Sompalli performed a second operation consisting of excisional debridement of the skin edges of the thigh that was necrotic tissue, debridement of muscle and soft tissues of the right thigh and right leg, and irrigation on August 3, 2015. *Id.* The postoperative diagnoses were clostridium necrotizing fasciitis of the right thigh and leg, and status post incision, drainage, and debridement of abscess with skin necrosis around the thigh incision. Finally, on August 7, 2015, Dr. Sompalli irrigated the right thigh and leg and closed the thigh and leg wounds. *Id.* The thigh wound was 10 cm wide and 15 cm long and the leg wound was 6 cm wide and 10 cm long.

On December 29, 2015, Dr. Poepping wrote,

> "There has been some discussion about whether or not this infection was related to her initial injury. I think there is absolutely no question that the infection was related to the initial injury, likely resulting from the hematoma, which was seeded by bacteria. I think there is no question that the 2 incidents are related to her initial injury."

Id. The doctor recommended proceeding with a manipulation under anesthesia and arthroscopic lysis of adhesions. He continued her therapy in the meantime.

On August 16, 2016, Dr. Poepping performed surgery consisting of right knee manipulation under anesthesia, arthroscopic lysis of adhesions, extensive synovectomy, and partial medial meniscectomy and chondroplasty. (PX 4). The postoperative diagnoses were right knee stiffness, medial meniscal tear, and synovitis. Dr. Poepping wrote in the operative report that Petitioner "...sustained a work-related injury to her right knee resulting in swelling. This led to eventual swelling over the anterior thigh, which became infected, requiring emergent irrigation and debridement...she was returned to me for further management and developed severe knee stiffness despite extensive physical therapy." Petitioner participated in more physical therapy following the surgery. In November 2016, Dr. Poepping wrote,

> "She is, I think, going to be a candidate for a knee replacement placed on he [sic] degree of arthritis and the stiffness that she has. I think currently her goal would be to maximize her strength and

> ultimately maximize her functionality, but realistically the thought that this would be a normal knee again is unrealistic…I think she will need a knee replacement sometime in the near future."

Id. He referred Petitioner to a joint specialist.

Dr. Markarian examined Petitioner on December 7, 2016. (PX 24). A December 8, 2016, MRI had the following impression: 1) degenerative disease of the knee, predominantly in its medial compartment with small joint effusion; 2) healing fractures of the medial and lateral tibial condyles seen with intra-articular extension of fracture line with associated marrow edema; 3) grade 4 chondromalacia at both the femoral and tibial condyles; 4) grade 4 chondromalacia patellae; 5) sprain of the base of the ACL; 6) grade I degeneration of anterior and posterior horns of the lateral meniscus; 7) grade 3 tear in the posterior horn of medial meniscus. (PX 25). A December 27, 2016, CT of the right knee revealed severe patellofemoral osteoarthritis with laterally subluxed patella, significant medial and lateral joint space loss, a 1.9 cm oval bone fragment along the medial joint line that may be inter-articular, and a small amount of fluid in the suprapatellar bursa. (PX 27). On January 18, 2017, the doctor wrote that Petitioner had insufficiency fractures, deformity, tricompartmental degeneration with prior infection, and instability. (PX 24). He believed Petitioner needed a total knee replacement given her deformity and referred her to a reconstruction specialist. *Id.*

Dr. Poepping has continued to recommend a total knee replacement surgery, even more PT, and kept Petitioner off work through the date of hearing. (PX 4). He last examined Petitioner on July 11, 2017.

Expert Opinions & Testimony

Dr. Poepping – Treater

Dr. Poepping testified on Petitioner's behalf via evidence deposition on March 21, 2017. (PX 29). Dr. Poepping testified that Petitioner's infection "…certainly puts her at risk for worsening stiffness and to be a chronic long-term problem due to the amount of scar from both the surgery and the infection that's going to form." *Id.* at 24. He testified that the work accident caused the medial meniscus injury due to the twisting nature of the injury. *Id.* at 42. Dr. Poepping opined that the necrotizing fasciitis and all medical treatment relating to that condition were caused by the work injury stating,

> "…I believe that she had edema in her thigh musculature on her MRI with her initial injury. She had swelling in that area, and this subsequently led to my opinion a hematoma in that area that is prone to infection unfortunately. And it fits very well with her course, meaning she didn't have any signs of infection when I first saw her. And as time went by, she developed that symptomatology."

Id. at 43. The doctor testified that while Petitioner's arthritis in the knee was preexisting, a total knee replacement is the only option due to the stiffness she developed due to the infection and

injury. *Id.* at 45. He testified that the infection and related surgeries are one cause for the need for a total knee replacement. *Id.* at 46. Without the recommended surgery, he opined Petitioner would be able to return to work in a seated capacity primarily. *Id.*

Dr. Poepping testified that Petitioner sustained an acute injury per the MRI as there was edema in the musculature and the posterolateral corner as well as a large effusion in the joint. *Id.* at 57. He testified that he was unaware of any cut, scrape, or blister on the thigh that Petitioner sustained due to the work accident. *Id.* at 61. He testified, "…if she gets an infection of the lower leg, she becomes bacteremic or the bacteria gets in the bloodstream and she has a hematoma or a reason for some bacteria to go somewhere else, it could seed that area through the bloodstream." *Id.* at 63.

Dr. Karlsson – Respondent IME

Dr. Karlsson testified on Respondent's behalf via evidence deposition on June 19, 2017. (RX 6). He examined Petitioner on April 11, 2016, reviewed medical records, and produced a report. *Id.* at 8. In addition to noting restricted motion of Petitioner's leg during his examination, Dr. Karlsson also noted some atrophy of about 3 cm on the right thigh compared to Petitioner's left thigh. *Id.* at 12.

Regarding his experience with treating infections, Dr. Karlsson testified,

> "For this particular type of infection, which is necrotizing fasciitis, it is something that unless it's the abdominal wall it's usually the orthopedic surgeon that's doing the surgery for it. So I have done debridements and care for these, and I am familiar with necrotizing fasciitis, its causes, its complications, its treatment and long-term effects."

Id. at 18-19. He testified that he has also reviewed medical literature on necrotizing fasciitis. He testified that necrotizing fasciitis affects the soft tissues, and does not affect the skin, bone, or joint. *Id.* at 20. It affects the fascia which is the layer between various muscles and will destroy and liquify those tissues. *Id.* Dr. Karlsson testified that he did not see any relationship between Petitioner's infection and her alleged work injury. *Id.* at 23.

Dr. Karlsson testified that there is no relationship between Petitioner's infection and the proposed knee replacement because the infection did not involve the knee joint and the type of bacteria involved also did not involve the knee joint. *Id.* at 38. He testified that the infection involved the soft tissues around the joint so nothing relating to the infection that would worsen Petitioner's arthritis. *Id.* He believed Petitioner reached MMI approximately three months after her arthroscopy and manipulation. *Id.* at 48. He is not licensed in infectious disease medicine. *Id.* at 63. He testified that it is impossible for anyone to say with certainty how the infection came about. *Id.* at 85.

Conclusions of Law

Petitioner bears the burden of proving every element of her case by a preponderance of the evidence. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 203 (2003). After carefully considering the totality of the evidence, the Commission reverses the Arbitrator's denial of the causal relation of Petitioner's current condition of ill-being and prospective medical benefits. The Commission modifies the Arbitrator's award of medical benefits and temporary total disability benefits. The Commission otherwise affirms and adopts the remainder of the Arbitrator's Decision.

After weighing the evidence, the Commission concludes that Petitioner met her burden of proving her current condition of ill-being is related to the work accident. The Commission finds the most credible evidence proves Petitioner suffered a twisting injury to her right knee that aggravated her preexisting degenerative knee condition. The Commission also finds the mechanism of injury supports a finding that Petitioner sustained a medial meniscal tear and at a minimum aggravation of a possible preexisting ACL tear. Unfortunately, less than ideal medical treatment and diagnoses within the first month after the work accident significantly impacted the trajectory of Petitioner's condition. The events leading up to and during Petitioner's eventual hospitalization on July 28, 2015, allowed an undiagnosed infection in Petitioner's right leg to fester and worsen. By the time Petitioner received proper treatment she was septic. There is no dispute that the infection and subsequent procedures to remove necrotic tissue in Petitioner's right leg significantly worsened her condition.

Both parties submitted expert opinions regarding whether the necrotizing fasciitis and leg cellulitis are causally related to the work accident. While both Drs. Poepping and Karlsson were credible, the Commission found the opinions of Dr. Poepping the most compelling given the medical evidence. The Commission notes that neither doctor is a specialist in infectious processes in general or necrotizing fasciitis specifically. Each doctor testified to some level of familiarity with necrotizing fasciitis, with Dr. Karlsson having the most experience treating the condition. Both doctors acknowledge the difficulty in determining the specific cause of the infection and Respondent's expert, Dr. Karlsson, testified that there is no way to truly know how the infection began. While we may be unable to determine how Petitioner's infection began, a review of Petitioner's condition up to her hospitalization on July 28, 2015, supports the opinion of Dr. Poepping.

Although the infection was not diagnosed until almost two months after the work accident, there is evidence that Petitioner began exhibiting signs of infection soon after her injury. The Commission agrees with Dr. Poepping's opinion that Petitioner likely developed a hematoma in her leg due to the work injury and this led to swelling and eventually the infection. Almost immediately, doctors noted effusion of the right knee and swelling. Doctors noted increasing effusion and swelling around the right knee throughout June and early July. In fact, the June 11, 2015, MRI of the right knee revealed three key findings relevant to this issue: 1) edema in the vastus medialis and lateralis muscles; 2) extensive soft tissue edema/contusion in the popliteal fossa and subcutaneous tissues predominantly along the later joint line; and, 3) knee joint effusion with gross distension of suprapatellar bursal space. (PX6). The irrefutable evidence that Petitioner immediately had findings of edema and effusion lends credence to Dr. Poepping's theory regarding the cause of the infection. Dr. Poepping testified,

> "...I believe that she had edema in her thigh musculature on her MRI with her initial injury. She had swelling in that area, and this subsequently led to my opinion a hematoma in that area that is prone to infection unfortunately. And it fits very well with her course, meaning she didn't have any signs of infection when I first saw her. And as time went by, she developed that symptomatology."

(PX29 at 43).

The credible evidence leads the Commission to conclude that Petitioner did not suffer from right knee pain, edema, and/or effusion prior to the work accident. Immediately following the accident, she began to develop swelling and effusion. The office visit notes show the swelling and effusion were significantly worsening. As the swelling and effusion progressed, Petitioner developed an infection leading to necrotic fasciitis. Due to the chain of events from June 2, 2015 until July 28, 2015, the Commission finds Petitioner more likely than not developed the debilitating infection due to the swelling and fluid buildup she sustained as a result of the work accident. Both Drs. Poepping and Karlsson agree that the necrotic fasciitis and subsequent debridement surgeries have contributed to Petitioner's current condition. Therefore, the Commission finds Petitioner's current condition of ill-being regarding her right knee is causally related to the work accident.

As Petitioner's current condition is causally related to the work accident, the Commission must modify the Arbitrator's denial of certain medical expenses. The Arbitrator correctly determined that all of Petitioner's treatment through the date of hearing was reasonable and necessary. However, the Arbitrator concluded Respondent is not liable for the medical expenses. The Commission views the evidence differently and finds the medical treatment Petitioner received through the date of hearing was reasonable, necessary, and causally related to the work accident. Therefore, Respondent is liable for the outstanding medical bills submitted by Petitioner. The Commission acknowledges that the Illinois Department of Healthcare and Family Services paid certain medical bills at significantly reduced rates for a total of $61,086.66 and claims a lien in that amount. However, the Commission does not have jurisdiction to adjudicate the lien.

The Commission must also reverse the Arbitrator's denial of prospective medical treatment. As already discussed, Petitioner's current condition is causally related to the work accident. The Commission finds the infection and subsequent related surgeries at a minimum contributed to Petitioner's need of the right total knee replacement Dr. Poepping continues to recommend. Therefore, Petitioner is entitled to the requested right total knee replacement and Respondent shall pay the associated medical expenses.

Finally, the Commission modifies the Arbitrator's award of temporary total disability benefits. Dr. Poepping has treated Petitioner since June 12, 2015. He is the most familiar with Petitioner's condition and her work capabilities. Dr. Poepping testified that he has never cleared Petitioner to return to work in any capacity. The medical records corroborate the doctor's testimony and provide additional evidence that Petitioner has been unable to work since her injury. Petitioner has an average weekly wage of $266.72; consequently, the minimum temporary total

disability rate of $220.00 is applicable. After carefully reviewing the evidence, the Commission finds Petitioner is entitled to temporary total disability benefits from June 2, 2015 through September 22, 2017, or 120-4/7 weeks. The Commission finds Petitioner is entitled to $26,525.62. As Respondent is entitled to a credit of $6,160.00 for benefits previously paid; thus, Respondent shall pay $20,365.62 in temporary total disability payments to Petitioner.

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 December 8, 2017, is modified as stated herein.

IT IS FURTHER ORDERED that Petitioner's current condition of ill-being relating to her right knee is causally related to the June 1, 2015, work accident.

IT IS FURTHER ORDERED that Respondent shall pay reasonable and necessary medical charges that relate to the work accident, as provided in Sections 8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED that Respondent shall approve and pay for reasonable and necessary prospective medical treatment in the form of the total right knee replacement recommended by Dr. Poepping.

IT IS FURTHER ORDERED that Respondent shall pay Petitioner temporary total disability benefits of **$220.00**/week for **120-4/7** weeks, commencing **June 2, 2015** through **September 22, 2017**, as provided in Section 8(b) of the Act. Respondent shall receive a credit in the amount of $6,160.00 for temporary total disability benefits previously paid to Petitioner.

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

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

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

19IWCC0180

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $70,000.00. 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.

APR 3 - 2019

DATED:

o: 1/29/2019
TJT/jds
51

Thomas J. Tyrrell

Michael J. Brennan

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

RIVERA, CARMEN
Employee/Petitioner

Case# **15WC018868**

SHREE DUTT INC DBA DUNKIN DONUTS
Employer/Respondent

19IWCC0180

On 12/8/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.45% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2512 THE ROMAKER LAW FIRM
CHARLES P ROMAKER
211 W WACKER DR SUITE 1450
CHICAGO, IL 60606

0507 RUSIN & MACIOROWSKI LTD
GLENN A BLACKMON
10 S RIVERSIDE PLZ SUITE 1925
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

19IWCC0180

Carmen Rivera
Employee/Petitioner

Case # 15 WC 18868

v.

Consolidated cases:

Shree Dutt, Inc. dba Dunkin Donuts
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 Arbitrator Andros, Arbitrator of the Commission, in the city of Chicago, on 8/18/17 and 9/22/17. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were Petitioner's earnings?

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

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

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

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

L. ☒ What temporary benefits are in dispute?

☐ TPD ☐ Maintenance ☒ TTD

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

N. ☐ Is Respondent due any credit?

O. ☒ Other whether the video evidence Rx. 7 is admissible under Doctrine of Completeness.

FINDINGS 19 IWCC0180

On the date of accident, 6-1-15, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $13,869.94; the average weekly wage was $266.72.

On the date of accident, Petitioner was 50 years of age, single, with 0 children under 18.

Respondent is not ordered to pay all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $6,160.00 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $6,160.00.

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

ORDER

The Arbitrator finds that Petitioner did sustain an accident that arose out of and in the course of her employment as alleged on June 1, 2015.

The Arbitrator finds Petitioner's condition of ill-being is unrelated to an accident arising out and in the course of her employment. Therefore, the claim for benefits is denied. All other issues are rendered moot.

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

#001 Arb. George J. Andros December 7, 2017

Signature of Arbitrator Date

DEC 8 - 2017

CARMEN RIVERA V. SHREE DUTT INC. dba DUNKIN DONUTS / BASKIN

FINDINGS OF FACT 15 WC 018 868

The parties stipulated that on June 1, 2015, the SHREE DUTT INC. d/b/a DUNKIN DONUTS/BASKIN (Hereinafter "Dunkin Donuts"), was operating under and subject to the provisions of the Act, and that an employee-employer relationship existed between Respondent and Petitioner. (*See* Request for Hearing Form, Arbitrator's Exhibit 1). The parties also stipulated that Petitioner gave timely notice of the accident within the time limits stated in the Act. The parties also stipulated that Petitioner's earnings for the year preceding the accident were $13,869.94 and that her average weekly wage was $266.72.

The parties also stipulated that Petitioner was 50 years old, single, with no dependent children. (Id.) This matter was tried on August 18, 2017 and September 22, 2017. On August 18, 2017 Petitioner testified and Owner Ravi Pandya testified for the Respondent. Petitioner submitted Exhibits 1 through 33 and all Petitioner's Exhibits were admitted into evidence. (Trans. August 18, 2017 at p. 5-7) Respondent's submitted Exhibits 1 through 6 and 8 through 13 and Respondent's Exhibits 1 through 5 were rejected, Exhibits 6, 8 and were admitted into evidence and Respondent's Exhibits 10 through 13 were rejected. (Trans. at p. 228-257)

PETITIONER'S TESTIMONY

On August 18, 2017, The Petitioner testified. (*See* Trans. at p. 13 and Request for Hearing Form, Arbitrator's Exhibit 1 at Paragraph 6). Petitioner testified that prior to the work accident of June 1, 2015, that she never injured nor had any pain or problems with her right leg or right knee. (Trans. at p. 13)

Petitioner testified that on June 1, 2015, she was working for Shree Dutt commonly known as Dunkin Donuts and that she worked on the cash register, salesperson and maintenance of the store. (Trans. at p. 13) Petitioner testified that on June 1, 2015 she started work at 1:00 pm and was supposed to work to 6:00 pm, but that she worked until 8:15 pm because there were so many customers that day. (Trans. at p. 13-14)

Petitioner testified that the work accident happened at Dunkin Donuts between 3:00 pm and 4 pm on June 1, 2015. (Trans. at p. 15) Petitioner further testified that on June 1, 2015 between 3:00 pm and 4:00 pm she was serving some cold coffee to a customer and when she turned to walk to hand the coffee to a customer, her right foot stuck to the floor and she twisted her right knee. (Trans. at p. 15) The accident was behind the cash register in the area of the iced coffee machine. (Trans. at p. 73)

Petitioner attempted to turn around so she could give a drink to a customer when the accident occurred. (Trans. at p. 76) The bottle of caramel was in front of the iced coffee machine. (Trans. at p. 77) There is a basket where you put the bottles and the bottles have a pump on it that faces the floor. (Trans. at p. 77)

Petitioner testified that the caramel was constantly spilled on the floor because the bottle it was in leaks. (Trans. at p. 78) When the Petitioner stepped onto the caramel it was sticky. (Id.) After the accident, the Petitioner felt pain in her right knee. (Id.)

After the accident on June 1, 2015, Petitioner continued to work until 8:15 pm. (Trans. at p. 16) Between 3;00 pm and when she left at 8:15 pm, Petitioner noticed that her right knee was swelling up and became very painful. (Trans. at p. 17) When Petitioner got home after work, her right leg was swollen and she had trouble getting her pants off because her right leg was so swollen. (Trans. at p. 16) When Petitioner woke up on June 2, 2015, her right knee was very swollen and she had excruciating pain to the point she could not stand up. (Trans. at p. 17)

On June 2, 2015, Petitioner called a co-worker to cover her shift at Dunkin Donuts and called and left a message to the Manager Kapil that she was going to the emergency room to seek medical attention for her right knee injury. (Trans. at p. 18) After leaving the emergency room, on June 2, 2015, Petitioner spoke to the manager Kapil and told him that as she was going to turn to give the coffee to the customer, her right leg got stuck on the caramel on the floor and she twisted her right knee and that she had pain. (Trans. at p. 22-23) Of note to the Arbitrator, Kapil did not testify for Respondent in rebuttable to Petitioner's testimony regarding accident issue.

Petitioner testified that she turned from the cold drink machine and her foot stuck to caramel on the floor on cross. (Trans. at p. 75-76) The caramel was in a bottle and it dripped onto the floor. (Trans. p 76-77) She also testifies that the caramel constantly dripped on the floor. (Trans. at p. 78)

On rebuttal Petitioner was asked about her conversation with Mr. Pandya on the she told Mr. Pandya how the accident occurred when she picked up her check a few days after the accident. (Trans. at p. 160-161) Petitioner told Mr. Pandya that she was serving iced coffee to a customer and when she went to turn around to hand the customer the coffee, her right foot/leg got stuck to the floor and when she turned around to hand in the coffee she twisted her right knee and she began to have right knee pain. (Trans. at p. 161) Petitioner denied telling Mr. Pandya that her right knee locked up. (Id.)

Petitioner also denied ever telling Mr. Pandya that the accident occurred at 8 pm on June 1, 2015. (Trans. at p. 163) She testified she told Mr. Pandya that the accident happened between 3:00 pm and 4:00 pm. (Id.) Petitioner also testified that the caramel container did leak a small amount and fell onto the floor. (Trans. at p. 163-165)

Petitioner testified at hearing she cannot push off with her right leg, has to use assistive devices to walk up flights of stairs and wears a right leg immobilizer. (Tr. 58) she bears a huge curvilinear scar on her right knee and right inner thigh;the photo of Petitioner's right leg taken in July of 2017 was entered into evidence at p. 60-62 and PX 32) As a result of the 6/1/2015 work accident and the injuries to her right knee and right leg, Petitioner's life has totally changed since she cannot bend down to put her socks and shoes on, her right leg is always numb and swollen; she cannot walk properly. (Trans. at p. 64) Petitioner walks with a limp and she has a huge hole in her right thigh where they took out the infection. (Trans. at p. 64)

RESPONDENT WITNESS

Respondent called Manager Ravi Pandya to testify. The Arbitrator vividly recalls the assurance the witness projected that 1) caramel syrup is much too expensive to allow it drip on the floor, the syrup bottles are in a bin and can not drip downward onto the floor and the floors are always devoid of spills. On cross examination Mr. Pandaya admitted that Petitioner told him she was walking and her knee locked up. (Trans. at p. 139) Mr. Pandya admitted that Petitioner was working when she was walking. However, he noted her knee locked up but that he did not hear about her turning or about the caramel on the floor. (Trans. at p. 139) He was not on site.

Petitioner did tell Mr. Pandya that she was walking, her knee locked up and she hurt her knee during her work at Dunkin Donuts. (Trans. p. 140-141) At this point, the Arbitrator notes the Petitioner testifying the syrup does shoot out of the nozzle onto the floor. Moreover, given the goal of quick service, walking back and forth to the service counter, etc., that spills do in fact occur. She has worked at other outlets of Dunkin Donuts for many many years. The mechanics of the knee occurrence is a factual dispute.

Mr. Pandya also testified at trial that parts of the surveillance video of June 1, 2015 he viewed showed Petitioner limping on the date of the accident. (Trans. p. 141) Dr. Karlsson testified that Petitioner was seen on the video limping with a stiff-legged gait on the right consistent with knee pain. (RX6 at p. 82) Mr. Pandya also testified at trial that parts of the surveillance video of June 1, 2015 he viewed showed Petitioner limping on the date of the accident. (Trans. p. 141) Dr. Karlsson testified that Petitioner was seen on the video limping with a stiff-legged gait on the right consistent with knee pain. (RX6 at p. 82)

More specifically, Mr. Pandya testified that he has worked for the respondent for around 10 years. At the time of the accident on June 1, 2015, he managed three stores. (T. 144). As general manager, his job duties included hiring and firing of employees, training employees, training managers, record keeping, operating the floor, cleaning, and everything to do with operation of the restaurant. He testified that he was familiar with the day-to-day operations of all the Dunkin Donuts locations he managed. (T. 95). He testified that he was familiar with the layout and operations of the store where the accident occurred on June 1, 2015. (T. 96). He interviewed and hired petitioner. He testified that petitioner worked at the store for approximately two or three months prior the alleged accident on June 1, 2015. (T. 96).

Mr. Pandya testified that he initially heard about the accident from the store manager, Kapil. Mr. Pandya testified that he did not speak to petitioner on June 2, 2015. (T. 143). He testified that he that he had a phone conversation with petitioner three to four days after the June 1, 2015 accident. (T. 97-99). Mr. Pandya testified that petitioner reported the circumstances of the accident to him during this telephone conversation. According to Mr. Pandya, petitioner stated that she was in the service area behind the counter on June 1, 2015. She was walking and her knee bent backwards. She stated to Mr. Pandya that "it just happened. It's one of these things that just happened." (T. 99). Mr. Pandya testified that petitioner never mentioned caramel or a twisting injury during this telephone conversation three to four days after the accident. (T. 99, 140). Mr. Pandya testified that petitioner gave him an approximate time of the accident during this telephone conversation. (T. 106, 158).

Mr. Pandya testified that after speaking to petitioner, he immediately conducted an investigation into the alleged work accident. In addition to speaking to petitioner, he spoke to the manager at the time, Kapil, and the employees on duty that day. (T. 100-101). He testified that he confirmed that timing of the accident on June 1, 2015 with these employees. (T. 106, 158).

Mr. Pandya testified regarding cameras inside the Dunkin Donuts store. He testified that these cameras continually record activities inside the store. (T. 104-105). He testified that he reviewed the footage from inside the store on June 1, 2015. Mr. Pandya testified that he reviewed eight hours of footage from inside the store. Mr. Pandya testified that he identified the relevant time period in the store video, based on his conversations with petitioner and his interviews with the store manager and other employees on duty on June 1, 2015. (T. 105-106).

Mr. Pandya testified that he pulled the time frame of the accident based on these conversations including petitioner's representations. He did not secure the entire 8-hour shift onto a disk because of storage limitations. (T. 106-107). He testified that he obtained footage from the store's system from the date of the accident through a program called evidence reviewer. (T.111) He testified that the video shows the activities inside the store on June 1, 2015 between the end of the 7:00 hour and crossing over into the 8:00 hour, P.M. (T. 112-113). He testified that the video he secured through the evidence reviewer program on the date of the accident includes a date and time stamp that cannot be altered. (T. 114, 115-116). The footage from inside the store was offered as Respondent's Exhibit 7.

Mr. Pandya testified the Ms. Rivera came into the store at the next payroll pickup date in June, 2015 to pick up her check. Mr. Pandya and Kapil spoke to her when she came. This was approximately 7-10 days after their initial phone conversation. (T. 120-121). Petitioner told Mr. Pandya during this face-to-face conversation that she was walking toward the front and her knee kind of locked up and bent the wrong way. She stated to Mr. Pandya that it just happened. Petitioner did not mention caramel during this conversation. (T. 122).

Mr. Pandya testified regarding the caramel referenced by Petitioner. Mr. Pandya testified that if there was caramel on the floor you would be able to see it on the floor. (T.123). He testified that he did not observe caramel on the floor on the video he reviewed from the date of the accident. (126).

Mr. Pandya testified that he has worked in the store at issue since 2004. He stated that he worked the floor. He made drinks. He helped customers. He operated the cash registers. (T. 125). He testified that he worked at each of the stores he managed at least three times a week, including the store where the alleged accident occurred on June 1, 2015. (T. 145). Mr. Pandya testified that he was sometimes required to work up to ten hours a day in a particular store. (T. 154). He admitted that he was not in the store in question on the date of the accident of June 1, 2015, but was likely in the store several days that week. (T. 153).

Mr. Pandya testified that he had never seen caramel drip or continuously leak onto the floor. (T. 126, 131). He testified that it would be impossible for the bottle to leak by itself. He testified that the pumping mechanism doesn't allow it. (T. 126.). He testified that the only time caramel will come out of the spout is when someone is actively pumping and there is something under it. (T. 106, 158).

Mr. Pandya testified that he had never seen caramel drip or continuously leak onto the floor. (T. 126, 131). He testified that it would be impossible for the bottle to leak by itself. He testified that the pumping mechanism doesn't allow it. (T. 126.). He testified that the only time caramel will come out of the spout is when someone is actively pumping and there is something under it. (T. 147, 149). Mr. Pandya testified that if someone pumps the spout with nothing under it, it will land on the bottle or on the service counter, not the floor. (T. 150). He has never seen caramel spilled on the floor in the Dunkin Donuts store. (T. 151-152).

In addition, Mr. Pandya testified that the Dunkin Donuts is a service restaurant and the goal was efficiency. If something was leaking, like cream out of a machine or caramel out of a bottle, this would be a direct cost to the store. It would be remedied immediately. He testified that leaking caramel would not be allowed. (T. 128) . Mr. Pandya testified that if someone pumps the spout with nothing under it, it will land on the bottle or on the service counter, not the floor. (T. 150). He has never seen caramel spilled on the floor in the Dunkin Donuts store. (T. 151-152).

PETITIONER REBUTTAL

On rebuttal Petitioner was asked about her conversation with Mr. Pandya; she told Mr. Pandya how the accident occurred when she picked up her check a few days after the accident. (Trans. at p. 160-161) Petitioner told Mr. Pandya that she was serving iced coffee to a customer and when she went to turn around to hand the customer the coffee, her right foot/leg got stuck to the floor and when she turned around to hand in the coffee she twisted her right knee and she began to have right knee pain. (Trans. at p. 161) Petitioner denied telling Mr. Pandya that her right knee locked up. (Id.)

Petitioner also denied ever telling Mr. Pandya that the accident occurred at 8 pm on June 1, 2015. (Trans. at p. 163) She testified she told Mr. Pandya that the accident happened between 3:00 pm and 4:00 pm. (Id.) Petitioner also testified that the caramel container did leak a small amount and fell onto the floor. (Trans. at p. 163-165)

SUMMARY / REVIEW OF HISTORIES IN MEDICAL RECORDS

Petitioner gave the same history of accident to the ER doctor at Community First Hospital, Mercy Medical Center on two occasions, Dr. Murtaza and Dr. Poepping in their initial visits. On June 2, 2015, Petitioner told the doctor at Community First Hospital that she was at work when she moved her foot on the floor and felt something give in her knee and that was at around 3:00 pm yesterday at work. (PX1 at p. 7) Petitioner testified that she told the ER doctor that she heard her right knee crack at the time of the accident. (Trans. at p. 19)

After Petitioner went to Community First Hospital she went to her employer right after the visit to the emergency room on June 2, 2015 and she spoke to the manager Kapil. (Trans. a p. 22) She told Kapil that she had an accident on June 1, 2015 and gave him the papers from the hospital. (Trans. at p. 23)

On June 4, 2015 Petitioner went to Mercy Medical and complained of right knee pain which she sustained at her job. (PX3 at p. 4) On June 6, 2015, Petitioner returned to the emergency room at Mercy Medical. (PX3 6/6/2015 visit at p. 3-5) The ER record stated that "she twisted her right knee at work on 6/1/2015. She states she felt it twist, had no pain for the first 1 hour, and then it started to swell and she was feeling it give out as she walked. Throughout that day the swelling and pain increased and it reached maximum intensity at about approximately 3 am. No past medical history on file." (PX 3 June 6, 2015 at p. 3) The ER Dr. Culen Kehoe stated that he suspected she has a ligamentous injury of her right knee and she may need an MRI and surgery. (PX 3 June 6, 2015 at p. 4)

On June 11, 2015, Petitioner went to see Dr. Murtaza at Illinois Orthopedic Network. (PX4) Petitioner told Dr. Murtaza that she was injured at work on June 1, 2015 she took a step and her right foot was anchored. (PX4 at 6/11/2017 Note)

On June 12, 2015, Petitioner told Dr. Poepping that she injured her right knee on June 1, 2015 while at work at Dunkin Donuts when her right foot got stuck on the floor on some caramel and she twisted her right knee. (PX8 at p. 1)

RESPONDENT'S EXHIBITS

Respondent admitted Exhibit Rx. 6 being the testimony at deposition of Dr. Troy Karlsson. (See Trans. Pp.224-229, 230) Respondent's Exhibit 7 was the store video and the Arbitrator reserved ruling as to its admission, as Issue O. (Trans. p. 231-232) Respondent's Exhibits 8 and 9 were State Farm's Payment List (RX8) and Response to Petitioner's Penalties Petition (RX9) were both admitted. (Tp. 232-235)

All admitted medical evidence from both sides has been reviewed and the contents of the admitted records & admitted reports and depositions have been taken into careful consideration in the issuance of the Award. The medical evidence in particular is extremely complex.

In review, even the existence of a blister has been brought to bear in the hearing. Petitioner testified that she did not have any cuts lacerations or blisters at any time. (Trans. at p. 36) Dr. Poepping testified that Petitioner did not have a cut or blister at any time he saw her. (PX29 at p. 61) Dr. Poepping testified that even if there was a blister, it was most likely caused by the swelling not the other way around. (PX29 p. 64)

Dr. Karlsson initially testified that a (the blister was) a likely site of allowing the bacteria to get through the barrier of the skin and set up infection. (RX6 at p.25) But then Dr. Karlsson was later asked if the infection caused the blister and he said "It's a possibility." (RX6 at p84-85) Dr. Karlsson also said there would have to be a break or weakness of the skin for an infection to enter there. (Id.) Dr. Karlsson testified that it is impossible to testify with any certainty how the infection came about. (RX6 p. 85) He also testified that it would be speculating to say how the infection occurred. (RX6 at p.79)

As to the video surveillance digital evidence, the general manager's testimony regarding the unavailability of the vast majority of the day's video surveillance recordation is very troublesome. The witness testified that the download of the same was limited because , as for him, it was essentially too impractical to transfer the large download into a file (Arbitrator summary). Thus the Respondent manager choose to edit the download to the limited time that he thought was relevant. By omission, he did present nor give reasonable excuses , so to speak, why the professional video company come to the hearing to present the full day, with more sophisticated technology

MEDICAL TREATMENT

After speaking with the Manager Kapil on June 2, 2015, Petitioner went to the emergency room at Community First Medical Center, previously known as Our Lady of Resurrection Hospital for medical care. (Trans. at p. 18) Petitioner told the doctor at Community First Hospital that she was at work when she moved her foot on the floor and felt something give in her knee and that was at around 3:00 pm yesterday at work. (PX1 at p. 7) Petitioner testified that she told the ER doctor that she heard her right knee cracked at the time of the accident. (Trans. at p. 19) The ER doctor diagnosed Petitioner with a right ACL and meniscal tear of the right knee and discharged Petitioner with crutches and an immobilizer and placed Petitioner off work. (PX1 at. p.8 and p. 10 and Trans. at p. 21)

After Petitioner went to Community First Hospital she went to her employer right after the visit to the emergency room on June 2, 2015 and she spoke to the manager Kapil. (Trans. a p. 22) She told Kapil that she had an accident on June 1, 2015 and gave him the papers from the hospital. (Trans. at p. 23) Kapil did not testify for the Respondent.

On June 4, 2015 she went to Mercy Medical and complained of right knee pain which she sustained at her job. (PX3 at p. 4) The ER doctor noted Petitioner had right knee tenderness and swelling with limited range of motion of the right knee. (PX3 at p. 4) The ER doctor gave Petitioner pain medications and placed Petitioner off work. (PX3 at p. 10-11 and Dr. Note)

On June 6, 2015, Petitioner returned to the emergency room at Mercy Medical. (PX3 6/6/2015 visit at p. 3-5) The ER record stated that "she twisted her right knee at work on 6/1/2015. She states she felt it twist, had no pain for the first 1 hour, and then it started to swell and she was feeling it give out as she walked. Throughout that day the swelling and pain increased and it reached maximum intensity at about approximately 3 am. No past medical history on file." (PX 3 June 6, 2015 at p. 3) The ER Dr. Culen Kehoe stated that he suspected she has a ligamentous injury of her right knee and she may need an MRI and surgery. (PX 3 June 6, 2015 at p. 4)

On June 11, 2015, Petitioner went to see Dr. Murtaza at Illinois Orthopedic Network. (PX4) Petitioner told Dr. Murtaza that she was injured at work on June 1, 2015 she took a step and her right foot was anchored. (PX4 at 6/11/2015 Note) Petitioner's right knee was swollen up twice the size of the left one. (Id.) Dr. Murtaza diagnosed Petitioner with right knee pain and a possible ligamentous tendon injury and referred her for a right knee MRI. (PX4 at 6/11/2015 Note) Dr. Murtaza also stated that "Petitioner will not be able to work at this this time until further evaluation and treatment is done." (PX4 at 6/11/2015 Note)

On June 11, 2015, Petitioner had an MRI of the right knee at Molecular Imaging upon Dr. Murtaza's referral. (PX6) The results of the MRI of the right knee were:

> Tear anterior cruciate ligament, Mild extrusion of the body of the medial meniscus, edema noted in the vastus medial and lateral medialis muscles, which are the thigh muscles and extensive soft tissue edema/contusion noted in the popliteal fossa. (PX6 at p. 2)

On June 12, 2015, Petitioner saw Dr. Thomas Poepping upon referral of Dr. Murtaza. (PX8 and PX4 at 6/11/2015 Treatment Orders "Orthopedic Consultation") Petitioner told Dr. Poepping that she injured her right knee on June 1, 2015 while at work at Dunkin Donuts when her right foot got stuck on the floor on some caramel and she twisted her right knee. (PX8 at p. 1)

Dr. Poepping stated that his examination of Petitioner's right knee that it showed a large effusion with medial joint tenderness. (PX8 at p. 1) Dr. Poepping's diagnosis was right knee ACL rupture, right knee medial meniscal tear and right knee posterolateral corner injury. (PX8 at p. 2) Dr. Poepping gave Petitioner a hinged brace and prescribed physical therapy even though her fascia was very stiff. (Id.) Dr. Poepping placed Petitioner off work on June 12, 2015. (PX 29 Dr. Poepping's Deposition at p. 10-11) When Petitioner saw Dr. Poepping her right leg was swollen and turning red in color. (Trans. at p. 28)

On June 23, 2015, Petitioner returned to see Dr. Poepping. (PX 4 at 6/23/2015 Note) Dr. Poepping noted Petitioner had right knee swelling and felt nauseated. (Id.) He changed Petitioner's medications and kept her off work. PX4 at 6/23/2015 Note)

Thereafter Petitioner went to H&M Medical for physical therapy on her right knee/right leg beginning July 6, 2015. (Trans. at p. 28 and PX 9) On July 19, 2015, Petitioner went to St. Mary of Nazareth ER complained of 2-3 days of nausea and vomiting, up to 5 times a day. (PX 11 at p. 4) Petitioner testified that she began to feel worse after seeing Dr. Poepping she began to throw up and having fevers. (Trans. at p. 29) On July 25, 2015, Petitioner went to Cook County Hospital complaining of right knee pain. (PX12)

On July 28, 2015, Petitioner returned to see Dr. Poepping and Dr. Poepping noted that there was obvious swelling of the right thigh with redness medially extending up the right medial thigh. (PX4 at 7/28/2015 Note) This swelling was in the same location of the vastus medialis where the swelling was initially noted on the MRI of June 11, 2015. (PX6) Dr. Poepping testified that on July 28, 2015 Petitioner's right thigh was indurated, which that it was very hard and swollen. (PX29 at p.14) Dr. Poepping placed Petitioner off work on July 28, 2015. (PX4 at 7/28/2015 Note) Based upon his examination, Dr. Poepping immediately sent Petitioner to St. Anthony Hospital Emergency Department. (PX4 at 7/28/2015 Note and PX 29 at p. 15)

Petitioner testified that on July 28, 2015 when she saw Dr. Poepping that her right thigh and right knee was red and black from the right thigh down to her shin. (Trans. at p. 31-34) On July 28, 2015, Dr. Poepping immediately sent Petitioner to St. Anthony Hospital once he saw her right leg condition. (Trans.34-35)

On July 28, 2015, Petitioner went to St. Anthony Hospital ER. (PX13) Petitioner told the ER doctor at St. Anthony's Hospital that she injured her right knee on June 1, 2015 at work and that she had seen an Ortho who sent her to the emergency room. (PX13 Progress Note) Petitioner was diagnosed with cellulitis and septic right knee. (PX13 Progress Note) An X-Ray was taken which demonstrated a large right knee effusion with gas gangrene. (PX 13 X-Ray report of Right Knee)

On July 29, 2015, underwent another MRI of the right lower extremity and Dr. Jared Browning (Radiologist) authored the MRI report and *inter alia* stated:

> There is a partially visualized subcutaneous fluid collection adjacent to the vastus medialis muscle extending down to the medial patella retinaculum. The visualized portion measures up to 10.6 x 3.3 cm. There is an extension of a portion of this collection posterior to the femur into the upper aspect of the popliteal fossa.
>
> Fluid collections with internal gas locules seen within the media; subcutaneous soft tissues and within the superior posterior compartment leg musculature, consistent with large abscesses.
>
> (PX13 MRI Report of 7-29-2015 and attached hereto)

On July 29, 2015, Petitioner had the first surgery performed by Dr. Sompali at St. Anthony Hospital. (PX13A) Dr. Sompali made a 12 cm incision on the medial aspect of the right thigh from the inferior pole of the patella down toward the right shin, where significant necrotic

tissue was excised using scissors, a blade and a ronguer and 300 milliliters of pus/purulent fluid was drained out. (PX13A at 7/30/2015 operative report) Dr. Sompalli next made a 10 cm incision was made in the medial right thigh and he debrided significant necrotic tissue from the right thigh and drained 100 milliliters of pus/purulent fluid. (Id.)

On August 3, 2015, Dr. Sompali performed a second surgery on Petitioner's right leg for the condition he now diagnosed as necrotizing fasciitis. (PX13A at 8/3/2015 operative report) Dr. Sompalli re-opened the same incision and he excised an 8cm area of the right inner thigh that still had necrotic tissue *involving muscle* and fascia of the right inner thigh. (Id.) The muscle excised was the vastus medialis muscle, which contained edema on the June 1, 2015 and July 28, 2015 right leg MRIs. (PX13A at 8/3/2015 operative report and PX6 MRI of Right leg of 6/11/2015)

Petitioner had a photograph taken of her right leg immediately after the surgery on 8/3/2015. (PX31) That photograph demonstrates the incisions of the right lower leg area and the right inner thigh area, which is the same area where there was swelling was noted on the 6/11/2015 right leg MRI. (Trans. at p. 40-41 and PX6 MRI of Right leg of 6/11/2015)

Petitioner testified that prior to the work accident she never had any infection in her right leg or right knee. Petitioner also testified that the area where Dr. Sompalli took out the tissue in her right leg on July 30, 2015 and August 3, 2015 was the same area where she had swelling right after the accident. (Trans. at p. 42-43)

On August 7, 2015, Dr. Sompalli Performed the third right leg surgery upon Petitioner's right leg at St. Anthony Hospital. (PX13A at 8/7/2015 operative report) On that date Dr. Sompalli inspected the right thigh area and found no further necrotic tissue and he irrigated the wound and closed it with nylon sutures. (PX13A at operative report of 8/7/2015)

Petitioner was discharged from St. Anthony Hospital on August 17, 2015 and transferred to Kindred Hospital. (p. 45 and PX15, Kindred Hospital Records) Petitioner testified that she was transferred to Kindred Hospital to do physical therapy to regain movement of her right leg so she could walk again. (p.45) At Kindred Petitioner had daily physical therapy from August 17, 2015 to September 10, 2015. (45-46 and PX15) Petitioner was transported from Kindred back to St. Anthony Hospital on two occasions to see Dr. Sompali. (p. 46 and RX 13) On those occasions she took ambulances to and from St. Anthony Hospital. (PX13, PX15 and PX17)

On September 10, 2015, Petitioner was transferred to Mercy Hospital for further medical care. (p. 46-47 and RX 19) Petitioner had daily physical therapy and two nurses caring for her. (p. 47) On September 22, 2015, Petitioner was discharged from Mercy Hospital and was taken to her home by ambulance. (PX18 and PX19)

On September 23, 2015, a nurse from Interim Health Care visited Petitioner at her home and gave her physical therapy and medications. (PX20) Petitioner received home health care from 9/23/2015 until 10/16/2015. (PX20) . (p. 47-48 and PX20)

On October 13, 2015, she returned to see Dr. Poepping at Illinois Orthopedic. (p. 48 and PX4 at 10/13/2015 Note) she could only flex her right knee to 30 degrees; Dr. Poepping

prescribed PTplus kept Petitioner off work.(PX4 at 10/13/2015 Note) Petitioner saw Dr. Poepping again on 11/17/2015 and 12/29/2015 and was placed off work on both visits. (PX4)

In his 12/29/2015 report, Dr. Poepping stated that there was absolutely no question that the infection in Petitioner's right knee was related to her initial injury and that the infection was likely resulting from a hematoma which was seeded by bacteria. (PX4 at 12/29/2015 Note) Dr. Poepping testified at his deposition that Petitioner's right leg/right knee infection started from a hematoma that occurred in the area of her right leg, which subsequently became seeded by bacteria and became an infection. (PX29, Depo p.25)

Dr. Poepping recommended that Petitioner undergo a manipulation under anesthesia and arthroscopic lysis of adhesions on 12/29/2015. (PX 4 at 12/29/2015 Note) Thereafter Petitioner continued physical therapy at H and M and saw Dr. Poepping on 1/26/2016, 2/23/2016, 4/19/2016, 6/14/2016 and 7/26/2016. (PX4) On each of those visits, Dr. Poepping recommended the arthroscopic surgery and placed Petitioner off work. (PX4)

On August 16, 2016, he performed arthroscopic surgery on Petitioner's right knee. (PX4A) That was Petitioner's fourth surgery on her right leg and right knee. Dr. Poepping performed a manipulation under anesthesia and arthroscopic lysis of adhesions as well as a medial meniscectomy of the right knee. (PX4A and PX 29 at p. 30-32) After the surgery on 8-16-2016, Petitioner's right leg improved to a certain extent. (Trans. p. 51) She was able to walk more and was able to bend her right knee a little bit more. (Trans. p. 52)

After right knee surgery on 8-16-2016, she again saw the doctor on 8/23/2016, 9/6/2016 and 10/4/2016, at which time Dr. Poepping was prescribing physical therapy and ordered Petitioner off work. (PX4) On November 1, 2016, Dr. Poepping again saw Petitioner again and recommended a right total knee replacement surgery. (PX4 at 11/1/2016 Note and PX 29 at p. 37-39) Petitioner was ordered off work; on November 29, 2016 Dr. Poepping again placed Petitioner off work.

Relative to a second opinion, Dr. Poepping referred her to Dr. Gregory Markarian for a second opinion regarding the right total knee replacement surgery. (See PX 4 at 11/29/20016 Recommended Treatment Orders "Referral to Dr. Markarian")

Petitioner saw Dr. Gregory Markarian on 12/7/2016 and 1/18/2017 at the referral of Dr. Poepping of ION. (PX24) On 1/18/2017, Dr. Markarian concurred with Dr. Poepping that Petitioner needs a right total knee replacement surgery. (PX24 at 1/18/2017 Note)

Dr. Poepping saw Petitioner on 1/10/2017, 2/21/2017, 5/2/2017, 6/13/2017, and 7/11/2017. (PX4) Dr. Poepping continues to recommend a right total knee replacement surgery and has kept Petitioner off work. (PX4) Dr. Poepping testified that it is his opinion that Petitioner needs a right total knee replacement because of the stiffness in her right knee as a result of the infection and surgeries;it is really her only option. (PX29 at p.45-46) Further, if Petitioner does not have the right total knee replacement surgery, she will only be able to work in a seated capacity. (PX29, Depo p. 46) Dr. Karlsson , Section 12 expert, testified that Petitioner could work in a primarily sedentary job with walking and standing of up to 4 hours. (PX6 at p. 48)

DR. POEPPING'S EVIDENCE DEPOSITION AND HIS OPINIONS

On March 21, 2017, Dr. Poepping gave his evidence deposition. (PX29) Dr. Poepping first saw Petitioner 11 days after the accident at G&T Orthopedics on June 12, 2015. (PX8) He then saw her from on June 23, 2015 to July 11, 2017 at Illinois Orthopedic Network. (PX4) Petitioner told Dr. Poepping that she had no prior medical problems with her right knee and right leg. (PX29 at 7-8) Dr. Poepping reviewed the 6/11/2015 MRI of the right knee and opined Petitioner had a right ACL tear and a large joint effusion in the musculature of the right quadriceps. (PX29 at p. 9 and p. 13) His diagnosis was that Petitioner had a right ACL tear and a right medial meniscus tear. (PX29)

On July 28, 2015, Dr. Poepping diagnosed Petitioner with a right cellulitis with redness extending up the right medial thigh that was hard and swollen. (PX29 at p. 14) Dr. Poepping immediately sent Petitioner to the St. Anthony Hospital emergency department because he was concerned with the severity of the infection in her right leg. (PX29 at p. 15) Dr. Poepping reviewed the three operative reports from St. Anthony Hospital and explained what was done by Dr. Sompali. (PX29 at p. 19-21) Dr. Poepping opined that the three right leg/right knee surgeries performed by Dr. Sompali in July and August 2015 were caused by and necessitated by the work injury of June 1, 2015. (PX29 at p.43)

Thereafter Dr. Poepping performed the arthroscopic surgery on Petitioner's right knee. (PX4A) That was Petitioner's fourth surgery on her right leg and right knee. Dr. Poepping performed a manipulation under anesthesia and arthroscopic lysis of adhesions as well as a medial meniscectomy of the right knee. (PX4A and PX 29 at p. 30-32)

Dr. Poepping testified that the 8/16/2016 right knee surgery and all his office visits were reasonable and necessary and caused by the work accident of 6/1/2015. (PX29 at p. 44)

Dr. Poepping also opined that Petitioner's right medial meniscus injury was caused by the work accident of June 1, 2015. (PX29 at p. 42) Dr. Karlson agrees that Petitioner's right medial meniscus injury was caused by the work injury. (RX6 at p. 70) in addition, Dr. Poepping also testified that Petitioner's right ACL was caused by or aggravated by the work accident of June 1, 2015. (PX29 a p. 42-43)

Dr. Poepping gave the opinion at his deposition that Petitioner's right leg/right knee infection started from a hematoma that occurred in the area of her right leg, which subsequently became seeded by bacteria and became an infection. (PX29, Dr. Poepping's Deposition at p.25) That area was consistent with the area where Petitioner had swelling initially on the June 11, 2015 MRI. (Id.)

He testified that Petitioner has been unable to work or had seated restriction from 6/12/2015 until the present. (PX29 at p. 45) Office notes also have Petitioner off work from 6/12/2015 to the present. (PX4) Petitioner testified that she has been off work by her doctor's orders from June 2, 2015 to the present. (Trans. at p. 55)

Dr. Poepping opined that Petitioner's needs a right total knee replacement surgery as a result of the 6/1/2015 work accident. (PX29 at p. 45) Petitioner testified that she wants the right total knee replacement surgery so that she has a chance at a normal life again. (Trans. at p. 54) Dr. Poepping testified that if Petitioner does not get the right total knee replacement

surgery she will not be able to work in any capacity other than seated and will not be able to stand for even a half hour at a time. (PX29 at p. 46-47) Dr. Poepping disagrees with Section 12 examiner Dr. Karlsson. Dr. Poepping believes infection in the right knee and right leg was caused by the work accident of 6/1/2015 because there was evidence of it in the 6-11-2015 MRI; Morever, the infection started with the trauma and was seeded by an infection. (PX29 50-51)

Petitioner testified that besides two workers compensation advances, Respondent has not paid TTD from 11/11/2015 to the present. (Trans. p. 57-58 and Arbitrator's Exhibit 1 at par. 8) In addition, Respondent denied payment of $159,411.59 in medical bills. (Arbitrator's Exhibit 1 at attached Bills List) As a result, Petitioner filed a Penalties Petition asking for 19K, 19L and Section 16 Penalties. (PX33) Respondent responded to Petitioner's Penalty Petition in writing and its' stated defense were the opinions of Dr. Troy Karlsson. (RX9) Moreover, Accident was placed in issue with the Respondent presenting the general manager.

DR. TROY KARLSSON'S EVIDENCE DEPOSITION AND OPINIONS

Respondent's Section 12 examiner, Dr. Troy Karlsson, testified by evidence deposition on June 19, 2017. Dr. Karlsson examined petitioner twice, reviewed her records and issued reports April 11, 2016, July 11, 2016, May 5, 2017 and June 7, 2017. (Rx. 6).

In addition to his orthopedic qualifications, Dr. Karlsson testified that has treated infections like the type of infection that petitioner suffered in her right leg. (Rx. 6, pp. 7, 20). Dr. Karlsson testified that there was no relation whatsoever between the infection in the tissues surrounding her knee and the work incident. The infection did not involve the right knee joint. (Rx. 6, p. 23, 80). Dr. Karlsson testified petitioner had a blister on her leg that was the likely site of allowing the bacteria to get through the barrier of the skin and set up the infection. (Rx. 6, p. 25, 58).

Dr. Karlsson also reviewed the video evidence from inside the Dunkin Donuts location on June 1, 2015 and testified that there was no evidence of a work-related injury. (Rx. 6, p. 27).

Dr. Karlsson further stated to a reasonable degree of medical certainty that there was no causal connection between petitioner's condition of the knee and the work accident. He testified that the medial meniscal tear was degenerative in nature. (Rx. 6, p. 29, 35, 58). He testified that the ACL tear was attritional as well and was more consistent with a degenerative tear. Dr. Karlsson testified that neither of these conditions was related to her work accident. (Rx. 6, p. 35).

Dr. Karlsson testified that a knee replacement would be a high risk procedure given petitioner's history of knee problems and infection. He testified that any knee replacement

would be unrelated to the injury or infection as the infection itself was not in the knee joint. The infection would not have worsened her arthritis in her right knee. (Px. 6, pp. 38, 46, 95).

Dr. Karlsson testified on cross-examination that a twisting injury would be a mechanism of injury for a meniscal tear. (Rx. 6, pp 69-70, 87). He testified that while an infection could cause a blister, it is more common for a blister to result from a break in the skin rather than as an effect of the infection. (Rx. 6, p. 84). He testified that a blister represents a loss of integrity of the skin that can lead to an infection. (Rx. 6, p. 84).

He admitted based on information presented by petitioner at the deposition that exact type of bacteria was unclear. He testified on re-direct examination that the infection was in the subcutaneous tissue of the proximal distal thigh and proximal lower left but not the knee joint. (Rx. 6, p. 95).

CONCLUSIONS OF LAW

This is one of the most complex medical legal plus factual cases seen by this Arbitrator in many years. As directed by the Appellate Courts the case is decided by the preponderance of the evidence. At hearing, both sides highlighted each and every point in favor of their position, compensable or not. The Act directs us to prepare a Statement of Facts for each Award; however, given the length of the records one can not site each and every medical point from all the providers and experts. Nevertheless, the identified facts infra are material factual points to highlight the entire record as a whole. By law and my application the Award is based upon the totality of the evidence, not just the highlights above.

Dr. Karlsson also opined that petitioner's ACL tear was the result of a degenerative process. He testified that the complete lack of an ACL visualized on the MRI would be more consistent with a degenerative tear. (Rx. 6, p. 35) Dr. Poepping could only testify that there was some acute

injury to the knee. He could not definitively say that the work accident actually caused the ACL to tear. (Px. 29, 57).

With regard to the infection, Dr. Poepping testified that he was not an infectious disease specialist. He admitted that his specialty was orthopedics. He had seen necrotizing fasciitis less than five times in fifteen years. (Px. 29, p. 65).

Dr. Karlsson testified that he was familiar with these types of infections. (Rx. 6, p. 7, 19). He described the type of infections and the procedures involved. He testified that he is familiar specifically with necrotizing fasciitis, its causes, its complications, its treatment and long term effects. He also testified that he has reviewed medical literature on the subject. (Rx. 6, 19). Dr. Karlsson was more qualified to testify regarding the subject.

Dr. Karlsson testified that the surgeries for the infection did not involve the right knee itself, but rather subcutaneous tissue of the leg. (Rx. 6, pp. 25, 58) Dr. Poepping admitted the same during his cross-examination. (Px. 29, p. 59).

Dr. Karlsson's actually reviewed petitioner's medical records prior to issuing opinions, including the surgical reports and records of Dr. Sompalli. He testified that the source of the infection was a blister on petitioner's leg. Dr. Sompalli described just such a blister on petitioner's right medial tibial area at the time of his initial evaluation of petitioner on July 29, 2015. (Px. 13).

Dr. Poepping testified that the blister was caused by the infection, not the other way around. However, he acknowledged in a November 1, 2016 record as well as at his deposition that an infection like Petitioner's could be caused by even a small break in the skin. (Px. 4; Px. 29, pp. 60, 62).

SUMMARY / REVIEW OF HISTORIES IN MEDICAL RECORDS

Petitioner gave the same history of accident to the ER doctor at Community First Hospital, Mercy Medical Center on two occasions, Dr. Murtaza and Dr. Poepping in their initial visits. On June 2, 2015, Petitioner told the doctor at Community First Hospital that she was at work when she moved her foot on the floor and felt something give in her knee and that was at around 3:00 pm yesterday at work. (PX1 at p. 7) Petitioner testified that she told the ER doctor that she heard her right knee crack at the time of the accident. (Trans. at p. 19)

After Petitioner went to Community First Hospital she went to her employer right after the visit to the emergency room on June 2, 2015 and she spoke to the manager Kapil. (Trans. a p. 22) She told Kapil that she had an accident on June 1, 2015 and gave him the papers from the hospital. (Trans. at p. 23)

On June 4, 2015 Petitioner went to Mercy Medical and complained of right knee pain which she sustained at her job. (PX3 at p. 4) On June 6, 2015, Petitioner returned to the emergency room at Mercy Medical. (PX3 6/6/2015 visit at p. 3-5) The ER record stated that "she twisted her right knee at work on 6/1/2015. She states she felt it twist, had no pain for the first 1 hour, and then it started to swell and she was feeling it give out as she walked. Throughout that day the swelling and pain increased and it reached maximum intensity at about approximately 3 am. No past medical history on file." (PX 3 June 6, 2015 at p. 3) The ER

Dr. Culen Kehoe stated that he suspected she has a ligamentous injury of her right knee and she may need an MRI and surgery. (PX 3 June 6, 2015 at p. 4)

On June 11, 2015, Petitioner went to see Dr. Murtaza at Illinois Orthopedic Network. (PX4) Petitioner told Dr. Murtaza that she was injured at work on June 1, 2015 she took a step and her right foot was anchored. (PX4 at 6/11/2017 Note)

On June 12, 2015, Petitioner told Dr. Poepping that she injured her right knee on June 1, 2015 while at work at Dunkin Donuts when her right foot got stuck on the floor on some caramel and she twisted her right knee. (PX8 at p. 1)

RESPONDENT'S EXHIBITS

Respondent admitted Exhibit Rx. 6 being the testimony at deposition of Dr. Troy Karlsson. (See Trans. Pp.224-229, 230) Respondent's Exhibit 7 was the store video and the Arbitrator reserved ruling as to its admission, as Issue O. (Trans. p. 231-232) Respondent's Exhibits 8 and 9 were State Farm's Payment List (RX8) and Response to Petitioner's Penalties Petition (RX9) were both admitted. (Tp. 232-235)

All admitted medical evidence from both sides has been reviewed and the contents of the admitted records & admitted reports and depositions have been taken into careful consideration in the issuance of the Award. The medical evidence in particular is extremely complex.

ISSUES

Based upon the Stipulation Sheet signed by the Parties, the matters in dispute are as follows:

(C) Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
(F) Is Petitioner's current condition of ill-being causally related to the injury?
(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? If the Arbitrator does not award Petitioner's Total Knee replacement surgery, what is the Amount of Permanent Partial Disability?

(L) What temporary benefits are in dispute? TTD?

(M) Should penalties or fees be imposed upon Respondent?
(O) Should the Video Submitted by Respondent be admitted into Evidence?

(*See* Arbitrator's Exhibit 1, Request for Hearing form and Trans. at p. 9-11).

The parties stipulated that the parties were operating under the Act on June 1, 2015, that Petitioner gave notice of the accident within the time limits stated in the Act, that Petitioner's earnings for the 52 weeks preceding the accident was $13,869.94 and her AWW was $266.72, that Petitioner was 50 years old, single with no dependents and that Respondent had a credit of $6,160.00 for TTD paid.

(*See* Arbitrator's Exhibit 1, Request for hearing form).

CONCLUSIONS OF LAW

This is one of the most complex medical legal plus factual cases seen by this Arbitrator in many years. As directed by the Appellate Courts the case is decided by the preponderance of the evidence. At hearing, both sides highlighted each and every point in favor of their position, compensable or not. The Act directs us to prepare a Statement of Facts for each Award; however, given the length of the records one can not site each and every medical point from all the providers and experts. Nevertheless, the identified facts infra are material factual points to highlight the entire record as a whole. By law and my application the Award is based upon the totality of the evidence, not just the highlights above.

Regarding the issue C "Did an Accident Occur that Arose Out of and in the Course of the Employment by Respondent," the Arbitrator finds the following:

The Arbitrator finds that Petitioner's testimony and history to all the doctors she saw was credible and consistent; The Arbitrator finds on the totality of the evidence that it establishes that she had a work related accident on June 1, 2015 when she turned to hand the cup of coffee to the customer and her right foot stuck to the floor and she injured her right knee. The Arbitrator cites testimony Trans.p.15;line 10-16, p.161-165; p.166:line 10 to end.

Based upon Petitioner's testimony at trial and the histories of the accident that Petitioner gave to ER doctor at Community First Hospital, Mercy Medical Center on two occasions, Dr. Murtaza and Dr. Poepping in their initial visits, the Arbitrator holds that Petitioner had an accident that arose out of and in the course of her employment with the Respondent on June 1, 2015.

Petitioner's testimony as to how the accident happened on June 1, 2015 between 3:00 pm and 4:00 pm was consistent and credible. Petitioner's testimony was consistent with the histories in the medical records of the ER doctor at Community First Hospital, Mercy Medical Center on two occasions, Dr. Murtaza and Dr. Poepping in their initial visits.

While Respondent disputed accident in the Request for Hearing Form, Respondent's own witness, Ravi Pandya, testified as follows:

Q. I believe you testified that Carmen Rivera told you she was walking and her knee locked up, is that correct?
A. Yes.
Q. And she was doing that during her employment time at

Dunkin Donuts, Shree, correct?
A. Yes, Shree Dutt Inc., yes.
(Trans. at p. 139)

Q. But she did tell you that she was walking, that her knee locked up and she did that during the course of her employment for Dunkin Donuts?
A. She mentioned that during her shift her knee locked up as she was walking.
Q. And she hurt her knee?
A. Yeah.
(Trans. at p. 140)

Mr. Pandya also testified at trial that parts of the surveillance video of June 1, 2015 he viewed showed Petitioner limping on the date of the accident. (Trans. p. 141) Dr. Karlsson testified that Petitioner was seen on the video limping with a stiff-legged gait on the right consistent with knee pain. (RX6 at p. 82)

Petitioner testified that at the time of the accident she was serving some cold coffee to a customer and when she turned to hand the coffee to a customer, her right foot stuck to the floor and she twisted her right knee.

Petitioner was performing a task incidental to employment with Respondent, turning to hand a coffee to a customer, where her foot got stuck on caramel on the floor. BOTH her turning to serve coffee to a customer and her foot sticking on the floor independently serve as a basis for the Arbitrator to find that Petitioner's right knee injury occurred in the course of her employment.

The issue of whether the caramel was on the floor is a disputed factual issue. Petitioner was present and Mr. Pandya was not. Petitioner is the only witness with personal knowledge of whether her right foot got stuck on caramel on the floor on June 1, 2015. The Arbitrator finds it did so.

Regarding Issue (F) Is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds the following:

The conclusion of law for issue F is based upon the totality of the evidence. The Arbitrator finds as a matter of law the Petitioner's condition of ill being and all sequelae are by a preponderance of the evidence, not causally connected to the accident in the case at bar.

The testimony of Dr. Troy Karlsson is adopted as more persuasive than that of Dr. Poepping. The Arbitrator underscores his testimony at deposition as follows: pages- 7, 18:L18-23 plus page 29. P.23,L18-21, p.38,L13. P.46, L16-18; p.58, 6-24 then p.59,L 1-2;p.61,L4-7; p.94, L2-24; p.95,L 1-2. "Ghere" objections in both depositions are all overruled but preserved in record.

As to issue (J), Were the Medical Services Reasonable and Necessary? ;Has Respondent paid all appropriate charges for same?The arbitrator holds the following:

Having found that Petitioner suffered a work related right knee injury on June 1, 2015 in the course of her employment and that said injuries were not caused by the work accident of June 1, 2015 as stated in Issue C and Issue F above, the following unpaid medical bills were incurred in medical treatment for Petitioner's right knee and right leg- but denied in the case at bar:

Medical Provider	Date of service	Amount
Mercy Health System	6/4/15-6/6/15	$822.25
Illinois Orthopedic Network (ION)	6/11/15-6/13/17 (Present)	$22,905.71
Molecular Imaging	6/11/15	$2,336.00
G & T Orthopaedics	6/12/15	$400.00
Hand & Medical Center (HM)	7/06/15-6/14/17 (Present)	$63,813.45
St. Anthony Hospital	7/28/15-8/28/15	$0.00
Healthcare & Family Services	8/1/15-10/15/15	$61,086.66
Kindred Hospital Chicago	8/17/15-9/10/15	$0.00
Nova Pharmacy	8/17/15-1/11/17	$612.17
Mercy Hospital	9/10/15-9/22/2015	$0.00
Interim Health Care	9/23/15-10/16/15	$0.00
Metro Anesthesia Consultants (Anestheisa-ION)	8/16/16	$2,898.98
Dr. Markarain	12/07/16-1/18/17	$621.37
Midwest Open MRI	12/08/16	$2,260.00
Archer Open MRI	12/27/2016	$1,655.00
		Total: $159,411.59

In addition to the above bills, Illinois Healthcare and Family Services (Public Aid) paid the medical bills of St. Anthony Hospital, Kindred Hospital, Interim Health Care, Dr. Sompalli and other doctors who treated Petitioner for Cellulitis/Septecimia/Necrotizing Fasciitis of the right knee and right leg. (PX14) Illinois Healthcare and Family Services paid these medical providers $61,086.66 at its significantly reduced rates. (For example St. Anthony Hospital was paid $27,699.33 for a bill of $149,951.00, which is a much more significant reduction than the Illinois Worker's Compensation Fee Schedule and as a result those amounts do not need to be reduced. See PX14 at p. 1)

At trial, Petitioner had admitted medical bills from Mercy Health System $822.25 (PX3), Illinois Orthopedic Network (ION) $22,905.71 (PX5), Molecular Imaging $2,336.00 (PX7), G & T Orthopaedics $400.00 (PX8), H and & Medical Center $63,813.45 (PX10), Nova Pharmacy $612.17 (PX 16), Metro Anesthesia Consultants $2,898.98, (PX22), Dr. Markarian $621.37 (PX24), Midwest Open MRI $2,260.00 (PX25), and Archer Open MRI $1,655.00 (PX26) totaling $159,411.59 plus the $61,086.66 paid by Public Aid..

Dr. Poepping testified that the treatment given at St. Anthony Hospital was reasonable and necessary. (PX29 at p.44) Dr. Poepping also testified that his medical care and the 8/16/2016 surgery was reasonable and necessary and caused and necessitated by the work accident of June 1, 2015. (PX29 at p.44) Dr. Karlsson opined that the 8/16/2016 right knee surgery performed by Dr. Poepping was reasonable and necessary. (RX6 at p. 15)

All of the treatment was recommended as reasonable and necessary by the treating doctors, Dr. Murtaza, who referred Petitioner for the 6/11/2015 from ION, Dr. Poepping at ION, who referred Petitioner to physical Therapy at H and M Physical Therapy, St. Anthony Hospital, who in return referred Petitioner to Kindred Hospital, Mercy Hospital and Interim Health Care. Dr. Poepping also referred Petitioner to Dr. Markarian for a second opinion and Dr. Markarian referred Petitioner to Archer Open MRI for a right knee MRI on 12/27/2016.

Petitioner also had admitted a Illinois HealthCare and Family Services (Public Aid) Lien of $61,086.66 for the medical bills Public Aid paid for Petitioner's treatment at St. Anthony Hospital, Kindred Hospital, Interim Health Care, Dr. Sompalli and other doctors who treated Petitioner for Cellulitis/Septicemia/Necrotizing Fasciitis of the right knee and right leg. (PX14)

Pursuant to 305 ILCS 5/11-22a provides the IDHFS with the right of subrogation. The IDHFS may subrogate a public aid recipient's recovery from any private or public health care coverage or casualty coverage, including coverage under the Workers' Compensation Act and the Workers' Occupational Diseases Act. 305 ILCS 11/22a.) paid the medical bills of St. Anthony Hospital, Kindred Hospital, Interim Health Care, Dr. Sompalli and other doctors who treated Petitioner for Cellulitis/Septicemia/Necrotizing Fasciitis of the right knee and right leg.

Based upon the totality of the evidence, including Dr. Poepping's medical records and the medical opinions in his deposition, as well as the other medical records supporting the treatment performed for the amount billed, the Arbitrator concludes that all of Petitioner's medical charges are reasonable and necessary to attempt to cure her right knee and right leg injuries.

Since the Arbitrator found no causation the Arbitrator denies an Award of $159,411.59 in medical bills listed above, as provided in Sections 8(a) and 8.2 of the Act. The Arbitrator also denies the Award of the $$61,086.66 paid by Illinois HealthCare and Family Services as shown in PX14)

Regarding Issue K: Is Petitioner entitled to Prospective Medical Care--A Right Total Knee Replacement Surgery?

Based upon the finding of no causal connection, no prospective care is awarded.

Regarding Issue L:What temporary total disability benefits are due and owning under section 8 ?

Given the findings infra on the issue of causation, no temporary total disability is awarded.

ISSUE (M) Should penalties and/or fees be imposed upon Respondent?

No penalties and or fees are ordered in the case at bar. The Respondent has made a good faith challenge to the payment of compensation plus the causation is denied, as above.

See Avon & Brinkman cases.

ISSUE (O) Should the Video from June 1, 2015 Submitted by Respondent Be admitted into Evidence?

Respondent seeks admission of a video taken on the date of the accident of June 1, 2015 for the time period of 8:00 pm to 8:30pm only. (RX7) Respondent's witness Ravi Pandya, testified that he viewed the store video from the whole shift for June 1, 2015. (Tr. p. 106) Mr. Pandya's excuse for not copying the whole video was that it did not fit on a disk. (Trans. at p. 106-107) However it was only 15-30 minutes of footage. (Trans. at p. 108 and p. 113) Counsel for Petitioner objected to the video's admission based upon the Illinois evidence Rule of Completeness. (Trans. p. 132-136)

Mr. Pandya testified at trial that parts of the video showed Petitioner limping. (Trans. p. 141) Dr. Karlsson also testified that Petitioner was seen limping with a stiff-legged gait on the right consistent with knee pain. (RX6 at p. 82)

This Arbitrator reserved its ruling on admission of the video RX7 as Issue O. (Tr. p. 110) The Illinois Worker's Compensation Act incorporates and applies the Illinois Rules of Evidence to the extent that they do not conflict with the Act. 50 Ill. Adm. Code Section 9030.70(a).

Under Illinois Rule of Evidence 106, Remainder of or Related Writings or Recorded Statements, the Respondent must produce the entire surveillance video of June 1, 2015, which was reviewed by Ravi Pandya based upon Illinois Rule of Evidence 106 once the adverse party requires the introduction of the remainder statement or recording. Respondent did not produce the complete video of the entire shift of June 1, 2015 and the portion of the video for which Respondent seeks admission is denied.

In the case at bar, the Arbitrator, in his discretion, does make an adverse inference that Respondent's failure to produce the complete video of the work day of June 1, 2015 since the video was under Respondent's exclusive control and a reasonably prudent person would have produced the whole surveillance video from June 1, 2015 if it were favorable to Respondent and no reasonable excuse was proffered. IPI 5.01 (See also Dugan v Weber, 175 Ill.App.3rd1088, 530 N.E.2nd 1007 (1st Dist. 1988); Kersey v Arrow Corp. 344 Ill.App.3rd 690, 800 N.E.2d 847 (2d. Dist. 2003)

The Arbitrator holds that Respondent should have submitted the entire day's video from the date of the accident, June 1, 2015. The Arbitrator holds that the Respondent violated the Rule of Completeness and thereby rejects Respondent's Exhibit 7, the Surveillance video. (RX7)

The Arbitrator further sayth naught.

STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Dwayne Mitchell

Petitioner,

vs.

No. 12 WC 40721

Chicago Transit Authority,

Respondent.

ORDER

This matter comes before the Commission on a Petition for Penalties filed by Petitioner on September 26, 2018, with due notice given, seeking an order against Respondent that payment for Petitioner's medical expenses be made directly to Petitioner pursuant to the 19(b) decision issued by Arbitrator Ciecko on July 17, 2018. The matter came for hearing on October 24, 2018 before Commissioner Stephen Mathis, and a record was made. The Commission having been advised of the facts and law, finds penalties are not warranted.

A 19(b) hearing was conducted on May 9, 2018. On July 17, 2018 the Arbitrator's decision was filed which provided, in relevant part, as follows;

> Respondent shall pay reasonable and necessary medical services for Petitioner, pursuant to the medical fee schedule, from October 24, 2012 forward to: Preferred Open MRI; Pain care (sic) Consultants; Illinois Sports Medicine & Orthopedic Surgery Center; Athletico; The Spine Center; Dr. Avi Bernstein; and Advocate Lutheran General Hospital as provided in Sections 8(a) and 8.2 of the Act.

Petitioner seeks unspecified penalties, asserting that the language of the arbitrator's decision specifies payment of medical expenses be made directly to Petitioner. The language of the arbitrator's decision is clear and unambiguous. The medical providers to whom payment of medical expenses is to be made are identified by name.

The Commission, having considered the merits of the petition, finds that an award of penalties is not warranted.

IT IS THERFORE ORDERED BY THE COMMISSION that the petition for penalties is hereby denied.

DATED: APR 4 - 2019
SM/msb
44

Stephen J. Mathis

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

JUSTIN NANCE,

Petitioner,

vs. NO: 17 WC 9002

GRASSER'S PLUMBING & HEATING, 19IWCC0181

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, causal connection, medical expenses, prospective medical care, temporary disability, and penalties and fees, and being advised of the facts and law, modifies the Decision of the Arbitrator, which is attached hereto and made a part hereof as stated below and otherwise affirms and adopts the Decision of the Arbitrator. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total disability compensation, medical benefits, 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 completed installing a furnace at the customer's home early. He was returning to the employer's place of business, in a company truck on a route that would take him back to the business. Petitioner was carrying a check from the customer to the employer for the work. It was the only job that Petitioner had been given for that day.

. Petitioner decided to stop by his father's house before returning to the business. This required him to make a left turn off of the route back to the business. While stopped in the left

lane to make the turn, Petitioner was struck by another vehicle, causing Petitioner to injure his neck.

Petitioner would not have been stopped on the road but for the need to make the left turn to go to his father's home.

Petitioner told the adjuster that he was going to his dad's house at the time of the accident. He did not tell the adjuster the reason he was going to his dad's house. Petitioner had no work-related reason to go to his dad's house at the time, or at least that was known at the time of denial of benefits.

Respondent denied medical treatment because the accident did not arise out of or in the course of Petitioner's employment.

At the time of the hearing Petitioner testified that he was going to his dad's house to use the bathroom. He testified that there was no policy in place regarding where employees could/should take bathroom breaks. Based upon the personal comfort doctrine the injury is compensable.

The Commission views the evidence with respect to the denial of benefits differently than the Arbitrator in this case. Based upon the information available at the time of denial of medical treatment, Respondent had a valid reason to deny benefits. Petitioner deviated from the route back to the place of business with no explanation of the reason to the adjuster. Therefore, the denial of treatment was not unreasonable or vexatious. The Commission vacates the award of penalties and fees but otherwise affirms and adopts the findings of the Arbitrator.

We disagree with the Arbitrator's finding that Respondent's defense of this claim warranted the imposition of penalties and attorneys' fees. The Commission finds, based upon the evidence, that the award of penalties pursuant to Section 19(l) in the amount of $5,880.00; Section 19(k) in the amount of $6,960.94 and attorneys' fees in the amount of $2,784.38 under Section 16 of the Act is not warranted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 24, 2018 is hereby modified as stated herein., and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $497.21 per week from March 14, 2017 through September 25, 2017, 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 Petitioner's medical bills totaling $14,226.36, pursuant to the Medical Fee Schedule as provided

in Sections 8(a) and 8.2 of the Act, with credit given for payments made in accordance with Section 8(j) of the Act, or by the workers' compensation carrier directly.

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 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 $28,000.00. 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: APR 4 – 2019
o-02/07/19
SM/msb
44

Stephen J. Mathis

Deborah Simpson

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

NANCE, JUSTIN
Employee/Petitioner

Case# **17WC009002**

GRASSER'S PLUMBING & HEATING
Employer/Respondent

19IWCC0181

On 4/24/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.98% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

0357 QUINN JOHNSTON HENDERSON ET AL
CHRISTOPHER CRAWFORD
227 N E JEFFERSON ST
PEORIA, IL 61602

STATE OF ILLINOIS)
) SS
COUNTY OF LA SALLE)

19IWCC0181

☐ 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)

Justin Nance
Employee/Petitioner
v.
Grasser's Plumbing & Heating
Employer/Respondent

Case # 17 WC 9002

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christine Ory**, Arbitrator of the Commission, in the city **Ottawa**, on **September 25, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident **March 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 **$38,782.12**; the average weekly wage was **$745.81**

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

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

ORDER

Temporary Total Disability

Respondent shall pay TTD from **March 14, 2017 through September 25, 2017, or 28 weeks @ $497.21 per week.**

Medical Benefits

Respondent shall pay bills totaling **$14,226.36** subject to the fee schedule and pursuant to the provisions of §8 and §8.2 of the Act, with credit to be given for payments made in accordance with §8 j of the Act, or by the workers' compensation insurance carrier directly.

Penalties and Attorneys' Fees

Respondent shall pay **penalties of $5880.00 under §19 l, $6, 960.94 under §19 k, attorneys' fees of $1,363.24 under §16 of the Act** as respondent's failure to pay temporary total disability was unjustified, unreasonable and vexatious.

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 Mory

Signature of Arbitrator

April 19, 2018

Date

IC ArbDec19(b)-p 2

APR 24 2018

19IWCC0181

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Justin Nance	)
Petitioner,	)
vs.	) **No. 17 WC 9002**
Grasser's Plumbing & Heating	)
Respondent.	)
	)

ADDENDUM TO ARBITRATOR'S DECISION
FINDINGS OF FACTS AND CONCLUSIONS OF LAW

This matter proceeded to hearing under the provisions of §19b/§8a in Ottawa on September 25, 2017. The parties agree that on March 13, 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 petitioner gave notice of the alleged accident within the time limits stated in the Act. They agree petitioner's wage, in the year pre-dating the claimed accident, was $38,782.12, and his average weekly wage, calculated pursuant to §10 was $745.81.

At issue in this hearing is as follows:

1. Whether the petitioner sustained accidental injuries that arose out of and in the course of his employment;
2. Whether petitioner's current condition of ill-being is causally connected to the claimed injury.
3. Whether respondent is liable for medical bills.
4. Whether petitioner is due temporary total disability.
5. Whether penalties and attorneys' fees should be imposed upon respondent.

STATEMENT OF FACTS

Petitioner had been employed by respondent for 11 years; the last two years installing furnaces and air conditioners at customers' houses. Petitioner was issued a company truck four years earlier. Petitioner works 7:00 AM to 4:30 PM Monday through Friday and sometimes on Saturdays. Respondent has no handbook regarding time off or breaks for employees. The custom and practice by respondent's employees was to take a half hour lunch and a fifteen-minute break in the morning and a fifteen-minute break in the afternoon.

In regard to a bathroom break, petitioner understood respondent's employees would use a customer's house, or whatever is closest; such as a gas station or even the employee's own home.

Petitioner had not injured his neck or back before March 13, 2017. Petitioner normally worked alone. He took his work orders from respondent's manager, Chris Davis. Respondent is located in the town of McNabb. Petitioner lived in the town of Magnolia, which is south of McNabb. Petitioner's job order was in the town of Lacon, which is south of Magnolia.

On March 13, 2017, petitioner drove the company vehicle from his home in Magnolia up to respondent's business in McNabb, loaded up the furnace and all materials necessary to install he furnace and drove down to Lacon. He arrived at the customer's home at about 7:45 A.M. He was at the customer's home until about 12:30. He had taken his half hour lunch break while at the

customer's home, but had not taken is fifteen-minute morning break. He had the customer's old furnace in the back of the company truck. He was paid by check.

He was returning to respondent's location in McNabb, on Route 89, when he had to use the bathroom. He decided he was going to take a left off Route 89 to go to his father's house nearby to use his bathroom. He was stopped on Route 89, intending to take a left onto Stagecoach Road, when he was rear-ended. Petitioner was not aware of any public facility in Magnolia. The closest facility he knew of was at his father's house on Stagecoach.

Petitioner estimated the other vehicle was traveling at 45 MPH. After the accident, he called Chris Davis to report he was in an accident. Davis then had petitioner talk to respondent's manager, Jim Zera. Zera called the police. Petitioner did not tell Davis or Zera why he was stopped, or that he intended to make a left turn [onto Stagecoach] at the time of the accident.

As respondent's vehicle was drivable after the accident, he drove back to respondent's in McNabb, gave the check to respondent and went home.

Petitioner felt a little stiffness after the accident. The next morning his neck was really sore. He went to St. Margaret's Hospital emergency room. He was given medication and three days off. A few days later, he went to orthopedic surgeon, Dr. Blair Rhode. Dr. Blair took X-rays, and then ordered physical therapy. Eventually he underwent a MRI. He had weeks of physical therapy. Dr. Rhode has kept petitioner off work since the first time he saw petitioner.

Petitioner went from physical therapy to work hardening. At the time of hearing, petitioner had been in work hardening for a couple of weeks and anticipated he would continue with work hardening for another four to six weeks. Petitioner was offered a steroid shot, which he refused as he didn't want a shot. No surgery was anticipated. He is taking Norco for pain.

He has put his bills through Blue Cross and Blue Shield, respondent's group insurance. Originally, some of the medical bills had been paid by workers' compensation insurance.

On cross-examination, petitioner admitted he had one or two cigarettes at the job that morning even though he claimed he had not taken a morning break. Petitioner said his father was not home at the time as he was a semi-truck driver and gone all week.

Petitioner gave a statement to the insurance adjuster. In the statement he said: "I was actually going to swing through the house, my dad's house real quick and then I was heading and going – bringing a check to work from the customer's house. I left earlier that day". At the time of the statement to the insurance adjuster, petitioner did not disclose that the reason he was going to his father's house was to use his bathroom. However, the adjuster never specifically asked petitioner the reason for going to his father's house.

After the accident, petitioner was so shook-up he did not use the bathroom until he got home a few hours later.

St. Margaret's Hospital Records (PX.1)

Petitioner was seen in the emergency room on March 14, 2017 for injuries he claimed were the result of a rear-end accident the day before. He complained of neck and low back pain. An exam was performed. The diagnosis back pain. He was kept off work until March 16, 2017.

The cervical X-ray on March 30, 2017 showed mild degenerative disc and facet joint disease.

A cervical MRI was done on May 9, 2017. The MRI showed mild degenerative C4 through C7, with narrowing at C4-C5 and C6-C7. There was a tiny disc protrusion at C4-C5. There was no cord pathology identified.

He received physical therapy for the cervical strain in May and June, 2017.

Orland Park Orthopedics/Dr. Blair Rhode Records (PX.2)

Petitioner was first seen by PA Mark Bordick, under Dr. Blair Rhode's supervision, on March 16, 2017 for the claimed work injuries. The diagnosis was low back pain from a lumbar strain and a whiplash injury. Two weeks of rest was prescribed. He was kept off work.

On March 30, 2017, petitioner was again seen by PA Bordick. The diagnosis remained the same. Physical therapy was prescribed. Petitioner remained off work.

On April 27, 2017 petitioner was seen by Dr. Rhode for continued lower cervical, upper thoracic pain. The Spurling maneuver was negative. A cervical MRI was ordered. He was kept off work.

On May 11, 2017, Dr. Rhode reported the MRI showed evidence of a central C4-C5 disc herniation. Physical therapy was instituted and petitioner was kept off work.

On May 25, 2017, Dr. Rhode continued physical therapy and kept petitioner off work. On June 22, 2017, due to significant symptomology, Dr. Rhode referred petitioner to a spine surgeon and kept him off work.

On July 14, 2017, petitioner was seen by PA Bordick. He continued to have lumbar and cervical spine symptomology and was again referred to a spine surgeon. He was kept off work.

The findings and recommendations of PA Bordick were the same on July 26, 2017. On August 9, 2017, as petitioner continued with symptoms, he was put back in physical therapy and kept off work.

St. Margaret's Hospital Bills (PX.3)

$701.00 - March 14, 2017
$746.00 - March 30, 2017
$3,339.00 – May 9, 2017
$1,513.50 - May 22, 2017 through May 31, 2017
$2,334.00 – June 1, 2017 through June 30, 2017
$1,201.25 – August 23, 2017 through August 28, 2017

Center for Sports Medicine/Dr. Blair Rhode Bill (PX.4)

$4,391.60 - March 16, 2017 through July 26, 2017

Hospital Radiology SCVS Bill (PX.5)

$62.00 Charge (No date printed on bill)

Maps (PX.6 & PX.7)

These maps show the location of Magnolia in relationship to McNabb, as well as the location of where the accident occurred.

Respondent's Response to Petitioner's Petition for Penalties and Attorneys' Fees

Respondent filed a response to petitioner's petition for penalties and attorneys' fees claiming petitioner was not in the course of his employment at the time of the accident.

CONCLUSIONS OF LAW

The Arbitrator adopts the Finding of Facts in support of the Conclusions of Law.

The Arbitrator had the opportunity to view petitioner and his mannerisms; petitioner was straight forward with his answers. The Arbitrator found petitioner to be credible.

C. With respect to the issue of whether an accident occurred that arose out of and in the course of petitioner's employment with respondent, the Arbitrator makes the following conclusions of law:

Petitioner was a traveling employee, who was driving respondent's vehicle; returning from respondent's customer to respondent's office. He was on Route 89, which was a direct route from the customer's home to respondent's office, when he decided he needed to use a bathroom. He testified that the closest bathroom he was aware of was his at his father's house, which was on Stagecoach, just off Route 89. He was stopped to make a left turn off Route 89 onto Stagecoach when he was rear-ended.

Based upon the aforementioned facts, the Arbitrator finds petitioner's accident arose out of and in the course of his employment for two reasons. One is that petitioner had not yet left Route 89. Regardless of the reason, stopping on a road is an inherit and foreseeable risk as a travelling employee while driving. He could have been stopped for a variety of reasons. The fact that he was stopped to make a left turn to go towards his father's house is irrelevant.

Second, petitioner would be considered in the course of his employment, under the personal comfort doctrine. Petitioner was left to his own devices to find a bathroom while on the road doing his work for respondent. The fact that he was stopped to make a left turn to go to the bathroom at his father's house kept him in the course of his employment under the personal comfort doctrine.

The Arbitrator considered the fact that respondent did not present any evidence to rebut petitioner's testimony.

For these reasons, the Arbitrator finds petitioner was in the course of his employment when he was stopped in respondent's vehicle on Route 89 at the time of the accident. Accordingly, the Arbitrator finds that petitioner's injuries resulted from an accident on March 13, 2017, that arose out of and in the course of his employment with respondent.

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 prior back or neck injuries. The medical evidence supports a finding that petitioner's whiplash/strain injury to his neck, resulting in a central C4-C5 disc herniation, and low back pain, were caused by the work accident. Respondent offered no evidence to refute causation.

The Arbitrator therefore finds petitioner's lower back pain and central herniated C4-C5 disc was caused by the work accident that necessitated the medical treatment by St. Margaret's Hospital and Dr. Blair Rhode with Center for Sports Medicine and resulted in petitioner's temporary total disability from March 14, 2017 to the date of hearing.

J. With respect to the issue regarding medical bills, the Arbitrator makes the following conclusions of law:

Having found for petitioner on the issue of whether petitioner's accident arose out of and in the course of his employment with respondent, the Arbitrator awards the following bills, in accordance with §8 and §8.2 and the fee schedule, with credit given for any payment made by Blue

Cross or Blue Shield pursuant to §8 j, and any credit for payment made under workers' compensation:

1. St. Margaret's Hospital Bills:
   $701.00 - March 14, 2017
   $746.00 - March 30, 2017
   $3,339.00 – May 9, 2017
   $1,513.50 - May 22, 2017 through May 31, 2017
   $2,334.00 – June 1, 2017 through June 30, 2017
   $1,201.25 – August 23, 2017 through August 28, 2017

2. Center for Sports Medicine/Dr. Blair Rhode $4,391.60 bill - March 16, 2017 through July 26, 2017

The Arbitrator makes no award for the claimed $62.00 bill from Hospital Radiology as it was not itemized, it provided no explanation for the charges,
there is no date of service or CPT code.

L. With respect to the issue regarding TTD, the Arbitrator makes the following conclusions of law:

The medical records of St. Margaret's Hospital and Dr. Blair Rhode's supports petitioner's claim he was temporarily totally disabled from his work injuries for the period from March 14, 2017 through the date of hearing on September 25, 2017, which is 28 weeks. The Arbitrator, therefore, awards 28 weeks of TTD at the rate of $497.21 per week.

M. With respect to the issue regarding penalties and attorneys' fees, the Arbitrator makes the following conclusions of law:

The Arbitrator finds respondent's defense of this claim had no merit and was unreasonable given the fact that petitioner was a travelling employee, petitioner had not deviated from the route when the accident occurred, and had a legitimate reason to be stopped to make a turn for his personal comfort. Respondent failed to bring forth any evidence to refute petitioner's claim.

Therefore, the Arbitrator awards penalties pursuant to §19 (l) of the Act at $30 per day for 196 days, or $5880.00; $6,960.94, pursuant to §19 (k) of the Act [50% of $13,921.88]; and attorneys' fees under §16 in the amount of $2,784.38 [20% of $13,921.88]

The Arbitrator cannot award penalties for medical expenses as the specific claim for medical bills that may be owed under §8 or §8.2 of the Act was not shown.

STATE OF ILLINOIS)
) SS.
COUNTY OF SANGAMON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Tammy Horner,

Petitioner,

vs.

NO: 14 WC 11452

Capital Healthcare Rehab Centre,

19IWCC0182

Respondent.

DECISION AND OPINION ON REVIEW

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

Findings of Fact

In the interest of efficiency, the Commission primarily relies on the Arbitrator's very detailed recitation of facts. On the date of accident, Petitioner was employed as a CNA and an activities aid. She sustained an injury to her right hand after a slip and fall on a wet floor. Petitioner testified that she felt extreme pain and some numbness in her right hand immediately following the work accident. When asked to identify the location of the numbness, Petitioner indicated her thumb, index and middle fingers, and into the palm around those fingers.

Petitioner sustained a prior injury to her right hand in 2010. The medical records show Petitioner was diagnosed with a right thumb sprain with no significant pathology noted on an MRI. Petitioner underwent conservative treatment for the injury, including a cortisone injection into the thenar prominence of the right hand and therapy. Petitioner was not a surgical candidate and an MRI of the thumb showed subtle tenosynovitis involving the flexor carpi ulnaris and flexor pollicis longus tendons, a mild strain of the flexor pollicis brevis muscle belly, and fluid at the carpal joint involving the pisiform and triquetrum. Petitioner's right thumb pain never fully resolved prior to the current work accident; however, she testified that her complaints following the work accident are different. For example, Petitioner testified that prior to this accident she never experienced problems with tingling and numbness in her right hand. Her testimony and the medical records

also reflect that she complained of increased pain following the accident. Petitioner testified that she never returned to the "baseline" pain she experienced prior to this accident.

Following the work accident, Petitioner continued to complain of significant pain in her right hand, particularly along the right thumb CMC joint. Her doctors prescribed conservative treatment including physical therapy, bracing and splinting, and home exercises. Dr. Ma first examined Petitioner on December 27, 2013. By April 2014, Petitioner began complaining of numbness and tingling in her hand and fingers. Given the new complaints of numbness and tingling in the right hand, Dr. Ma ordered an EMG/NCV study to rule out both carpal tunnel and cubital tunnel syndromes.

A May 2, 2014, EMG/NCV study of the right arm revealed mild right carpal tunnel syndrome with no evidence of ulnar or radial neuropathy or peripheral neuropathy. Dr. Ma subsequently diagnosed very mild carpal tunnel syndrome in the right hand. He recommended Petitioner complete an FCE to determine any work restrictions. Respondent did not authorize the requested FCE. On June 27, 2014, Dr. Ma advised Petitioner to continue conservative treatment including activity modification, bracing, and possibly a steroid injection.

Dr. Greatting first examined Petitioner on August 7, 2014. Petitioner complained of pain in the thenar and CMC joint area, numbness and tingling in her entire right hand, and weakness. She reported experiencing numbness and tingling intermittently in her hand during the day and painful numbness and tingling occasionally in her hand at night. The exam revealed a complaint of diminished sensation to light touch in the tip of her fingers, a positive Tinel and Phalen compression test over the carpal tunnel which caused numbness in all fingers. Dr. Greatting also noted some tenderness over the right thumb CMC. He recommended an MRI to rule out any early arthritic abnormalities in the CMC joint or any ligamentous injury. The May 29, 2015, MRI of the right thumb had the impression of mild osteoarthritis and mild first flexor tenosynovitis. Dr. Greatting diagnosed osteoarthritis of the CMC joint of the right thumb. He recommended a corticosteroid injection into the thumb CMC joint and opined that if the injection helped for a period Petitioner might potentially be a candidate for thumb CMC arthroplasty. Petitioner expressed a fear of injections.

Petitioner did not return to Dr. Greatting until March 31, 2016. She complained of increasing pain in her right thumb over time. The exam revealed tenderness over the right thumb CMC joint and pain and crepitation with the grind test. Dr. Greatting again recommended an injection, which Petitioner refused. He told Petitioner that if her symptoms became severe enough she might benefit from a thumb CMC joint arthroplasty. Petitioner was to follow up as needed. She returned in late June 2016 primarily for complaints concerning her left arm, but also to obtain a new right thumb comfort cool splint for her right thumb CMC joint arthritis. On July 11, 2017, Petitioner returned to Dr. Greatting for a final visit. Petitioner complained of pain into the right hand and localized the pain in the CMC joint of the right thumb. She rated her pain a 7/10. There were no abnormal findings during the physical exam and updated x-rays were negative for any abnormality. The nurse told Petitioner that her exam, x-rays, and the prior EMG/NCS were negative.1 She recommended Petitioner take diclofenac gel for any pain. The nurse wrote,

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1 There is some confusion regarding whether an October 2016 EMG was of the left or right arm. Although the report is not in evidence, it appears from the medical records that this EMG was of the left arm. This confusion does

> "She did inquire as to whether or not she would be able to get permanent disability and I explained to her that her findings were negative today. She then stated that Dr. Greatting had previously given her permanent restrictions, but I cannot find any evidence of this in her chart."

(PX7). Dr. Greatting signed off on the office visit note.

During the hearing, Petitioner testified that pain wakes her up occasionally. She testified that she experiences numbness almost daily. She now has difficulty performing tasks such as vacuuming and baking due to her right-hand pain. She described the pain as "burning." She must take breaks due to her hand pain and baking a cake is difficult because stirring causes her hand to start burning. Petitioner testified that she is unable to grip the steering wheel when driving because her right hand will begin to hurt; thus, she now drives with one hand. She testified that she drops things as well. She testified that she uses both hands to lift a gallon of milk to avoid dropping it. Petitioner testified that she has had to change the way she pushes heavy people in wheelchairs at work to avoid injuring her right hand. She indicated that instead of gripping the handle on the wheelchair, she places her palm on the handle and pushes. She testified that her unrelated left arm injury also makes it harder for her to perform her job. She takes over the counter pain medication such as ibuprofen and Tylenol daily. Petitioner continues to wear a brace on her right wrist daily.

Expert Opinion

Dr. Williams – Respondent IME

Dr. Williams performed an IME at Respondent's request on May 21, 2014. (RX1). Petitioner complained of pain at rest of 7-8/10 and with activity 10/10. She complained of numbness and tingling in the entire hand, interrupted sleep due to pain in the mid palm, pain with driving, and weakness. Dr. Williams reviewed medical records and prior x-rays. His examination of Petitioner revealed a positive Tinel's at the right carpal tunnel and a negative Phalen's bilaterally. The exam also revealed CMC joint tenderness on the right with no crepitus or grinding and no evidence of instability or significant dorsal subluxation at the CMC joint. There was no significant swelling and no instability at the MCP joint. Dr. Williams opined that Petitioner sustained a right thumb carpal metacarpal joint sprain. He had concerns regarding Petitioner's motivation because she had been in treatment for eight months and reported no significant benefit from any form of treatment, despite an essentially negative MRI. Dr. Williams recommended a second MRI to determine if there was evidence of any pathology at the carpometacarpal joint.

Conclusions of Law

After carefully considering the evidence, the Commission modifies the Arbitrator's award regarding causal connection, medical bills, and the nature and extent of Petitioner's disability. The Commission affirms and adopts the remainder of the Decision of the Arbitrator.

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not affect the Commission's reasoning.

19IWCC0182

The Arbitrator concluded Petitioner did not meet her burden of proving her current condition of ill-being is causally related to the work accident. Instead, the Arbitrator determined any causal connection ended on June 27, 2014. The Arbitrator also denied a causal connection between Petitioner's diagnosis of mild carpal tunnel syndrome and the work accident. The Commission interprets the evidence differently from the Arbitrator. After reviewing the evidence, it is clear Petitioner met her burden of proving her current condition of ill-being is causally related to the work accident.

The evidence shows that while Petitioner had pre-accident complaints regarding her right thumb, there is a distinct difference in Petitioner's complaints after this work accident. Petitioner reported to her doctors that the pain worsened after the accident and has never returned to pre-accident levels. This work accident resulted in Petitioner experiencing pain in not only her right thumb, but also her right hand. She also developed new symptoms of numbness and tingling in her entire right hand. The May 2014 EMG study revealed mild right carpal tunnel syndrome which corresponds with her progressively worsening complaints. There is no evidence disputing the causal connection of the May 2014 EMG finding of mild right carpal tunnel syndrome to the work accident. There is also no evidence that Petitioner had similar complaints of numbness and tingling or a diagnosis of right carpal tunnel syndrome before this work accident. Additionally, Petitioner's mechanism of injury supports a finding of the causal connection of the carpal tunnel syndrome diagnosis.

As the Commission modifies the Arbitrator's causation determination, the Commission also modifies the Arbitrator's award of medical bills accordingly. The Commission finds Respondent is liable for all reasonable and related medical services relating to treatment to Petitioner's right hand following the work accident. This includes any related outstanding charges from Springfield Clinic for Dr. Greatting's treatment as well as any related outstanding charges from Midwest Occupational Health Associates.

Finally, the Commission must modify the Arbitrator's nature and extent award to reflect Petitioner's diagnosis of right carpal tunnel syndrome. As the date of accident occurred after the effective date of the amendment, an analysis pursuant to §8.1b of the Act is necessary. The Act states that "... [n]o 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." §8.1b(b). The Arbitrator weighed all five factors and determined Petitioner suffered a 2% loss of use of the right hand due to the work accident. The Commission views the evidence differently than the Arbitrator. After carefully considering the evidence, the Commission finds Petitioner sustained a 7% loss of use of the right hand due to this work accident.

(i) The reported level of impairment pursuant to subsection (a)

Neither party produced an AMA impairment rating. Thus, the Commission assigns no weight to this factor.

(ii) The occupation of the injured employee

Petitioner works as an Activities Aide for Respondent. Her duties include pushing clients in wheelchairs to various activities. Petitioner returned to her usual occupation as an Activities Aide and has continued to perform her duties without incident. There is no evidence that Petitioner ceased working as a CNA for any issue relating to the work accident. No doctor has prescribed permanent restrictions due to Petitioner's work injury. Thus, Commission assigns some weight to this factor.

(iii) The age of the employee at the time of the injury

Petitioner was 42 years old on the date of accident. It is reasonable to expect she will live with the residual pain and symptoms from the work accident for several years. Thus, the Commission assigns some weight to this factor.

(iv) The employee's future earning capacity

Petitioner returned to her normal occupation as an Activities Aide following the work accident. She continues to work full duty and no doctor has prescribed permanent restrictions related to the work accident. Petitioner submitted no evidence that her future earning capacity has been affected in any way by her work injury. Thus, the Commission assigns some weight to this factor.

(v) Evidence of disability corroborated by the treating medical records

Petitioner sustained a right thumb and hand sprain as a result of the work accident. The work accident also either caused or aggravated Petitioner's diagnoses of right thumb CMC joint osteoarthritis and mild right carpal tunnel syndrome. Although more than one doctor recommended Petitioner undergo a steroid injection to improve her pain complaints, Petitioner declined as she is afraid of injections. Thus, Petitioner's injury was treated conservatively with physical therapy and splints/braces. During her last office visit in July 2017, Petitioner's physical exam and x-rays were negative for any abnormality. While Petitioner returned to her normal job as an Activities Aide, she testified that her right-hand condition affects the way she completes tasks such as pushing heavier patients in wheelchairs. She also reported difficulty performing personal tasks such as driving, vacuuming, and baking. Petitioner also complained of a weakened grip and a history of dropping items. The medical records show that although her final medical examination was normal, Petitioner continued to complain of right-hand pain and pain localized in the CMC joint of the right thumb. Given the issues discussed herein, the Commission assigns significant weight to this factor.

After carefully weighing all the evidence, the Commission modifies the Decision of the Arbitrator and finds Petitioner suffered a 7% loss of use of the right hand pursuant to §8(e).

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 November 6, 2017, is modified as stated herein.

19IWCC0182

IT IS FURTHER ORDERED that Respondent shall pay to Petitioner permanent partial disability benefits of $253.00 for 14.35 weeks, because Petitioner's injuries caused a 7% loss of use of the right hand, as provided for in §8(e) of the Act.

IT IS FURTHER ORDERED that Respondent shall pay all reasonable and necessary medical charges, including those for services provided by Midwest Occupational Health Associates and Springfield Clinic, that relate only to treatment Petitioner's right hand, as provided in Sections 8(a) and 8.2 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.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $4,000.00. 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: APR 8 - 2019

o: 2/5/19
TJT/jds
51

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HORNER, TAMMY L
Employee/Petitioner

Case# **14WC011452**

CAPITAL HEALTHCARE REHAB CENTRE
Employer/Respondent

19IWCC0182

On 11/6/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.26% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2046 BERG & ROBESON PC
STEVE W BERG
1217 S 6TH ST
SPRINGFIELD, IL 62703

1872 SPIEGEL & CAHILL PC
KATERINA KYROS
15 SPINNING WHEEL RD SUITE 107
HINSDALE, IL 60521

19IWCC0182

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

TAMMY L. HORNER
Employee/Petitioner

v.

CAPITAL HEALTHCARE REHAB CENTRE
Employer/Respondent

Case # 14 WC 011452

Consolidated cases: N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Springfield**, on **August 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 _____

FINDINGS

On **September 30, 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. Petitioner's proved causation through June 27, 2014 but not thereafter.

In the year preceding the injury, Petitioner earned **$20,469.36**; the average weekly wage was **$393.64**.

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

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

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

ORDER

Petitioner failed to prove her current condition of ill-being in her right hand and thumb is causally connected to her accident of September 30, 2013. She did establish a causal connection for her right hand/thumb sprain/strain through June 27, 2014.

Petitioner is awarded any remaining/outstanding balances for services rendered by MOHA and Dr. Ma through June 27, 2014 as shown in PX 2. Respondent is to receive credit for all bills previously paid. Petitioner is not awarded any medical bills subsequent to June 27, 2014.

Respondent shall pay Petitioner permanent partial disability benefits of **$253.00/week** for **4.1 weeks**, because the injuries sustained caused the **2% loss of the right hand,** as provided in Section 8(e) of the Act.

Respondent shall pay Petitioner compensation that has accrued between **September 30, 2013** and **August 31, 2017** and shall pay the remainder of the award, if any, in weekly installments.

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

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

Signature of Arbitrator

10-27-17
Date

Tammy L. Horner v. Capital Healthcare Rehab Centre, 14 WC 11452

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Petitioner was involved in an undisputed accident on September 30, 2013. (AX 1) The disputed issues are causal connection, medical bills, and the nature and extent of Petitioner's injury. (AX 1)

The Arbitrator finds:

Petitioner was seen at Midwest Occupational Health Associates (MOHA) on November 19, 2010 regarding an injury date of May 27, 2010. Petitioner had been diagnosed with a right thumb strain that occurred on that date and had been treated by Drs. Sinha and Wottowa. Both doctors did not feel Petitioner needed surgery. She had, however, undergone a cortisone injection to the thenar eminence of her right hand on October 18, 2010 but she was continuing to complain of significant pain. An MRI had been obtained and showed subtle tenosynovitis involving the flexor carpi ulnaris and flexor pollicis longus tendons along with a mild strain of the flexor pollicis brevisu muscle belly and fluid at the carpal joint involving the pisiform and triquetrum. APN-C Molly Baur summarized the MRI as showing no significant pathology. Petitioner had been on light duty for almost six months and continued to complain of pain that was keeping her from performing her work activities. Petitioner expressed fear that she might be lifting a patient and have a sudden stab of pain and drop the patient. She was assured that there was no disruption or internal derangement of her right hand, wrist, or fingers that would contribute to a sudden loss of grip. The plan was to return Petitioner to regular duty, to continue using Ibuprofen and Tylenol as needed, and to continue with her occupational therapy exercises. When so informed, Petitioner inquired as to when her next appointment would be or who should she follow up with, and she was told that after six months of conservative treatment, two separate consultations, cortisone injections, therapy, light duty, and no significant findings on MRI, there was nothing further to be addressed. Ms. Baur noted, "Subjective complaints of pain and tolerance are not a treatable condition. Her original injury of her right thumb strain from 5/27/10 has been completely evaluated, treated, and addressed." (PX 9)

Petitioner was involved in an undisputed accident on September 30, 2013 when she slipped on a wet floor while going to shut a light off. She landed on her hands and buttocks. Petitioner completed an Incident Report thereafter. (PX 1)

Petitioner was seen at Midwest Occupational Health Associates on September 30, 2013. She gave a history of the accident explaining that she landed with her hands extended out to brace her fall. She did not hit her head. Her primary complaint was discomfort in her right palm and thumb area and her thumb was swollen. A pain drawing confirmed the area of discomfort. Petitioner rated her pain at a 5-6 out of 10 which was denoted as moderate to severe symptoms. She denied any numbness or tingling. Petitioner acknowledged having suffered a muscle strain to her right hand in 2010 but the symptoms resolved. Petitioner's job was described as both a CNA

and activity person. Petitioner was noted to be right hand dominant. Her current medications included Ibuprofen as needed. On examination Petitioner's right hand showed signs of edema and ecchymosis along the thenar eminence extending into the right thumb. Range of motion of the right thumb was limited due to the edema and Petitioner was unable to oppose her thumb to her pinky finger. She had full range of motion of her wrist and remaining fingers. Petitioner was diagnosed with a right thumb contusion. X-rays were taken of her right hand but revealed no acute abnormalities on initial review. Petitioner was given a thumb spica splint to use over the next few days although she was to periodically remove it to perform motion exercises. She was also told to use extra strength Tylenol for pain (as needed), to apply ice, and to refrain from lifting over five pounds with her right hand. (PX 3)

Petitioner returned to MOHA on October 8, 2013 reporting her hand was improving overall but, at night, throbbing was waking her up and she was requesting stronger medication. The bruising was gone but there was some ongoing swelling along the thenar muscles and achiness in the thumb. A pain drawing was consistent with her complaints. She reported occasional use of Tylenol. Petitioner's range of motion was described as improving. Her diagnosis was unchanged. Tylenol 3 was recommended at night along with additional exercises. She was to return in one week. (PX 3)

Petitioner was seen in follow-up at MOHA on October 15, 2013. She completed a pain drawing regarding her right hand complaints. Petitioner's history of accident was again noted and Petitioner further acknowledged having sustained a right hand muscle strain in 2010; however, she claimed those symptoms had resolved. On examination, Petitioner's right hand revealed some mild edema and uncomfortable range of motion. She could now oppose her thumb to all fingers and had full range of motion of her wrist. Petitioner was diagnosed with a right thumb contusion. Her current medications included Ibuprofen as needed. A prescription for Tylenol 3 was refilled and Petitioner was told to continue with limited activity, see physical therapy for an evaluation and treatment, if appropriate, and return in one week. (PX 3)

As instructed, Petitioner returned to MOHA on October 29, 2013. At this visit it was noted that Petitioner had been having thumb pain for many years, having injured it in 2010 resulting in extreme pain since then as it had never been the same. Petitioner reported increased thumb pain after her recent fall at work, noting her level of pain before the fall was a "6" and now it was a "7." Petitioner's right thenar eminence had some ecchymosis. Her grip was normal. She was wearing a cock-up splint when working but not at home. Petitioner acknowledged that nighttime pain would sometimes awaken her and that this was an issue before her recent accident. She was assessed with a sprain/strain and hand pain. Medications were not addressed. Dr. Ferguson wanted Petitioner to proceed with therapy but Petitioner was reluctant to do so as she had a vehicle that scared her to drive. Petitioner was going to speak with "Sedonia" about going somewhere closer to her home. (PX 3)

Petitioner underwent an initial evaluation with physical therapy on November 14, 2013. According to the history contained in the doctor's office note, Petitioner had slipped on a wet floor on September 30, 2013 and fallen backwards on outstretched hands behind her. She noted an immediate onset of "severe pain" in her right hand. Petitioner had been seen at MOHA and undergone x-rays that were negative. She denied any other tests. Petitioner also reported hurting her arm/hand on June 22, 2010 and being unable to return to work as a CNA and, in turn, she was moved to the job of "Activities Aide." According to the note, "Client states she is very upset as her hand has hurt everyday since the injury in 2010." Petitioner reported her sleep is interrupted due to severe symptoms. Petitioner was independent in her self care but made limited use of her right upper extremity as tolerated. She was primarily using her left hand. Doing dishes and laundry was limited. She was working light duty in the laundry. Petitioner also reported tingling in the fingertips of digits 1 – 3 on the right hand, occasionally, and a decreased sensation with all of her right fingertips. On examination no evidence of swelling or redness was apparent; however, Petitioner displayed "significant guarded use" of her right upper extremity. Petitioner's rehab potential was described as "guarded" given Petitioner's right hand pain symptoms dating back to June of 2010 "only made worse by this fall on the right hand." Petitioner was noted to have significant pain behaviors. Her range of motion and strength were decreased slightly and she reported limited use/function due to the symptoms; however, she tolerated treatment activities fairly well. Petitioner also reported that attending therapy could be a challenge as she questioned having money to travel to therapy even though she lived in town. She was receptive to home exercises and was described as cooperative and attentive. She was to be seen 2 – 3 times a week for two weeks. Her current medications included Ibuprofen, Tylenol, Tylenol #3, and Naproxen. (PX 4)

Petitioner again returned to MOHA on November 18, 2013 reporting continuing complaints in the right thenar eminence. Petitioner reported the injury began in 2010 and she was in extreme intense pain at that point in time and then re-injured it. The therapist had contacted Dr. Ferguson concerned that there might be some subluxation of Petitioner's trapezium given some abnormal clicking and popping being noted with motion of the thumb. Petitioner was placed in a thumb Spica splint, restricted from using her right hand and new x-rays were taken. Petitioner's diagnosis was listed as right thumb strain. Petitioner's pain drawing showed involvement of the entire right hand and wrist and her pain scale rating was a "7-8/10" (very intense to severe problems). Medications were not addressed at this visit. (PX 3)

Petitioner returned to physical therapy on November 21, 2013 reporting her hand "hurt like heck." Petitioner was continuing to report significant pain levels and appeared complaint with exercises but required cueing to wrap her thumb with her fingers with the ulnar deviation stretch. (PX 4)

Petitioner again presented for physical therapy on November 27, 2013, November 29, 2013 and December 3, 2013. Her primary complaints centered around her right thumb, especially at its base near the anatomical snuff box. She appeared to be moving her wrist/hand with more

ease but with ongoing complaints. The trapezium was displaying subluxation with thumb flexion/extension. The therapist felt she might benefit from an orthopedic hand consultation. (PX 4)

Petitioner followed up at MOHA on December 5, 2013. Dr. Ferguson noted Petitioner's 2010 injury to her right thumb with persistent pain and the re-injury fairly recently. Petitioner did not feel therapy was helping; however, the doctor had spoken with the therapist who did feel Petitioner was making some progress although the therapist was concerned about some subluxation. Petitioner described her pain as intensifying, sharp, and constant. The right thenar eminence was noted to be tender to touch; however, there was no obvious ecchymosis, swelling, or redness. There was a noticeable click and pop in her thumb when going through range of motion. In light of the concern about subluxation, x-rays had been ordered but they failed to show any movement of the bone. Dr. Ferguson's impression was "sprain/strain of hands" and she recommended Petitioner be seen by a hand specialist. Medications were not addressed at this visit. (PX 3)

Petitioner, accompanied by a family member, presented to Dr. Ma at Springfield Clinic on December 27, 2013. (PX 7) Petitioner's current medications included Tramadol, Ibuprofen 600 mg., and Ranitidine. According to the history contained in the doctor's office note, Petitioner had slipped on a wet floor on September 30, 2013. When seen by Dr. Ma, Petitioner reported working in a nursing home. Dr. Ma wrote, "The patient stated that her right thumb was slapped when she was trying to prevent someone from falling at work 2 years ago. She stated that her right thumb has been painful ever since." Petitioner had been seen by Dr. Wottowa and Dr. Sinha and treated with a brace and occupational therapy for a thumb sprain. Petitioner further reported worsening pain in the right thumb when she fell on a wet floor at work on September 30, 2013. She stated her thumb was constantly painful, aching and throbbing ("7/10" on a pain scale). Petitioner denied any numbness or tingling in her right hand. On examination Petitioner had mild tenderness to palpation in the thumb CMC joint area; however, her thumb was table to varus and valgus stress. She could move all fingers with no difficulties. Her right thumb was well perfused with good capillary refill. Dr. Ma did note a mild prominence in the thumb CMC joint but the joint also appeared stable. X-rays taken that day were negative for fracture or dislocation of the right thumb. Dr. Ma's assessment was a sprain of the right thumb. Dr. Ma did not recommend another MRI but noted a prior one done a few years earlier which had been negative. He did advise that Petitioner work with activity modification, bracing, stretching and nonsteroidal anti-inflammatory medication. Voltaren gel was prescribed for local use and she was to use her right hand as tolerated and return in six to eight weeks. (PX 7)

Petitioner returned to MOHA on February 21, 2014. At that time she reported her right thumb was quite painful and excruciating. She had been taking Ibuprofen over-the-counter as needed for pain. The Voltaren gel ordered by Dr. Ma had not been approved through workers' compensation. Petitioner was frustrated with the pain and concerned if she could return to work

as a CNA. Petitioner was currently working folding laundry. Petitioner reported using Ibuprofen as needed. On exam there was an area of prominence in Petitioner's right thumb that was mildly tender to palpation. Petitioner moved all fingers without any difficulty and she had full range of motion throughout the remainder of her hand. FNP Heim and Dr. Brower reviewed Dr. Ma's recent note commenting that he had not recommended an MRI. As she was scheduled to return to Dr. Ma the following week, no other recommendations were made. Petitioner was noted to feel unable to return to her regular job duties given her concern with nighttime excruciating pain. (PX 3)

Petitioner signed her Application for Adjustment of Claim herein on February 26, 2014. (AX 2)

Petitioner, accompanied by a family member, returned to see Dr. Ma on February 28, 2014, reporting ongoing right thumb pain complaints. Dr. Ma again noted Petitioner's injury from approximately two years earlier when her thumb was "slapped" trying to keep someone from falling. Dr. Ma noted Petitioner had been seen by Dr. Wottowa in orthopedic surgery and Dr. Sinha in plastic surgery and treated with a brace and occupational therapy for a thumb sprain. Dr. Ma noted that her right thumb had been painful ever since but she experienced worsening pain in it when she fell on a wet floor at work on September 30, 2013. "She stated that her right thumb was constantly painful. She described the pain as aching and throbbing, 7/10 on pain intensity scale." She denied any numbness or tingling in her right hand. On palpation of her thumb, mild tenderness was noted in the CMC joint area. Her right thumb remained stable to varus and valgus stress. She was diagnosed with a sprain of the IP joint of her hand. No treatment changes were made. She was to return in 6 to 8 weeks. (PX 7)

Dr. Ma re-examined Petitioner on April 18, 2014. Petitioner was present with a family member and her case manager. Dr. Ma again reiterated her earlier history going back two years earlier. Petitioner was reporting constant aching and pain with some recent numbness and tingling in her right hand (all fingers) that would awaken her at night. Her exam was unchanged from her earlier visit with the noted additional finding of a questionable positive Tinel's at the carpal tunnel and a mild prominence in the thumb CMC joint. Dr. Ma ordered an EMG/NCV study to rule out carpal tunnel syndrome. She could work with activity modification, bracing, stretching and NSAIDs. She was to return in 6 to 8 weeks. (PX 7)

Petitioner underwent an EMG/NCV study on May 2, 2014 with Dr. Gelber. According to the doctor's report Petitioner worked as a CNA and had originally been hurt in 2010 when grabbing a patient and "since then she had been having pain in her wrist and hand, along with numbness and tingling of all her fingers." She was being referred to test for possible carpal or cubital tunnel syndrome. He concluded the study was abnormal as it showed mild right carpal tunnel syndrome. (PX 6)

At the request of Respondent Petitioner underwent an examination with Dr. James Williams on May 21, 2014. Dr. Williams' report contains a detailed discussion of Petitioner's prior treatment since the accident in 2013. He repeatedly noted that Petitioner took exception to some of the histories recorded in the notes of Dr. Ma as she claimed right hand pain as opposed to just right thumb pain and she claimed symptoms of numbness and tingling in her hand when the reports from office visits stated to the contrary.

Dr. Williams found wrist extension strength on the right to be limited as well as digital flexion and digital extension strength. He found a positive Tinel's on the carpal tunnel on the right. Dr. Williams' impression was that Petitioner suffered a right thumb carpal metacarpal joint sprain. Dr. Williams felt Petitioner's "prognosis for recovery was reasonable, although it appears as though this has now been going on for over 8 months and the patient has not had any significant benefit from any form of treatment, but yet her initial MRI showed no significant injury and my concern is the motivation of the patient. I do not believe the claimant is currently disabled at this time. I believe at any point she can continue to work light duty. At this point, in regards [sic] to treatment, I think a second MRI is in order to once again determine if there is evidence of any pathology at the carpometacarpal joint. If there is not, I would then return the patient to regular duty work with no restrictions. I would not anticipate any permanency with this injury. I think the patient is close to a result. I do not feel she is at MMI yet at this point." (RX 1, p. 4/5) Dr. Williams further commented that with regard to her current level of disability he felt it was mild to moderate but that was based more so on her effort rather than her actual injury. He felt she exhibited some evidence of malingering and lacked any significant evidence of injury to her thumb. He also commented that regarding her numbness and tingling, he wished to see the earlier records of the treating doctors as he felt there was some discrepancy between Petitioner's documentation as to when it began in comparison to what was noted by Dr. Ma. He did feel Petitioner exhibited some evidence of malingering, symptom magnification and a poor effort that day. Due to some discrepancies between Petitioner's claim as to when her numbness and tingling began and what was contained in Dr. Ma's records, Dr. Williams also expressed the desire to see the records of Drs. Sinha and Wottowa as well as those from MOHA. (RX 1, p. 4/5)

Petitioner, with no one accompanying her, returned to Dr. Ma's office on May 30, 2014. Her exam was unchanged from her last visit. She was advised that Dr. Gelber's electrodiagnostic studies suggested mild right carpal tunnel syndrome. Petitioner was continued on her restrictions with the added recommendation for a steroid injection but Petitioner indicated that steroid injections did not appear to work for her. She also advised Dr. Ma that she was unable to get the Voltaren gel on her own due to "financial restrictions." In order to give her a work recommendation, the doctor felt she needed an FCE. Thereafter, she was to return. (PX 7)

Petitioner again returned to see Dr. Ma on June 27, 2014. The FCE had been denied by workers' compensation. Petitioner's exam was unchanged. She was advised to continue light duty until further evaluation by a second opinion. Petitioner was advised to contact workers' compensation for a second opinion or IME. She was to return on an as-needed basis. Because the

FCE test was declined, Dr. Ma indicated that he was unable to detail specific work restrictions and continued her on light duty at that time, noting that would remain in effect until she was further evaluated by a second opinion or "IME." (PX 7)

On August 7, 2014 Petitioner presented to Dr. Mark Greatting. Petitioner gave the doctor a history of her problem going back to 2010 and then falling on September 20, 2013 with increased pain. When seen by the doctor she acknowledged seeing Drs. Wottowa and Sinha after the 2010 accident. Petitioner's current complaints included pain in the thenar and CMC joint area and numbness/tingling in the whole hand along with weakness. Dr. Greatting reviewed x-rays taken in September and December of 2013 and found them unremarkable. Petitioner reported taking nonsteroidal agents with no help but getting some relief with a wrist splint and heat. She denied any improvement from therapy. She had also been seen by Dr. Williams. Petitioner was continuing to work with restrictions. On examination it was noted that Petitioner had diminished sensation to light touch in her fingers. She had both a positive Tinel's and positive a Phalen's over her right carpal tunnel. She also had tenderness over her right thumb CMC and popping in the carpometacarpal joint area was noted upon passive flexing and abducting of the thumb metacarpal. Petitioner was assessed with right thumb pain and right hand numbness and tingling, and crepitation of the thumb area was noted at the CMC joint. Dr. Greatting recommended an MRI and ongoing work restrictions. (PX 7)

The MRI of Petitioner's right thumb was eventually authorized and obtained on May 29, 2015. Dr. Becker's impression was that of mild osteoarthritis and mild first flexor tenosynovitis. (PX 7; RX 4)

Petitioner followed up with Dr. Greatting on July 15, 2015, having last been seen on August 7, 2014. Dr. Greatting advised Petitioner that the MRI revealed some mild osteoarthritis and mild first compartment flexor tenosynovitis. Dr. Greatting felt the symptoms in Petitioner's right thumb CMC joint were most likely related to early arthritic changes in her CMC joint. Dr. Greatting wrote, "She has had different injuries to that area described in her August 7, 2014 note." She "may" have had a sprain or ligamentous injury to the joint which then ultimately resulted in the development of the arthritis. He felt she should try a corticosteroid injection into the joint to see if it helped with her symptoms but Petitioner had significant concerns about it since she had a fear/phobia of needles. Petitioner wished to discuss it with her attorney and would then get back to the doctor. She was told she could continue with the same restrictions and wear the splint as needed. She was advised to return as needed. (PX 7)

Dr. Greatting re-examined Petitioner on March 31, 2016 regarding her right thumb carpometacarpal joint osteoarthritis. Petitioner was reporting increasing pain over time. She was wearing a wrist splint which didn't really support her thumb but she felt it helped. She was tender over the right CMC thumb joint and had pain and crepitation with the grind test. The doctor again discussed an injection but she didn't wish to proceed. She was also told that if her symptoms became severe enough she might benefit form a thumb CMC joint arthroplasty. She

was going to try a Comfort Cool splint on her thumb and return as needed. Work restrictions were not mentioned. (PX 7)

Petitioner returned to see Dr. Greatting on May 4, 2016 regarding left arm pain. She reported pushing a person in a wheelchair in December of 2015 when the chair stopped suddenly and Petitioner felt arm pain in her left triceps and forearm area that had persisted. She was taking 200 mg. of Ibuprofen (3-4 tablets) up to four times a day. Dr. Greatting felt she had a chronic muscular strain in her left triceps and medial forearm. He ordered therapy and ongoing light duty work. No right-sided complaints were mentioned. (PX 7)

Petitioner returned to see Dr. Greatting on June 29, 2016 regarding her left arm and forearm but also mentioned needing a new right thumb comfort cool splint. Workers' compensation had not authorized the therapy for her arm and she had been told by "another doctor" that she could work without restrictions regarding her left arm. Dr. Greatting felt she should continue with her right arm restrictions and agreed none were necessary for the left arm. (PX 7)

Petitioner again returned to see Dr. Greatting on February 16, 2017 regarding her left arm. Dr. Greatting could find nothing abnormal with her left upper extremity which would require any further evaluation or treatment. He noted that when she returned for her radiographs, she asked about work restrictions for her left arm; however, Dr. Greatting did not feel any were necessary. She was released to return as needed. (PX 7)

Petitioner was contacted by Dr. Greatting's nursing staff on February 18, 2017 and advised her left upper extremity x-rays were normal as was the EMG/NCS. Dr. Greatting felt Petitioner could use her left arm without any restrictions or limitations and she could take over-the-counter medications as needed and use ice or heat if it helped. She was advised to return as needed. (PX 7)

On July 11, 2017 Petitioner returned to Dr. Greatting's office regarding her right hand/thumb. Petitioner described her right hand pain as constant and localized it to the CMC joint of the right thumb. He noted "She states this has been going on for many years." Petitioner had a prior history of injury in 2010 and in 2013 working as a CNA. Her most recent injury in 2013 involved a fall on a wet floor. She described her pain as achy, a "7/10" in severity at rest and exacerbated by lifting a gallon of mild. Petitioner had been using her elbow to drive as she was having so much pain with gripping. According to Petitioner a mouse ate her flyer on basilar joint osteoarthritic pain so she wanted another copy. She denied any mechanical symptoms. An EMG from October 17, 2016 revealed no abnormalities. Petitioner was wearing a Comfort Cool brace and taking 800 mg. of Ibuprofen three times a day and alternating with Tylenol. She denied any additional complaints or concerns. While Petitioner was examined by CNP Mirjam Naughton, Dr. Greatting signed off on the note as well.

On examination, Dr. Greatting noted Petitioner had full range of motion in all fingers of the right hand and wrist and 5/5 muscle strength in all planes of movement. She was grossly neurovascularly intact in the right upper extremity. Finkelstein's test was negative. Grind test was negative. Ulnar stress, ballottement, scaphoid shift and Watson's tests were negative. X-rays taken that day were negative for any abnormality. Dr. Greatting confirmed his discussion with Petitioner wherein he explained to her that her x-rays, exam that day, and EMG study were all negative. If she was having pain he told her she could use diclofenac gel and he gave her prescription. He also told her she could continue using her brace as needed. Petitioner inquired as to whether she would be able to get permanent disability and "I explained to her that her findings were negative today." Petitioner reported that Dr. Greatting had previously given her permanent restrictions but no evidence of that could be found in her chart. It was also noted that she had not undergone a functional capacity evaluation. Petitioner was advised to return if needed or contact the office with any additional questions or concerns. (PX 7)

Petitioner's case proceeded to arbitration on August 31, 2017. Petitioner was the sole witness testifying at the hearing. The disputed issues were causal connection, nature and extent, and medical bills.

Petitioner, who was wearing a brace on her right hand/wrist at the time of the hearing, testified that as of September 30, 2013 she was working for Respondent as a CNA and an activities aide. As a CNA, Petitioner takes care of residents assisting with showering, dressing, transfers, and activities of daily living. When engaged in patient transfers she uses a gait belt for assistance. It is a "hands on" job constantly. As an activities aide, Petitioner interacts with the residents and assists them with conversation, movies, and activities. It is a less physical position than that of a CNA. The only physical activity she engages in as an aide is to push the residents in their wheelchairs when necessary. On September 13, 2013, while going to turn on a light, Petitioner fell with her hands behind her. Petitioner testified that her right hand was in severe pain and she was crying. Her left hand was not injured in the fall. Petitioner described the pain as severe and unrelenting. She then felt numbness in her thumb, index finger, middle finger, and palm of her hand. The tingling is in all her fingers. Petitioner denied every experiencing those symptoms before.

Petitioner acknowledged injuring her right hand/thumb in 2010 at work. The injury was at the base of her right thumb. Petitioner was asked if she pursued any workers' compensation benefits for that injury and she replied that "they" were mean to her and basically told her to go back to work because there was nothing wrong with her. Petitioner testified that she was treated at MOHA, the facility she was sent to by Respondent, and released to regular duty on November 19, 2010.

Petitioner denied any further injuries to her right hand/thumb between then and September 30, 2013.

Petitioner testified that she is right hand dominant.

Petitioner testified that after going to MOHA she was put on restricted duty which Respondent accommodated. She treated at MOHA for several months. When asked if she could do her CNA work she replied no indicating she had to end it because she couldn't lift or anything anymore. That happened a couple of days after the accident.

Petitioner denied any improvement from physical therapy. She was eventually referred to Dr. Ma, a hand specialist, who kept her on restrictions which Respondent continued to accommodate. Petitioner would file, help feed residents, and answer the phone. She was also able to continue with some of the activities. Petitioner testified that Dr. Ma "wanted to do something" but it wasn't authorized.

Petitioner testified that she next went to Dr. Greatting who kept her on restrictions. On June 29, 2016 Petitioner received a work restriction slip that, to Petitioner's knowledge, has never been removed or changed.

Petitioner testified that she continues to wear a brace at work, when driving and, as needed, at home. It is periodically replaced and the most current one she has was obtained in July of 2017. They last about 3-4 months and then fall apart. Petitioner is still working for Respondent but only as an activities aide. The activities she performs as an aide are no different than the ones she was performing before her 2013 accident.

Petitioner testified that her right hand was going numb while she was on the witness hand. It will also hurt and wake her up at night. She notices the numbness daily. Petitioner used to wash her car all the time but if she did it now it would probably take a few hours. She can no longer vacuum her car and it is hard to vacuum the house. When she does so, her hand starts hurting and burning so she will have to take a break. When stirring something in a bowl, her hand will also start burning. Gripping the steering wheel is very difficult because her hand starts hurting "real bad." She no longer grips the steering wheel with her right hand, preferring to use the left hand only. She also drops things and has to use both hands to pick things up (such as a gallon of milk or a coffee pot). When pushing heavy people in a wheelchair her hand will also hurt. She has altered how she holds the handles on a wheelchair, using her palm rather than her hand.

Petitioner acknowledged a separate injury to her left arm. As a result of the two injuries, things are "harder." She has tried home exercises but nothing helps her right hand. She takes over-the-counter Ibuprofen and Tylenol every day. She has not followed up with Dr. Greatting because he said he couldn't do anything for a long time.

On cross-examination Petitioner testified that she told the doctors the truth each time she visited them regarding her complaints and history. She recalled going to therapy and being very truthful and honest about her 2010 accident. She further acknowledged that when she was

released in 2010 she still had pain complaints and wanted some additional treatment. She was afraid she wouldn't be able to lift patients or would drop things due to the hand pain she was experiencing. Petitioner continued working as a CNA after the 2010 accident and would disagree with the history provided to the therapist wherein it was noted she was unable to continue as a CNA. She also acknowledged that she became an activities aide sometime before September 30, 2013. She also acknowledged that she limited some of her work activities as a CNA because of the hand pain from her 2010 accident. She also acknowledged that when she saw the occupational therapist she told him her hand hurt every day since the 2010 accident. She agreed that she rated her pain a "6/10" before her 2013 accident and a "7/10" after the accident. She also agreed that she told every doctor that she continued to have pain from the 2010 accident up to the 2013 accident. Petitioner also testified that the pain before the 2013 accident was now and then but after it became daily and nightly. Prior to September 30, 2013 she worse a brace for her right arm but then she quit.

Petitioner also acknowledged injuring her left arm in an accident in 2015 and she continues to have pain in her left hand. She takes the medication for her left hand, too. Petitioner acknowledged still working but that her left hand hurts also.

Petitioner testified that she tried to be seen by the doctor on July 11th when she got her new brace but she wasn't allowed to.

Petitioner testified that she is currently taking Gabapentin but she wasn't sure who prescribed it to her and it may be for both arms. She thought Dr. Greatting had prescribed it.

On redirect examination Petitioner denied any right wrist/hand pain "just before" September 30, 2013. She also denied wearing a brace just before the accident believing she had stopped wearing it when she was released in November of 2010.

Petitioner's medical bills are found in PX 2.

The Arbitrator concludes:

Petitioner's credibility.

Petitioner was not an altogether credible witness in light of inconsistencies and contradictions in the medical records and between her testimony and the medical records. Petitioner testified she was always honest and forthright with her doctors. She also testified that she immediately noticed numbness and tingling in her right hand after she fell on September 30, 2013. However, the MOHA records from that same day indicate that she denied any symptoms of numbness and tingling. Furthermore, Petitioner's medical records continue to reflect no complaints of numbness or tingling until Petitioner was examined by Dr. Williams in May of 2014 at which point she indicated the records were wrong because she had always had those complaints. Petitioner could have deposed any of her doctors to corroborate problems with

numbness and tingling immediately after the 2013 accident but she didn't. The Arbitrator finds the histories contained in the medical records to be more credible and persuasive than Petitioner's testimony given their closer proximity to the date of accident and concerns about Petitioner's motivation in this matter.

Not only did Respondent's examining physician, Dr. Williams, pick up on some signs of symptom magnification but her treating physicians all commented on it either directly or indirectly. Petitioner seems to have some motivational issues (both in November of 2010 and when being treated by Dr. Greatting for both upper extremities) as she wished for work restrictions at both times when none were felt necessary due to relatively benign exams.

Additionally, Petitioner misrepresented her treatment history to Dr. Williams as she told him she had seen Dr. Wadhwa (Wottowa), Dr. Sinha, and Dr. Ma since her 2013 accident. However, no records from Dr. Wottowa or Dr. Sinha were introduced into evidence corroborating that representation. Further, it appears from other histories that those visits with Dr. Wottowa and Dr. Sinha took place after her 2010 thumb accident and before the instant one.

Petitioner also referenced undergoing a cortisone shot to her right hand after the 2013 accident but that, too, wasn't corroborated by the medical records. Rather, she underwent the injection after her 2010 accident. Petitioner also told Dr. Williams that she was working in May of 2014 with restrictions for both arms; however, no evidence of restrictions to her left arm were found in the record for May of 2014.

The Arbitrator is doubtful whether Petitioner was being truly forthright concerning when she stopped working solely as a CNA and began working as an activities aide. Again, while she testified it had nothing to do with her 2010 accident, the history contained in the initial therapy records states otherwise.

Petitioner testified that she is currently on Gabapentin and believed Dr. Greatting prescribed it. She did not submit a bill for reimbursement of Gabapentin medication. Dr. Greatting's records do not reflect that he ever prescribed it for her. His office visit note of May 4, 2016 states that it was prescribed to Petitioner by her primary care doctor. No records from a primary care doctor were admitted into evidence. The Arbitrator declines to find that the Gabapentin was prescribed for Petitioner's right hand. She views Petitioner's testimony regarding this as misleading and undermining of her overall credibility.

The Arbitrator also notes a reference to an updated EMG/NCV study performed on October 17, 2016. It was reportedly negative and the report, itself, was not included in the record. Petitioner provided no testimony concerning why it was done or who ordered it.

With the foregoing in mind, the Arbitrator addresses the various issues of the case.

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

Petitioner suffered a fall on September 30, 2013 when she slipped on a wet floor and fell backwards landing on her hyper-extended hands and wrists. She developed immediate pain in her right hand and right thumb and was seen the same day of the injury by Midwest Occupational Health Associates. She would continue to treat with Dr. Ma and Dr. Greatting. As a result of that undisputed accident Petitioner sustained a right hand/thumb sprain. While Dr. Ma did not clearly and unequivocally state in his office notes that Petitioner's condition was work-related, his office notes indicate such.[1] Additionally, Dr. Williams, Respondent's examining physician, agreed that Petitioner sustained a sprain/strain. Dr. Greatting did not address causation.

Petitioner has also been diagnosed with right carpal tunnel syndrome (albeit mild) and right osteoarthritis of the CMC joint of her thumb. Petitioner failed to prove that either of these conditions were causally connected to her accident. No doctor provided a causation opinion regarding Petitioner's mild right carpal tunnel syndrome. Given the entry in Dr. Greatting's July of 2017 office note referencing a more recent negative EMG/NCV study, the condition may have even resolved. With regard to the osteoarthritis of the CMC joint, the Arbitrator notes Dr. Greatting's discussion of the diagnosis in his July 15, 2015. At that time he referenced that Petitioner had sustained two accidents to that area as described in his original office visit with Petitioner. Dr. Greatting never stated that the osteoarthritis was causally related to the September 30, 2013 fall.

The Arbitrator is unable to find causation based upon a chain of events given her considerable doubts and concerns as to Petitioner's overall credibility and motivation herein. There were simply too many inconsistencies between Petitioner's testimony and information contained in the medical records and while Petitioner felt some of the entries in her medical records were erroneous she took no steps to correct them. Regarding her symptoms of numbness and tingling in her right hand, her testimony as to its immediate onset at the time of the accident was uncorroborated by her treating medical records. Furthermore, the Arbitrator is troubled by the absence of Dr. Wottowa's and Dr. Sinha's records concerning Petitioner's treatment to her right thumb prior to the accident herein. Also, the negative EMG/NCV study from 2016 is not a part of the record. Petitioner acknowledged she had problems with her right thumb going back to the 2010 accident. While she tried to down play them during the hearing her medical records suggest ongoing pain complaints and limitations since 2010. Given her motivational and credibility issues, her testimony wasn't persuasive.

In summary, there is no question that Petitioner injured her right thumb/hand on September 30, 201. She also had a prior injury to that thumb/hand. The question is to what extent she injured her right hand/thumb in the 2013 accident. Based upon the overwhelming weight of the

[1] See each office note under "Chief Complaint."

objective medical evidence in the record, it appears that Petitioner had severe right hand and thumb pain before September 30, 2013. While Dr. Ma found her condition while he was treating her to be work-related when he last saw her on June 27, 2014 he suggested a second opinion or IME. He left her on temporary restricted duty until that appointment. Petitioner then followed up with Dr. Greatting on August 7, 2014. Dr. Greatting was aware of both the 2010 and 2013 accidents. He never opined Petitioner's osteoarthritic condition in her right thumb was due to her 2013 accident. In light of the foregoing, the Arbitrator finds it reasonable to end causation for her work injury of September 30, 2013 on June 27, 2014 when she was last examined by Dr. Ma and to limit that injury to a right hand/thumb sprain/strain.

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?

Consistent with her causation determination, Petitioner is awarded those medical bills found in Petitioner's Exhibit 2 incurred through June 27, 2014.

Petitioner's Exhibit #2 contains medical bills from Midwest Occupational Health Associates and billing from Springfield Clinic. The billing from MOHA reveals total charges of $1622.80 with an outstanding balance of $473.80. There is a Statement from Springfield Clinic dated 12/6/16 with pending charges of $37.00. The Arbitrator declines to award that charge as it is not itemized. Petitioner's bills from Dr. Ma (Springfield Clinic) have been paid. The Arbitrator declines to award the bills from Dr. Greatting (Springfield Clinic) consistent with her causation determination. Respondent's Exhibit #2 shows medical payments made by Respondent. Therefore, Respondent is entitled to a credit for any bills previously paid.

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

For accidents occurring after September 1, 2011, the Arbitrator must look to the five factor test in determining permanent partial disability.

With regard to the first factor, an impairment rating, neither party submitted one. Therefore, the Arbitrator gives no weight to this factor.

As to the second factor, the nature of the employment, Petitioner worked for Respondent as a CNA and "Activities Aide." She has continued to work as an "Activities Aide." While Petitioner testified she stopped working as a CNA shortly after the 2013 accident, that was voluntarily done so by her. No doctor has indicated she is unable to resume that position. Petitioner's ongoing complaints of pain are subjective as Dr. Greatting has found her last examinations for both upper extremities to be negative. Objectively, it appears Petitioner is capable of resuming the work activities she had at the time of her accident. For this reason, the Arbitrator gives this factor some weight.

With regard to the third factor, age, Petitioner was 42 years old on the date of his accident. No direct evidence was presented as to how Petitioner's age affects her disability, if any. As such, the Arbitrator places little weight on this factor.

With regard to the fourth factor, future earning capacity, no evidence was presented as to how Petitioner's future earning capacity has been affected by her injury. No direct evidence concerning future earning capacity was introduced. Therefore, the Arbitrator gives no weight to this factor.

Finally, with regard to the fifth factor, evidence of disability as corroborated by the treatment records, the Arbitrator notes that medical records do not corroborate any ongoing disability causally related to her 2013 accident. As of her last visit with Dr. Greatting in 2017 the doctor noted that Petitioner's physical examination was negative and her EMG and x-rays were negative. He did not feel any permanent disability was present as all of her findings were negative. While Dr. Ma had previously given Petitioner light duty restrictions while he treated her, he never stated they were permanent. Dr. Greatting, her subsequent doctor, imposed no permanent restrictions.

Based upon the foregoing, and in light of concerns regarding Petitioner's credibility, the Arbitrator concludes that Petitioner has sustained permanent partial disability to the extent of 2% loss of use of the right hand.

****

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Michael Pearl,

Petitioner,

vs.

NO: 16 WC 34526

Chicago Chesed Fund, Inc.,

19IWCC0183

Respondent.

DECISION AND OPINION ON REVIEW

A Petition for Review and a Motion on Settlement Contract on Review having been filed by Petitioner herein and notice given to all parties, this cause came before Commissioner Thomas J. Tyrrell for hearing on October 25, 2018, in Chicago, Illinois. The Commission, after being advised of the facts and law, finds it has jurisdiction to review the settlement contract at issue. The Commission also finds there was a mutual mistake of fact between the parties regarding the amount of the outstanding Blue Cross Blue Shield lien. Finally, the Commission rescinds the settlement contract and remands this matter to the Arbitrator for further proceedings.

Procedural History

On August 1, 2011, Petitioner injured his left foot while carrying a piece of furniture down stairs while at work. The parties reached an agreement to settle the case on a disputed basis. The settlement negotiations involved discussions regarding outstanding medical bills and/or liens. Arbitrator Soto approved the Settlement Contract Lump Sum Petition and Order ("settlement contract") on March 26, 2018. The approved settlement amount is $29,500.00 and includes the following language:

> "The Settlement Amount represents 27 ½ percent permanent partial disability to the LEFT FOOT ($18,848.54), plus payments toward a BCBS lien ($164.96) and an unpaid medical bill or lien from Physicians Immediate Care ($271.50), plus disputed TTD benefits ($912.04), plus disputed future medical bills and expenses ($5,000.00), with the remainder to conclude all other issues in the case, including without limitation any and all unpaid liens and/or outstanding medical bills and expenses."

Soon after April 19, 2018, Petitioner received notice from the group insurance carrier (BCBS) claiming a lien in the amount of $13,790.00 instead of the $164.96 documented in the settlement contract. Petitioner filed a Petition for Review on April 24, 2018.

On June 26, 2018, Petitioner filed a Motion on Settlement Contract on Review and set the motion on Commissioner Tyrrell's July 18, 2018, Chicago Review Call. Petitioner's motion asked the Commission to reject the settlement contract as "the approval of the contract based upon the mutual mistake of fact is not in the best interest of the parties." After an informal discussion during which Respondent questioned whether the Commission had jurisdiction to even consider either the pending Petition for Review or Petitioner's motion, Commissioner Tyrrell requested the parties fully brief the question of jurisdiction. Both parties fully briefed the issue and made arguments on the record during a hearing before Commissioner Tyrrell on October 25, 2018.

Conclusions of Law

There are two issues the Commission must consider to properly resolve this matter. First, the Commission must determine whether it maintains the jurisdiction to review a settlement contract when a petitioner files for review 29 days after the Arbitrator approved the contract. Next, the Commission must determine whether the facts of this case warrant the rescission of the settlement contract. After carefully considering the facts and the relevant law, the Commission finds it possesses jurisdiction to review the settlement contract.

The Commission is an administrative agency and thus has limited powers. The Commission's powers are limited to those explicitly granted by the legislature. *See Alvarado v. Indus. Comm'n*, 216 Ill. 2d 547, 553 (2005). Surprisingly, no Illinois court has directly addressed the question of whether a settlement contract approved by an Arbitrator is considered a decision of the Arbitrator or a decision of the Commission. This is the crucial issue in this matter. Section 19(b) provides that a decision of the Arbitrator shall become the decision of the Commission unless a Petition for Review is filed within 30 days after receipt of the decision. Contrarily, a decision of the Commission becomes final if a proceeding for review is not filed within 20 days of receipt of notice of the decision pursuant to Section 19(f)(1) of the Act. Here, the Commission only has jurisdiction to review the settlement contract if the contract is effectively a decision of the Arbitrator and thus has a 30-day review period. The parties do not dispute that the Petition for Review was filed 29 days after the contract was approved.

There is at best minimal guidance provided by Illinois courts regarding the applicable period of review for such a settlement contract. The cases providing any guidance involve the issue of the Commission's jurisdiction to consider post-settlement fee disputes between a petitioner's former and current attorneys. In support of his argument that he timely filed the Petition for Review, Petitioner primarily relies on the Appellate Court's dicta in *Yocum v. Indus. Comm'n*, 297 Ill. App. 3d 813 (1998). In *Yocum*, the Arbitrator approved a settlement contract without resolving the pending fee petition was still pending. The former attorney filed a motion before a Commissioner seeking an allocation of attorneys' fees and the Commission issued an award allocating the fees between both attorneys. The second attorney argued the Commission lacked subject matter jurisdiction to consider the fee dispute because his opponent failed to file a Petition

for Review within 30 days of the Arbitrator's approval of the contract. The Court determined the former attorney's motion was sufficient to preserve the Commission's jurisdiction over the fee dispute. As the record was unclear as to whether both the arbitrator and the Commission approved the settlement contract, the Court commented on the filing deadlines for both scenarios:

> "The dispute as to fees was before the arbitrator and the Commission and the April 25, 1996, motion by Delano was timely. If only the arbitrator approved the settlement, the motion was timely because it was filed within 30 days of the arbitrator's approval of the contract on April 15, 1996. The motion was also timely if we assume the Commission as well as the arbitrator approved the contract on April 15, 1996."

Yocum, 297 Ill. App. 3d at 817. Thus, the *Yocum* Court indicated that a settlement contract approved by an Arbitrator is the same as an arbitration decision and has a 30-day period for review pursuant to Section 19(b).

Respondent relies on the Illinois Supreme Court's dicta in *Alvarado v. Indus. Comm'n.*, 216 Ill. 2d 547 (2005). In *Alvarado*, the Court considered the question of the Commission's jurisdiction to consider a fee dispute once a settlement contract becomes a final award. In this case, the petitioner fired his original attorney and hired a new attorney. An arbitrator later approved a settlement contract; however, the fee dispute remained outstanding. The former attorney learned of the settlement agreement approximately four months after the arbitrator approved the contract and he filed a motion seeking fees. The Supreme Court stated the following regarding period of review of a settlement contract:

> "we agree...that the Commission's approval of a settlement agreement becomes a final award after 20 days if no petition for review is filed, and that the Commission no longer has jurisdiction to reopen or reconsider an award beyond that date except as specifically provided in the Act."

Alvarado, 216 Ill. 2d at 558. The court went on to find the Commission had jurisdiction to consider the fee petition.

Absent any precedential decision by either the Appellate Court or the Supreme Court, this Commission is inclined to interpret the Act in the most reasonable and equitable light. The Commission also has considered that the *Yocum* and *Alvarado* decisions did not involve an issue that would directly impact a petitioner's recovery for his workers' compensation claim. Fee disputes involve only the portion of the settlement allocated to attorneys' fees. The Commission is loath to reach a conclusion that would have a detrimental direct impact on Petitioner in this matter. Therefore, the Commission finds a settlement contract approved by an Arbitrator has the same effect as a decision by an Arbitrator. Pursuant to Section 19(b), such a settlement contract does not become a final decision of the Commission until 30 days after its approval. The Commission possesses proper jurisdiction to review the settlement contract if a Petition for Review is timely filed. Any other conclusion would effectively rob the Commission of jurisdiction to

review any settlement contracts approved by an Arbitrator. After all, if a contract approved by an Arbitrator is immediately considered to be a decision of the Commission, pursuant to Section 19(f)(1), only the Circuit Court would have jurisdiction to review a contract if a proceeding for review is timely and properly filed. This result contradicts longstanding practice and procedure at the Commission.

Illinois statutes should be construed in a manner that avoids "absurd, unreasonable, unjust, or inconvenient results." *Kinn v. Prairie Farms*, 368 Ill. App. 3d 728, 731 (2003) (citing *In re Mary Ann P.*, 202 Ill. 2d 393, 406 (2002)). The Commission's conclusion that Petitioner timely filed his Petition for Review avoids an unjust result. During settlement negotiations, both parties considered the payment of outstanding medical bills and/or liens important. This is shown by the identification of two specific liens in the contract. At the time of contract approval, both parties believed BCBS had a lien in the amount of $164.96. However, Petitioner later received notice from the insurer that the outstanding lien is $13,790.00. This is $13,625.04 more than the parties believed. The settlement contract does not provide that Respondent must hold Petitioner harmless from claims by BCBS for outstanding charges; thus, if the settlement contract stands, Petitioner would be personally liable for the remaining $13,625.04 owed to BCBS. This would result in Petitioner receiving only $9,957.96 from the settlement after he paid the outstanding lien. Both parties executed the settlement contract with the mutually mistaken belief that the BCBS lien was only $164.96. As it is clear from the settlement contract that the parties intended to resolve the outstanding lien as part of the disputed settlement, the Commission finds rescission of the contract is appropriate due to this glaring mutual mistake of fact.

Finally, for the foregoing reasons, the Commission considers rescission of the contract to have the same effect as the Commission rejecting the settlement contract. Pursuant to Section 9070.40(d) of the Administrative Rules of the IWCC, any additional settlement contract must be presented to the Commissioner who rejected the prior settlement contract for consideration. As this matter is assigned to Commissioner Thomas J. Tyrrell, the parties must submit any subsequent settlement contract to Commissioner Tyrrell for consideration.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's Motion on Settlement Contract on Review filed June 26, 2018, is hereby granted. The Commission hereby rescinds and rejects the settlement contract approved on March 26, 2018, due to the parties' mutual mistake of fact regarding the amount of the BCBS lien.

IT IS FURTHER ORDERED that the pending Petition for Review filed by Petitioner on April 24, 2018, is hereby dismissed.

19IWCC0183

IT IS FURTHER ORDERED that the parties shall submit any further settlement contracts to Commissioner Thomas J. Tyrrell, or a Commissioner sitting in his stead, pursuant to Section 9070.40(d) of the Administrative Rules of the IWCC.

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

DATED: APR 8 - 2019

d: 2/5/19
TJT/jds
51

Thomas J. Tyrrell

Michael J. Brennan

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Morris Washington, legal custodian and guardian
of Kennedy Washington, daughter and beneficiary
of Sheree Mayfield, deceased,

Petitioner,

vs.

NO: 17 WC 18052

19IWCC0184

Northeastern Illinois University,

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 all issues, and being advised of the facts and law, reverses the Decision of the Arbitrator for the reasons stated below. Furthermore, the Commission awards survivor and burial benefits pursuant to Section 7 of the Act to Petitioner on behalf of the deceased employee's minor daughter, Kennedy Washington.

Findings of Fact

This case involves an employee, Sheree Mayfield ("Decedent"), who sustained what proved to be a fatal injury on June 19, 2015, while performing her work duties. On that date, Decedent sustained a right tibial plateau fracture while playing in a student/faculty basketball at one of her assigned schools. Unfortunately, she died of a pulmonary embolism a few days after undergoing surgery to repair the fracture. At her time of death, Decedent had one minor child named Kennedy Washington. Petitioner Morris Washington is the father and legal guardian of Kennedy Washington. At the time of her death, Decedent worked as a college access counselor for Respondent's GEAR UP program.

Colette Thelemaque-Collier testified on behalf of Petitioner. On the date of accident, she was the Assistant Director of the GEAR UP Program and supervised Decedent. (Tr. at 15). GEAR UP stands for Gaining Early Awareness and Readiness for Undergraduate Programming and is a federally funded grant used to increase college access and graduation rates for first generation college students. *Id.* at 16. The program works with Chicago Public Schools ("CPS") and the team provides workshops to parents and students as well as support through college and career exposure

and engagement activities. *Id.* She explained "engagement activities" as:

> "...primarily we conduct workshops in the classroom that explore the connection between college and careers, we engage students in college visits, career days, career exploration, team building activities, family financial aid workshops. So anything relative to allowing the students to gain more exposure and access to college, and also promoting positive relationships between parents and students."

Id. at 16-17. Team building exercises include experiential education such as activities where students can think about collaboration and overcoming obstacles through physical activities or cooperative games. *Id.* at 17. She testified that this could include playing in a sporting event together.

Thelemaque-Collier testified that the college access coordinators travelled to various schools away from the program's central office. She testified that Decedent's job duties included managing a high school site team, providing the scope of work covered by the grant, assisting in workshops for parents and students, professional development training, and coordinating events. *Id.* at 18. Decedent was assigned more than one high school and Thelemaque-Collier testified that it was reasonable for Petitioner to engage with the participating students in activities. *Id.* at 19. Thelemaque-Collier testified that her understanding of Decedent's injury is that she broke her femur while playing basketball with students participating in the program. *Id.* at 19. She testified that it was foreseeable for Decedent to engage in that type of activity and that playing basketball with the students furthered the purpose of the program. *Id.* at 20. Thelemaque-Collier testified that playing basketball was not mandatory but was a reasonable or foreseeable activity for a college access coordinator.

Wendy Stack testified on Respondent's behalf and has worked for Respondent for 28 years. Her current title is Associate Vice President, Access, Innovation, and Research and Executive Director, Center for College Access and Success. *Id.* at 25. Stack testified that the primary purpose of the college access program is to increase the high school graduation rate, the rate of students attending college, and the college graduation rate of CPS students. *Id.* at 27.

Stack testified that Decedent worked with the CPS college and career coach at her assigned school and her responsibilities included working with the post-secondary team at the high schools which may include counselors, other coaches besides the GEAR UP coach, and assistant principals. Stack testified that Decedent's responsibilities were focused on improving the students' success rates at the high school and their college readiness upon graduation. *Id.* Decedent was assigned to Hancock High School and would periodically work with college access coordinators from other area high schools. When asked about Decedent's mandatory job duties, Stack testified,

> "Supervising the tutors, mentors, et cetera, as I said earlier, making sure that students were receiving the GEAR UP services like tutoring, being involved in after school programs, recruiting students for summer or Saturday type programs that we

> provided…this grant requires a dollar-for-dollar match that's non-federal. So she would also be responsible for trying to document those funds, those matching funds by working with the school to do that."

Id. at 30-31. She testified that participating in athletic activities is not mandatory and that there were many other activities happening that day in which Decedent could participate because it was the last day of school.

Stack testified that there is a central office for the Center and confirmed that Decedent had an assigned work space at that office. *Id.* at 32. She agreed that Decedent's job required her to travel away from the central office to engage students at her assigned school(s). She testified that it was foreseeable for Decedent to engage students in activities such as basketball as a method of engagement. *Id.* at 33.

The hospital discharge record reports Decedent was in the hospital from the date of accident through June 23, 2015 (the date of death). (PX5). The admitting diagnosis was a right tibial plateau fracture. Decedent gave a history of playing in a faculty/student basketball game and felt a twisting sensation in her right knee when she landed after a jump. She was transported to the ER and underwent surgery consisting of a closed reduction and placement of a spanning external fixator. The surgery was uneventful, but Decedent stayed in the hospital longer than usual due to her difficulty ambulating with crutches. Per the discharge note, everything was normal until June 23, 2015. On that date, Decedent completed her physical therapy and was placed in a chair. While sitting in the chair, her eyes rolled in the back of her head and she lost consciousness. Medical personnel tried to resuscitate Decedent for over an hour.

The death certificate states that Decedent sustained a right knee tibial plateau fracture while playing basketball. The causes of death are pulmonary thromboembolism, deep venous thrombosis of the right calf, and blunt force injuries of the right lower extremity. (PX4).

Conclusions of Law

Petitioner bears the burden of proving each element of Decedent's case by a preponderance of the evidence. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 203 (2003). He must show by a preponderance of the evidence that Decedent suffered a disabling injury which arose out of and in the course of her employment. *Id.* The phrase "in the course of employment" refers to the time, place, and circumstances surrounding the injury. *Id.* To satisfy the "arising out of" prong, Petitioner must show that the injury "had its origin in some risk connected with, or incidental to, the employment." *Id.* After carefully considering the evidence and relevant law, the Commission finds Petitioner met his burden of proving Decedent's injury arose out of and in the course of his employment.

The Commission finds the Arbitrator correctly determined that Decedent was a traveling employee when the accident occurred. A traveling employee is an employee whose duties require them to travel away from their employer's premises. *Venture-Newberg-Perini v. Ill. Workers' Comp. Comm'n*, 2013 IL 115728, ¶ 17. Illinois courts have found that injuries sustained by a

traveling employee arising from the following three categories of acts are compensable: 1) acts the employer instructs the employee to perform; 2) acts which the employee has a common law or statutory duty to perform while performing duties for the employer; and 3) acts which the employee might be reasonably expected to perform incident to his assigned duties. *Id.* at ¶ 18.

Here, both witnesses had direct knowledge of Decedent's job and testified that her position required her to travel to at least one high school to engage with students participating in the program. Respondent does not dispute Decedent was at the high school in pursuit of her work duties. Respondent's witness, Wendy Stack, even testified that the Center for College Access and Success which runs the GEAR UP program has a central office and that Decedent had an assigned work space in the office. Respondent offered no evidence to refute this testimony. Decedent's injury occurred while she participated in an event at one of her assigned schools. Thus, Decedent was a clearly traveling employee at the time of her accident. After carefully considering the law and the totality of the evidence, the Commission finds Decedent's injury occurred while she performed an act her employer might reasonably expect her to perform incident to her assigned duties as a college access coordinator. Ms. Thelemaque-Collier, Petitioner's witness, and Ms. Stack both testified that while it was not mandatory for Decedent to participate in a faculty/student basketball game at her assigned school, her participation was reasonable and foreseeable.

Normally, the Commission's analysis would end with the determination that Decedent was a traveling employee who sustained an injury while performing a reasonable and foreseeable act. After all, if the employee is engaged in conduct that is reasonable and foreseeable, generally any resulting injury arises out of and occurs in the course of employment. However, in support of his conclusion that Petitioner did not prove Decedent sustained an injury arising out of and in the course of her employment, the Arbitrator relied exclusively on the voluntary recreational activity exclusion pursuant to Section 11 of the Act. Section 11 states in relevant part,

> "Accidental injuries incurred while participating in voluntary recreational programs including but not limited to athletic events, parties and picnics do not arise out of and in the course of the employment even though the employer pays some or all of the cost thereof. This exclusion shall not apply in the event that the injured employee was ordered or assigned by his employer to participate in the program."

820 ILCS 305/11. The Arbitrator did not address whether the Section 11 exclusion applied to an accident suffered by a traveling employee. Pursuant to *Bagcraft v. Indus. Comm'n*, 302 Ill. App. 3d 334 (1998), the Commission concludes the Section 11 exclusion of voluntary recreational activity is inapplicable when the injured employee is a traveling employee.

In *Bagcraft*, the claimant went on an annual corporate trip to visit a major supplier. In past years, the employees participated in recreational activities, including riding ATVs. *Id.* The claimant went for a ride on an ATV and died as a result of injuries he sustained during the ride. After reviewing the facts, the Appellate Court concluded that Section 11 is not applicable to traveling employees. *Id.* at 338. The court stated that Section 11 contained no language showing an intent by the legislature to abrogate the traveling employee doctrine. The Court assumed the

legislature enacted Section 11 with knowledge of the way in which the traveling employee doctrine evolved in common law. The Court wrote,

> "Without specific language directing application of section 11 to the traveling employee scenario, we cannot conclude that the legislature intended to abrogate an entire body of case law. We thus conclude that the proper analysis requires application of the traveling employee doctrine and not section 11."

Id. at 340. There are no subsequent cases or statutes limiting the *Bagcraft* ruling; thus, Decedent clearly sustained an injury arising out of and in the course of her employment during the June 19, 2015, faculty/teacher basketball game.

Respondent does not dispute that the causes of death listed on Decedent's death certificate, including pulmonary thromboembolism and deep venous thrombosis of the right calf, are causally related to her June 19, 2015, work injury. Respondent also does not dispute the reasonableness and necessity of any of the medical expenses resulting from the work injury. The parties stipulated that all medical bills were paid by Decedent's group health insurance through Respondent.

For the foregoing reasons, The Commission finds Decedent's death was the tragic result of the compensable injury she sustained on the date of accident. The Commission finds that Decedent died on June 23, 2015, leaving one survivor, as provided in Section 7(a) of the Act, including her daughter Kennedy Washington.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 15, 2018, is reversed in its entirety.

IT IS FURTHER ORDERED that Respondent shall pay death benefits, commencing **June 23, 2015**, of **$735.37**/week on behalf of the minor child of the decedent, ***Kennedy Michelle Washington***, born ***September 17, 2010***, to **Morris Washington**, natural parent and legal guardian of Kennedy Washington because the injury caused the employee's death, as provided in Section 7 of the Act. Respondent shall pay death benefits until Kennedy's 18th birthday or until her 25th birthday if she is enrolled as a full-time student in an accredited educational institution.

IT IS FURTHER ORDERED that Respondent shall pay ***$8,000*** for burial expenses to the decedent's surviving child or the person(s) incurring the burial expenses, as provided in Section 7(f) of the Act.

IT IS FURTHER ORDERED that commencing on the second July 15th after the entry of this award, Petitioner may become eligible for cost-of-living adjustments, paid by the ***Rate Adjustment Fund***, as provided in Section 8(g) of the Act.

IT IS FURTHER ORDERED 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.

19IWCC0184

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.

DATED: APR 8 - 2019

o: 2/11/19
TJT/jds
51

Thomas J. Tyrrell

Michael J. Brennan

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WILLIAMSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ROBERT DEERE,

Petitioner,

vs.

NO: 15 WC 11627

THE AMERICAN COAL COMPANY,

Respondent.

19IWCC0185

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, exposure, arising out of and in the course of employment, causal connection, permanent disability, legal and evidentiary error, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

Findings of Fact and Conclusions of Law

The Commission adopts the Arbitrator's Statement of Facts in its entirety, however, the Commission views the evidence different from the Arbitrator. The Commission finds no reason to disturb the finding of the Arbitrator as it pertains to coal workers' pneumoconiosis, however, the Commission finds Petitioner contracted a disabling pulmonary occupational disease as a result of an exposure that arose out of and in the course of his employment under the Act. Therefore, the Commission vacates the Arbitrator's Conclusions of Law and substitutes the following:

Petitioner proved by a preponderance of the evidence that he sustained an occupational disease arising out of and in the course of his employment. In so concluding, the Commission finds the testimony of Dr. Paul to be credible and most persuasive with regard to the Petitioner's condition of chronic obstructive pulmonary disease.

Petitioner testified he worked in the coal mine for 40 years and the last 38 being below ground. He testified in addition to coal dust, he was regularly exposed to and breathed silica dust, roof bolting glue fumes, diesel fumes and trowel on, a glue used to put tiles up on the wall. He testified he was exposed to coal dust on the date he retired. Petitioner's medical records reflected treatment for upper respiratory infections, sinusitis and coughs over the years. With these acute conditions, Petitioner complained of cough, sometimes with, and sometimes without, sputum production. Petitioner testified that when he would get a cold his breathing would become labored, or he would cough up black sputum beginning in the early-to-mid 1980's. (T, p. 29-30) Petitioner testified that since he left the mine, his breathing problems "pretty much stayed the same." (T, p. 30) He testified he cannot seem to take a deep breath when trying to do yard work or playing with his grandkids. (T, p. 31) He testified that his hobbies and activities of daily living are now affected. He testified he can no longer ride a bike, or run and or trek into the back woods when hunting. (T, p. 32)

The Commission agrees with the Arbitrator that Dr. Castle's and Dr. Meyer's interpretation of Petitioner's chest x-rays are more persuasive than those of Dr. Smith and Dr. Paul regarding the presence of coal workers' pneumoconiosis in Petitioner's lungs but would not go so far as to say, as the Arbitrator did, that Dr. Paul's opinion regarding Petitioner's chronic bronchitis and chronic obstructive pulmonary disease is not persuasive. To the contrary, Dr. Paul is board certified in allergy, asthma and immunology. Although, by his own admission, Dr. Paul is not a B-reader, the Commission recognizes Dr. Paul's long history of treating coal miners for coal mine-induced lung disease and equally long history of interpreting chest x-rays of coal miners, but those histories cannot be said to be the same as taking the B-reading course and passing the B-reading test. Dr. Paul's experience makes his opinion as credible as one can be without the requisite training that a B-reader possesses.

With respect to the chest x-ray interpretations of Petitioner's certified B-reader, Dr. Smith, the Commission notes that, as Dr. Meyer testified, there can be disagreement between B-readers concerning the presence of small opacities on a chest x-ray. Dr. Meyer disagreed with Dr. Smith's report. (Rx1, Exhibit B). As Dr. Meyer testified, one of the most important parts of the B-reader training and examination is making a distinction between a 0/1 and 1/0 film. (Rx1, pp. 35, 36)

Dr. Castle testified that he is a certified B-reader and he reviewed the chest x-ray dated November 12, 2015 and that there were no parenchymal abnormalities consistent with pneumoconiosis. Dr. Castle testified that Dr. Smith interpreted the same film and indicated that there were opacities throughout both lung fields classified as P/P with a profusion of 1/0. He testified that this meant that Dr. Smith also considered that the film may be negative. Dr. Smith did not testify.

The Commission finds it instructive to have testimony of a B-reader that explains the idiosyncrasies of B-reading and, more specifically, a positive and/or negative B-reading finding. For this reason, the Commission finds Dr. Meyer's and Dr. Castle's testimony helpful and more persuasive than the x-ray interpretation reports of Dr. Smith and Dr. Paul with regard to coal workers' pneumoconiosis.

The Commission disagrees with the Arbitrator, however, with respect to the evidence

demonstrating pulmonary disease. The Commission is persuaded by Dr. Paul's explanation of his diagnoses of chronic bronchitis and chronic obstructive pulmonary disease. Petitioner was seen by Dr. Paul at the Central Illinois Allergy and Respiratory Service on November 12, 2015 and underwent what was referred to as a black lung evaluation. Dr. Paul testified that he noted in his report that the pulmonary function tests were within normal limits. He further testified that under the AMA Guides to Impairment, Sixth Edition, the pulmonary function testing would not be within normal limits; rather, it would be considered mildly abnormal based on the FEV1/FVC ratio. He testified that it would indicate an obstructive impairment which would be compatible with chronic bronchitis. Dr. Paul also testified that coal dust can cause chronic bronchitis and chronic bronchitis is one of the things that make up the chronic obstructive pulmonary disease syndrome. (Px1, pp. 13,14) Dr. Paul opined that the coal dust environment to which Petitioner was exposed caused his conditions of chronic bronchitis and chronic obstructive pulmonary disease. Dr. Paul also opined Petitioner has significant pulmonary impairment caused by coal dust. (Px1, p. 16)

Dr. Paul noted Petitioner had coughing and wheezing during upper respiratory infections which would hang on about two months and he would get these four or five times per year. Dr. Paul testified that amount of coughing, eight to ten months a year for a number of years, fulfills the definition of chronic bronchitis. Although Dr. Paul did not review Petitioner's medical records, those from Logan Primary Care Services, Inc., support regular visits for coughs that would, at times, linger. (Rx3, 3/15/00 -"cough never really resolved...cough worse at night...deep breath forces him to cough"; 1/17/01-- "cough" prescribed antibiotic for 10 days; 8/27/01- cough; prescribed antibiotic; 2/3/04-5-day history of upper respiratory symptoms, productive cough, Acute Bronchitis; 3/20/06-Assessment: Upper respiratory infection-off-work; 11/3/06-Subjective: nasal discharge, cough, sore throat, green sputum. Duration of symptoms: 2 months on and off. Prescribed antibiotic and cough medicine; 11/7/07- Throat inflamed. Assessment: Upper respiratory infection; 12/4/09- Diagnosis: Upper respiratory infection viral; 9/10/12- congestion, cough; 1/20/18- congestion, cough and sore throat, worsening. Prescribed antibiotic; 1/30/18: Respiratory: Positive for cough)

The Commission finds the records from Logan Primary Care Services, Inc. are not dispositive of Petitioner's entire medical history and do not contradict the history that Petitioner provided to Dr. Paul. Thus, by Dr. Paul's definition, Petitioner has chronic obstructive pulmonary disease.

The Commission notes that Dr. Castle performed a medical records review and concluded Petitioner did not suffer from any pulmonary disease or impairment occurring as a result of his occupational exposure to coal mine dust. Dr. Castle reviewed the Petitioner's medical records noting there was never a diagnosis made of chronic bronchitis or chronic obstructive pulmonary disease. Dr. Castle testified that a cough is not considered an objective determinate of pulmonary impairment. Dr. Castle also testified, however, that having pulmonary function tests within the range of normal does not mean your lungs are free of any long damage, injury or disease. (DepT, p. 62) Dr. Castle also testified there is no objective measure of a cough but that does not mean it is without importance, medically speaking. (DepT, p. 66)

Dr. Castle then testified that if he had taken a patient history he could have asked the right questions and figured out whether Petitioner was giving an accurate history to Dr. Paul and how it

squared with his treating records, but at the time he issued his report and at the time of his testimony, he was without that information in his dataset. He conceded on cross-examination chronic bronchitis is a diagnosis determined by patient history and that chronic bronchitis is one of the chronic obstructive pulmonary diseases. Dr. Castle qualified his answer adding, "it is considered chronic obstructive pulmonary disease provided there is evidence of obstruction, and in the absence of obstruction it is simply bronchitis." (DepT, pp. 73-74)

The Commission notes that Dr. Castle was critical of the method Dr. Paul used in his determination of Petitioner's FEV1/FVC ratio. Dr. Castle opined that the Petitioner's FEV1/FVC 74% ratio, which proved Dr. Paul's theory that Petitioner had obstruction, was faulty. Given Dr. Paul's extensive experience, that he examined the Petitioner and took his own history, the Commission finds that Dr. Paul's testimony regarding Petitioner's FEV1/FVC ratio of 74% proving obstruction to be more persuasive than Dr. Castle's testimony because Dr. Castle did not perform his own pulmonary function tests, nor did he cite any studies to support his assertion that Dr. Paul's methodology to arrive at a FEV1/FVC ratio was incorrect, and most important, Dr. Castle did not examine Petitioner and did not have the opportunity to ask Petitioner's questions.

Petitioner testified that his complaints since leave mining on January 30, 2015 have remained stable. The Commission recognizes that although Petitioner's health has remained stable, since his mining career ended, the ill-effects of that career still linger.

The Commission, based on the evidence, finds Petitioner's employment as a coal miner exposed him to coal mine dust and other mining substances that resulted in him developing chronic obstructive pulmonary disease. The Commission finds the evidence supports a finding that Petitioner suffered a permanent partial disability as a result of his employment with Respondent. Thus, the Commission finds that an analysis under Section 8.1b(b) is warranted.

The Commission finds neither party submitted an impairment rating report or opinion into evidence under Section 8.1b(b)(i), thus no weight is given to the first factor.

With regard to subsection (ii) of Section 8.1b(b), the occupation of the employee, the Commission notes that the Petitioner is retired, but his occupation at the time of exposure was a coal miner; the Commission gives this factor some weight;

With respect to Section 8.1b(b)(iii), the Commission notes that the Petitioner was 62 years old at the time he retired, the same date as his last exposure. Given that the Petitioner is at the end of his career, and he has remained stable, the Commission gives this factor significant weight;

Under Section 8.1b(b)(iv), as it relates to Petitioner's future earning capacity, the Commission finds that Petitioner has not proven that his future earning capacity will be diminished. Petitioner testified that when he retired from working, he receives a pension, has a 401k and signed up for Medicare. The record is silent regarding any connection between his condition of ill-being and effect on his future earning capacity, thus the Commission gives this factor little weight;

With respect to the treating medical records as corroborative of Petitioner's disability under

19IWCC0185

Section 8.1b(b)(v), the Commission notes Petitioner's treating medical records indicate Petitioner's condition has remained stable since he was last in a mine, but those same medical records indicate Petitioner's chronic bronchitis, characterized by Dr. Paul as chronic obstructive pulmonary disease, is an ongoing issue, to be indicative of Petitioner's disability, and assigns moderate weight to this factor.

The determination of permanent partial disability is not simply a calculation, but an evaluation of all five factors as stated in the Act. In making this evaluation of permanent partial disability, consideration is not given to any single enumerated factor as the sole determinant. Therefore, after reviewing the entire record, and applying §8.1b(b) of the Act, the Commission concludes Petitioner's forty-plus year career as a coal miner introduced him to exposures that resulted in injuries to his pulmonary system and thus he suffered a 10% loss of use of a person as a whole under Section 8(d)2 as the result of the January 30, 2015 work-related accident.

The Commission further modifies the Arbitrator's Decision to correct a scrivener's error in paragraph four, the fifth line on page four, from "1975" to "2015."

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 16, 2018, is hereby reversed and modified for the reasons stated herein, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $735.37 per week for a period of 50 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the loss of use of 10% of the person as a whole.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $36,900.00. 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: APR 8 - 2019
KWL/bsd
O: 2/5/19
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Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DEERE, ROBERT
Employee/Petitioner

Case# **15WC011627**

THE AMERICAN COAL COMPANY
Employer/Respondent

19IWCC0185

On 5/16/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.03% 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:

0755 CULLEY & WISSORE
KIRK CAPONI
300 SMALL ST SUITE 3
HARRISBURG, IL 62946

1662 CRAIG & CRAIG LLC
KENNETH F WERTS
115 N 7TH ST PO BOX 1545
MT VERNON, IL 62864

STATE OF ILLINOIS)
)SS.
COUNTY OF Williamson)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

ROBERT DEERE
Employee/Petitioner

v.

THE AMERICAN COAL COMPANY
Employer/Respondent

Case # 15WC 011627

Consolidated cases: N/A

19IWCC0185

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Herrin**, on **March 14, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ Other **Sections 1(d)-(f) of the Occupational Diseases Act**

FINDINGS

On **January 30, 2015**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner's earnings were **$63,921.33** and Petitioner's average weekly wage was **$1,229.26**.

On the date of accident, Petitioner was **62** years of age, ***married*** with **0** dependent children.

Petitioner claims no medical or TTD, TPD, or maintenance benefits.

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

Respondent ***is*** entitled to a credit of **$0** for any medical bills paid through its group medical plan for which credit is allowed under Section 8(j) of the Act.

ORDER

Petitioner failed to prove he has an occupational disease due to an occupational exposure on January 30, 2015. Petitioner's claim for compensation is denied and no benefits are awarded.

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

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

Signature of Arbitrator

May 11, 2018
Date

Findings of Fact and Conclusions of Law

The Arbitrator finds:

Summary of the Medical and Depositions

Medical records of Logan Primary Care were admitted into evidence. Petitioner was seen on December 7, 1999, complaining of cough, cold, congestion, coughing up phlegm and eyes burning. His lungs were clear at the time. The assessment was that of an upper respiratory infection. (Respondent's Exhibit No. 3, p. 45). Petitioner was seen on March 15, 2000, with primary concern of a cough. He related that he was treated in December of 1999, and got better with medication, but his cough never really resolved. He had sinus drainage which was clear. The cough was non-productive and was described as a dry/tickle cough which was worse at night. When Petitioner attempted to take a deep breath, it forced him to cough. Examination of the lungs showed rate and depth were regular and unlabored on auscultation anteriorly and posteriorly. The diagnosis was sinusitis. (Respondent's Exhibit No. 3, p. 44). Petitioner was again seen on January 17, 2001, for congestion and sinusitis. According to the report he had sinusitis annually. His assessment remained that of sinusitis. (Respondent's Exhibit No. 3, pp. 42-43). Petitioner was seen on August 27, 2001, for an upper respiratory infection. He had no cough. Petitioner's lungs were clear to auscultation and percussion bilaterally. The diagnosis was upper respiratory infection. (Respondent's Exhibit No. 2, p. 39).

Petitioner was again seen at Logan Primary Care on February 3, 2004, for acute bronchitis. The physical examination of Petitioner's lungs showed they were clear to auscultation and percussion bilaterally. (Respondent's Exhibit No. 3, p. 36).

Petitioner was again seen at Logan Primary Care on March 20, 2006. At that time he was diagnosed with fatigue and an upper respiratory infection. (Respondent's Exhibit No. 3, p. 34). Petitioner was seen on November 3, 2006, for sinus congestion and cough. His lungs were clear to auscultation bilaterally. The assessment was sinusitis. (Respondent's Exhibit No. 3, pp. 32-33). Petitioner was seen on November 7, 2007, for fatigue and sore throat. His lungs were clear. The assessment was upper respiratory infection. (Respondent's Exhibit No. 3, p. 31). Petitioner was seen on December 4, 2009, for the flu. Physical examination of the lungs showed they were clear to auscultation bilaterally, with no wheezes, rhonchi or rales. The assessment was a viral upper respiratory infection. (Respondent Exhibit No. 3, pp. 29-30).

Petitioner was again seen at Logan Primary Care on September 10, 2012, for an upper respiratory infection. He had a non-productive cough. Physical examination of the

lungs showed they were clear to auscultation and percussion. (Respondent Exhibit No. 3, pp. 27-28).

Petitioner was seen at Logan Primary Care on July 22, 2013, for a kidney stone. On that date his lungs were clear to auscultation bilaterally with no wheezes, rhonchi or rales. (Respondent's Exhibit No. 3, pp. 25-26).

Petitioner's last day working for Respondent was January 30, 2015.

Petitioner signed his Application for Adjustment of Claim herein on March 27, 2015. (AX 2)

Petitioner saw Dr. Glennon Paul on November 12, 2015, at the request of his counsel. A written report followed. (Petitioner's Exhibit No. 1, Deposition Exhibit No. 2). According to the doctor's report, Petitioner was a non-smoker who was retired and didn't expect to go back to work. He was 63 years old and had worked in the coal mines for forty years until he retired in 1975. All of his work had been underground but he mostly worked at the face of the mine as a machine miner. His only problem with his lungs was that he would have coughing and wheezing whenever he had an upper respiratory tract infection which would "hang on" for about two months. He would get these four to five times per year and they had been ongoing for the last several years. Petitioner denied seeking medical treatment for it. Petitioner had a normal physical examination. His chest had normal inspiratory and expiratory effort with no chest wall deformities or dullness to percussion. Auscultation revealed no wheezes or rales. His CBC was normal. His pulmonary function studies were within normal limits. A chest-ray showed some fibronodular lesions through both lung fields to a mild to moderate degree. Dr. Paul's impression was simple type Coal Workers' Pneumoconiosis.

On November 24, 2015, and at the request of Petitioner's attorney, Dr. Henry K. Smith, board certified radiologist and B-reader, interpreted a chest x-ray of Petitioner dated November 12, 2015. Dr. Smith interpreted the chest x-ray as positive for pneumoconiosis, profusion 1/0 with P/P opacities in all lung zones. (Petitioner's Exhibit No. 2).

On February 23, 2016, and at the request of Respondent's counsel, Dr. Christopher Meyer, a B-reader, was asked to review a November 12, 2015 chest x-ray of Petitioner. He deemed the film over-exposed and unacceptable for ILO B-reading interpretation. It was a copy of a film and he noted the original analog examination might be of acceptable quality. (RX 1, Exhibit B)

On April 16, 2016, and at the request of Respondent's counsel, Dr. Christopher Meyer, a B-reader, reviewed a PA and lateral chest radiograph dated November 12, 2015, from Central Illinois Allergy and Respiratory. He interpreted the x-ray as negative for coal

workers' pneumoconiosis. Dr. Meyer further noted that he had reviewed a narrative summary and B-reading form prepared by Dr. Henry Smith regarding the same chest radiograph. Dr. Meyer expressed his disagreement with Dr. Smith's report wherein he found small opacities of size "p" with profusion of 1/0. His lungs were clear and there were no findings of coal workers' pneumoconiosis (cwp). (Respondent's Exhibit No. 1, Exhibit B).

On August 10, 2016, and at the request of Respondent's counsel, Dr. James R. Castle reviewed medical records and chest x-ray regarding Petitioner and issued a written report. Dr. Castle concluded that Petitioner did not suffer from any pulmonary disease or impairment occurring as result of his occupational exposure to coal mine dust. He found the pulmonary function study of November 12, 2015 to be entirely normal. He also reviewed the 11/12/15 chest x-ray of Petitioner and found no evidence of any parenchymal abnormalities consistent with pneumoconiosis. He further noted Dr. Smith's interpretation of a profusion of "1/0" stating that meant the doctor acknowledged the film could be negative for cwp. (Respondent's Exhibit No. 2, Exhibit C).

Deposition of Dr. Meyer

The deposition of Dr. Meyer was taken on September 30, 2016. Dr. Meyer has been board certified radiology since 1992. (Respondent's Exhibit No. 1, p. 8). Dr. Meyer has been a B-reader since 1999. (Respondent's Exhibit No. 1, pp. 20-21). Dr. Meyer was asked to take the B-reading exam by Dr. Jerome Wiot who was part of the original committee that designed the training program which is called the B-reader program. (Respondent's Exhibit No. 1, pp. 21-22). Dr. Meyer has recently been asked to have a more active academic role in the B-reader program. Dr. Meyer is on the American College of Radiology Pneumoconiosis Task Force which is engaged in redesigning the course, the exam and submitting cases for the B-reader training module and exam. Dr. Meyer testified that the faculty is typically experienced senior level B-readers. (Respondent's Exhibit No. 1, pp. 33-34). Dr. Meyer testified that radiologists have a 10% higher pass rate on the B-reading exam than other specialties. In Dr. Meyer's opinion radiologists have a better sense of what the variation of normal is. Dr. Meyer testified that one of the most important parts of the B-reader training and examination is making a distinction between a 0/1 and 1/0 film. (Respondent's Exhibit No. 1, pp. 35-36).

Dr. Meyer testified that the B-reader looks at the lungs to decide whether there are any small nodular opacities or any linear opacities and based on the size and appearance of those small opacities, they are given a letter score. (Respondent's Exhibit No. 1, p. 23). Dr. Meyer testified that specific occupational lung diseases are described by specific opacity types. Coal workers' pneumoconiosis is characteristically described by small round opacities. Diseases that cause pulmonary fibrosis, like asbestosis, will be described by small linear opacities. (Respondent's Exhibit No. 1, p. 29). The distribution of the

opacities is also described because different pneumoconioses are seen in different regions of the lung. Coal workers' pneumoconiosis is typically an upper zone predominant process. Idiopathic pulmonary fibrosis or asbestosis is a basilar or linear process. The last component of the interpretation is the extent of lung involvement or the so-called profusion. (Respondent's Exhibit No. 1, p. 24). Dr. Meyer testified that the profusion is basically trying to define the density of the small opacities in the lung. (Respondent's Exhibit No. 1, p. 31).

Dr. Meyer testified that at the request of Respondent's counsel, he reviewed a PA and lateral chest radiograph dated November 12, 2015, from Central Illinois Allergy and Respiratory. (Respondent's Exhibit No. 1, p. 41). Dr. Meyer testified that he first received a copy film which he judged to be unreadable for an ILO B-reading interpretation. Subsequently he received the original film for that date. He graded the subsequent original examination as quality 2. It was still a little over exposed but diagnostic. Dr. Meyer noted a wedged deformity of the thoracic spine but there were no findings of coal workers' pneumoconiosis. (Respondent's Exhibit No. 1, pp. 41-42).

On cross-examination Dr. Meyer acknowledged that an individual could have CWP pathologically. He was also asked about CT scans and their costs and risks of radiation. (Respondent's Exhibit No.1, pp. 42 – 47, 51- 52). Dr. Meyer was also asked about B-readings, including the reality that B-readers can disagree as to whether a film shows CWP or not. Dr. Meyer explained that it is important that the individual interpreting the film have ample experience in reading them to be able to sort out what is in the background and what is normal. (RX 1, pp. 47 – 51, 79 - 80) He agreed that medical records and pulmonary function studies would not change his opinion regarding what he might see on the x-ray. The x-ray is a piece of hard data and symptoms are symptoms and vary from person to person. He agreed that Category 1 CWP is an x-ray diagnosis. (RX 1, pp. 52-53) Dr. Meyer was also asked general questions about the nature of CWP. (RX 1, pp. 53 – 64, 66 - 67). He was also asked questions about progressive massive fibrosis. (RX 1, pp. 64-65)

Dr. Meyer testified that he does about 160 to 200 B-readings per month. He acknowledged that he is generally retained by the coal company rather than the coal miner. (RX 1, p. 67) The doctor was also asked about histoplasmosis, including where it can be found and how it appears on x-ray. (RX 1, pp. 67- 70, 74)

Dr. Meyer testified that one will find coal dust in all coal miner's lungs. The real question is when is the threshold achieved to result in there being enough coal to show up on an x-ray. (RX 1, p. 72) Dr. Meyer also testified that overexposure of a film makes it more difficult to appreciate the abnormalities of CWP. (RX 1, p. 72)

Dr. Meyer acknowledged that the first time he took the B-reader exam he failed it. (RX 1, p. 74) Dr. Meyer explained the circumstances surrounding the test result the first

time. (RX 1, pp. 87-88, 90 - 91) He testified that the opacities of CWP are found in the mid and lower lung zones. When asked if it can be found in themed and lower lung zones and not the upper lung zones on occasion, he responded, "Very rarely." (RX 1, pp. 77-78) Dr. Meyer was asked about the recent study by Laney and Petsonk. (RX 1, pp. 78, 80 - 85)

Dr. Meyer acknowledged that it is possible for a miner to have pneumoconiosis determined by pathology that was not appreciated on a radiographic study. It's also possible that a miner who has a split opinion on the existence of CWP can have it found on autopsy or biopsy. (RX 1, p. 87) He also acknowledged that there are studies showing that, at autopsy, as much as 50 percent of coal miners are found to have abnormalities of coal workers' pneumoconiosis when it might not have been apparent radiographically during life. (RX 1, p. 88) He also acknowledged that if a B-reading is negative that doesn't necessarily rule out that the miner might have the disease pathologically. (RX 1, p. 89)

On redirect examination Dr. Meyer testified that Petitioner has neither massive fibrosis or cor pulmonale. He had no evidence of bulla or hyperinflation. He further testified that the study by Laney and Petsonk did not address the early disease process. (RX 1, pp. 90 – 93) Dr. Meyer further testified that CWP is typically an upper-zone nodular disease and if a non-B-reader simply makes a diagnosis of pneumoconiosis one still doesn't know if it meets the technical criteria for the diagnosis because it isn't identified. (RX 1, p. 94)

Deposition of Dr. Paul

The deposition of Dr. Paul was taken on February 17, 2017. (PX 1) Dr. Paul was the Director of St. John's Respiratory Therapy and Clinical Assistant Professor of Medicine at the SIU Medical School. (Petitioner's Exhibit No. 1, p. 6). Dr. Paul was the senior physician at the Central Illinois Allergy & Respiratory Clinic. Those physicians specialize in allergy and pulmonary disease. They take care of patients with respiratory diseases, critical care, allergic diseases and some internal medicine problems. (Petitioner's Exhibit No. 1, p. 7). Dr. Paul is semi-retired and occasionally does black lung evaluations. He does not take any new patients. Dr. Paul supervises a DUI clinic's medical treatment program. (Petitioner's Exhibit No. 1, pp. 46-47). Dr. Paul is board certified in asthma, allergy and immunology. (Petitioner's Exhibit No. 1, p. 9). Dr. Paul testified that at the time he did his fellowship in 1970 to 1972, there were not any pulmonary fellowships developed. He testified that it was strictly in allergy, asthma and respiratory disease. (Petitioner's Exhibit No. 1, pp. 9-10). Dr. Paul is not an A-reader or a B-reader. He has never been board certified in pulmonary disease. (Petitioner's Exhibit No. 1, p. 46). Dr. Paul has seen hundreds of individuals at the request of Petitioner's counsel. (Petitioner's Exhibit No. 1, p. 46).

Dr. Paul testified that it was his understanding that Petitioner was a lifelong non-smoker. He worked for 40 years in the coal mines, all underground. (Petitioner's Exhibit No. 1, p. 11). According to Dr. Paul, Petitioner had coughing and wheezing during upper respiratory infections which would hang on about two months and he would get these four or five times per year. Dr. Paul testified that amount of coughing, eight to ten months a year for a number of years, fulfills the definition of chronic bronchitis. Dr. Paul testified that Petitioner had a negative methacholine challenge. (Petitioner's Exhibit No. 1, p. 12). Dr. Paul also testified that he recorded in his report that the pulmonary function tests were within normal limits. He testified that under the *AMA Guides to Impairment, Sixth Edition* the pulmonary function testing would not be within normal limits; rather, it would be considered mildly abnormal based on the FEV1/FVC ratio. He testified that it would indicate an obstructive impairment which would be compatible with chronic bronchitis. (Petitioner's Exhibit No. 1, p. 13). Dr. Paul also testified that Petitioner's chronic bronchitis was caused by coal dust exposure. He testified that Petitioner had coal workers' pneumoconiosis and COPD caused by the coal dust environment. Dr. Paul testified that in light of these diagnoses. Petitioner could not have any further exposure to the environment of a coal mine without endangering his health. (Petitioner's Exhibit No. 1, p. 15-16).

Dr. Paul testified that a person could have coal workers' pneumoconiosis and still have a negative chest x-ray. He testified that the gold standard for diagnosing pulmonary disease is pathologic review of the tissue itself. Dr. Paul testified that he had heard of studies that indicate that 50% or more of long term coal miners have coal workers' pneumoconiosis at autopsy even though during life it was never diagnosed radiographically. (Petitioner's Exhibit No. 1, p. 18). Dr. Paul testified that in order to have pneumoconiosis one must have, in addition to coal mine dust deposited in his lungs, a tissue reaction to it. That tissue reaction can be called scarring or fibrosis. The scarring of coal workers' pneumoconiosis cannot perform the function of normal healthy lung tissue. (Petitioner's Exhibit No. 1, p. 20). Dr. Paul testified that, by definition, if one has coal workers' pneumoconiosis, he would have some impairment in the function of the lung at the site of the scarring whether it could be measured by spirometry or not. (Petitioner's Exhibit No. 1, p. 21). A person could have radiographically significant coal workers' pneumoconiosis and normal pulmonary function testing, normal blood gases and normal physical examination of the chest. Coal workers' pneumoconiosis is considered to be a progressive disease. (Petitioner's Exhibit No. 1, p. 24).

Dr. Paul testified that Petitioner did not complain to him of shortness of breath. He was not taking any breathing medications when Dr. Paul saw him. Dr. Paul did not get a history from Petitioner of ever having taken breathing medications. Petitioner did not provide to Dr. Paul any past medical history of black lung. Dr. Paul did not review any treatment records regarding Petitioner. (Petitioner's Exhibit No. 1, p. 42). Dr. Paul's physical examination of Petitioner's chest revealed no sign of disease. Dr. Paul testified

that the FEV1/FVC ratio on the testing performed at his office was 74%. The forced vital capacity was normal at 109%, and the FEV1 was normal at 107%. Dr. Paul testified that under the *AMA Guides*, to be normal the FEV1/FVC ratio would need to be 75% or more. (Petitioner's Exhibit No. 1, p. 43). Petitioner's total lung capacity was normal. He had no restriction. He did not have an impairment in gas exchange. (Petitioner's Exhibit No. 1, p. 44).

Dr. Paul did not know the date of the chest x-ray he reviewed. He testified that the film quality was good. (Petitioner's Exhibit No. 1, p. 44). Dr. Paul testified that there were opacities present. He testified that Petitioner's chest x-ray had multiple different opacity types and they were all coal types. Dr. Paul did not remember what lung zones were involved. Dr. Paul did not give the film a profusion rating. (Petitioner's Exhibit No. 1, pp. 45-46).

Dr. Paul testified that Petitioner did not tell him that he left mining at the time he did due to a breathing problem. He also acknowledged that Petitioner did not tell him that he left mining when he did on the advice of a physician or that he was unable to perform the duties of his last job in the mine. (Petitioner's Exhibit No. 1, p. 46).

Deposition of Dr. Castle

The deposition of Dr. Castle was taken on June 8, 2017. Dr. Castle is a pulmonologist and is board certified in internal medicine and the subspecialty of pulmonary disease. (Respondent's Exhibit No. 2, p. 4). Board certification in pulmonary disease was first established in 1941. (Respondent's Exhibit No. 2, p. 32). Dr. Castle practiced in Roanoke, Virginia for 30 years. His practice was limited to pulmonary disease and chest disease, which encompassed critical care medicine. (Respondent's Exhibit No. 2, p. 7). Dr. Castle's practice included patients with occupational lung disease. He had some patients in his practice that had coal workers' pneumoconiosis. (Respondent's Exhibit No. 2, p. 8). Dr. Castle has been certified as a B-reader since 1985. (Respondent's Exhibit No. 2, p. 14).

Dr. Castle reviewed a chest x-ray dated November 12, 2015, from Central Allergy and Respiratory Service. Dr. Castle testified that there were no parenchymal abnormalities consistent with pneumoconiosis. He found no evidence of pneumoconiosis or any coal mine dust-induced lung disease on the chest x-ray. (Respondent's Exhibit No. 2, p. 28). Dr. Castle testified that there is no such thing as radiographically apparent pulmonary impairment. Dr. Castle testified that for a proper reading of a chest film for pneumoconiosis, the ILO classification sheet starts with the name of the individual, and the date of the film. He testified that the quality of the film is important. Then the reader determines whether or not there are any opacities, the type of opacities, the size of the opacities and the location of the opacities based upon side by side comparison with the

standard ILO films. (Respondent's Exhibit No. 2, p. 29). Dr. Castle noted that Dr. Henry Smith interpreted the same film and indicated that there were opacities throughout both lung fields classified as P/P with a profusion of 1/0. He testified that this meant that Dr. Smith also considered that the film may be negative. (Respondent's Exhibit No. 2, p. 31).

Dr. Castle testified that the pulmonary function study obtained on November 12, 2015, was valid and was entirely normal. He testified that there was no evidence of any physiologic abnormality of any cause including coal workers' pneumoconiosis and coal mine dust exposure. (Respondent's Exhibit No. 2, pp. 31-32). Dr. Castle concluded that Petitioner did not suffer from any pulmonary disease or impairment occurring as a result of his occupational exposure to coal mine dust. (Respondent's Exhibit No. 2, p. 32). Dr. Castle testified that Dr. Paul determined that Petitioner's FEV1/FVC ratio was 74%. Dr. Castle testified that in spirometry testing one is supposed to take the greatest forced vital capacity and the greatest forced expiratory volume in one second to determine what the FEV1/FVC ratio is. He testified that Dr. Paul did not do that. Dr. Castle testified that when the highest FEV1 and the highest FVC are used, Petitioner's FEV1/FVC ratio in the testing performed in Dr. Paul's office was 75%. He testified that this is exactly what was predicted for Petitioner. (Respondent's Exhibit No. 2, p. 26). Dr. Castle testified that the evidence did not indicate an obstruction. Dr. Castle testified that he is familiar with the *AMA Guides to the Evaluation of Permanent Impairment, Sixth Edition*. Employing Table 5.4 of the Guides, Petitioner would fall under Class 0 impairment. (Respondent's Exhibit No. 2, p. 27).

Dr. Castle also reviewed medical records. In his review of medical records of Petitioner, there was never a diagnosis made of chronic bronchitis or COPD. (Respondent's Exhibit No. 2, pp. 27-28). Dr. Castle testified that cough is not considered an objective determinate of pulmonary impairment. Dr. Castle testified that in his review of medical in this case there was no pathologic evidence of disease in Petitioner. From the objective testing performed on Petitioner, from a respiratory standpoint, he was capable of heavy manual labor. (Respondent's Exhibit No. 2, p. 28).

Dr. Castle agreed with the position taken by the American Thoracic Society that an older worker with a mild pneumoconiosis may be at low risk for working in currently permissible exposure levels until he reaches retirement age. He also testified that it is very unlikely for simple pneumoconiosis to progress once the exposure ceases. (Respondent's Exhibit No. 2, p. 32). Dr. Castle testified that to his knowledge, Petitioner had sufficient exposure to the environment of the coal mine to cause coal workers' pneumoconiosis in a susceptible host. He agreed that Petitioner's treatment records did not mention any evidence of pneumoconiosis but that alone would not rule it out. (Respondent's Exhibit No. 2, p. 34). Dr. Castle testified that it is true that one can have disease and have a negative chest x-ray. Dr. Castle testified that recent studies were shown as many as 50% of long term coal miners have pathological coal workers' pneumoconiosis that was not

appreciated by radiographic study during their lives. (Respondent's Exhibit No. 2, p. 40). Dr. Castle testified that coal workers' pneumoconiosis is basically an x-ray diagnosis except for the caveat about pathology. Dr. Castle described the abnormality of coal workers' pneumoconiosis as basically trapped coal dust in a part of the lung which ends up wrapped in scar tissue and can be accompanied by emphysema around it. (Respondent's Exhibit No. 2, p. 44). Dr. Castle testified that by definition, if a person has coal workers' pneumoconiosis, he would have an impairment in the function of his lungs at the site of the scarring. (Respondent's Exhibit No. 2, p. 45).

Dr. Castle acknowledged that one can have radiographically significant coal workers' pneumoconiosis and yet have normal spirometry and normal pulmonary function and even, possibly, no complaints. If they do have complaints, it is usually shortness of breath. (RX 2, p. 47) Dr. Castle, having reviewed Petitioner's medical records at Logan Primary Care did not see any evidence/documentation that Petitioner was having upper respiratory infections four or five times a year. (RX 2, pp. 72-73) He acknowledged that had he taken a patient history from Petitioner he could have asked the "right questions" to determine if Petitioner was giving an accurate history to Dr. Paul. As it stands, he relied upon the records. (RX 2, p. 73)

Dr. Castle charged $1,200.00 for his forensic review of medical films and $1.900.00 for his deposition. (PX 3)

Additional Medical Care

Petitioner was seen at Logan Primary Care on January 16, 2018, for hypertension. Petitioner reported being active and he was using the elliptical at John A. Logan three to four times a week. Petitioner did not have any shortness of breath. On physical examination, Petitioner's respiratory effort was normal and he had no respiratory disease. (Respondent's Exhibit No. 3, pp. 2-3). Petitioner was again seen on January 20, 2018, with an upper respiratory infection. His presenting symptoms included congestion, non-productive cough and a sore throat. His symptoms had been present for three days. The assessment was pharyngitis and a cough. The PA felt this was an acute condition that could be treated with medication. (Respondent's Exhibit No. 3, pp. 3-7). Petitioner was seen on January 30, 2018, for follow up on his hypertension. Petitioner reported that his acute pharyngitis was better, but he had minor cough. His review of systems was negative for shortness of breath and wheezing. (Respondent's Exhibit No. 3, pp. 7-9).

The Arbitration Hearing

Petitioner's case proceeded to arbitration on March 14, 2018. Petitioner was the sole witness testifying at the hearing. The issues in dispute were occupational disease, causal connection, Sections 1(d) through 1(f) of the Occupational Diseases Act, and the nature and extent of any injury.

Petitioner testified that he lives in Energy, Illinois. He was 65 years old at the time of arbitration and married to Teresa. Petitioner testified that he attended John A. Logan College for about two years but did not receive certificates or degrees. Petitioner further testified that he worked in the coal mine for 40 years with the first two years being above ground and the last 38 being below ground. Petitioner testified that in addition to coal dust, he was regularly exposed to and breathed silica dust, roof bolting glue fumes, diesel fumes and trowel on. Petitioner described trowel on as a glue used to put tiles up on the wall.

Petitioner's last date in coal mining was January 30, 2015, with Respondent at its Galatia mine. Petitioner was 62 years old on that date. His job classification was mine examiner. Petitioner testified that he was exposed to coal dust on that day. Petitioner testified that this was his last day working at Respondent because he retired. He testified that he had had enough. Petitioner has not looked for work or been employed since retiring from Respondent.

Petitioner testified that he started working for Ruttman in mine construction in 1975. That work was above ground. He was building the Monterey No. 1 mine. The first time he went to work underground was for Inland Steel Coal Company in 1977. He was hired as a shuttle car operator. Petitioner testified that the shuttle car would take the coal that was being cut from the face of the mine and transport it to the conveyor belt. He described this as a fairly dusty job. He worked in that position for one year. Then he became a continuous miner operator. He was actually operating the machine that cuts the coal from the face of the mine. Petitioner worked as a continuous miner operator for 15 years. He next worked as a laborer where he would fill in for anyone who was off and they kept putting him back on the continuous miner. Petitioner testified that he was temporarily assigned to the longwall. He worked in all positions on the longwall including shear operator, shield puller and even repairman. Petitioner testified that the longwall takes the place of the continuous miner. He described the longwall as a shear that runs along the face of the mine. It literally cuts the coal out of the wall. He testified that when that coal drops it is extremely dusty. Petitioner worked in that job for two to three years. Next Petitioner became a mine examiner. His duties were to check the belt lines, escapeways, working units, and ventilation to make sure there was enough air ventilating the faces. He had to make sure everything was up to regulation and code. He was walking all over the mine. He was doing the mine examiner job when he was exposed to the roof bolting glue fumes. As an examiner he was exposed to pretty much every

exposure in the mine. Petitioner was an examiner at Inland Steel for five or six years until he was laid off in July 2002. He was called back as a diesel scoop operator to take equipment out of the mine. His last day at Inland was May 27, 2003.

Petitioner went to work for Respondent in 2004 at the Millennium Portal in Galatia. He was hired in as an operator and then was put on the longwall for a period of time. He worked as an examiner for Respondent. He also ran diesel equipment for six months underground. He has not worked at any mine since his retirement.

Petitioner testified that he first noticed his breathing problems at work after he had been working on the continuous miner. He noticed that when he would get a cold or his breathing would become labored, he would cough up black sputum. He testified that it would have been somewhere early to mid-1980s when he first noticed his breathing problems. Petitioner testified that from the time he first noticed the breathing problems until he left the mines, it did not get any better. He testified that at times it got a little worse. He testified that his breathing problems have stayed pretty much the same since he left the mine. Petitioner does not take any breathing medications. Petitioner testified that he cannot seem to take a deep breath.

Petitioner testified that with yard work or playing with his grandkids he has to stop and rest. Petitioner testified that he has always been very active sports-wise. Petitioner testified that the last time he participated in sports would have been slow pitch softball approximately 20 years ago. While he was still working, he noticed the difference in his breathing ability and that he would get tired. Petitioner testified that he tries to stay active with his grandchildren. He testified that he quit bike riding and cannot run anymore. He tries to walk on the treadmill a little bit to keep himself in as good of shape as he can. Petitioner testified that he hunts. He testified that he did not use to hesitate to trek way back in the woods, but he cannot do that anymore. He tries to stay closer to the edge near the road. Petitioner testified that he deer hunts from a ladder stand. He testified that he killed a deer this past hunting season. Petitioner testified that he goes to John A. Logan College to work on an elliptical three or four times per week. He spends about 30 minutes there each time. He also does some light lifting. Petitioner testified that he spends quite a bit of time with his grandkids watching their sports. Petitioner testified that he lives on about eight acres. He mows the grass with a riding mower.

Petitioner testified that Dr. Mark Smith at Logan Primary Care was his family doctor until he retired a few years ago and now he sees Dr. Workman. He testified that he saw these physicians for breathing difficulties. He testified that when he would get bronchitis, he could not breathe and he would go to these doctors for treatment. He testified that the doctors were aware that he was a miner. Petitioner has never smoked. Petitioner takes medication for blood pressure. Petitioner testified when he treated with Dr. Smith and Dr. Workman at Logan Primary Care, he was honest with him in sharing

whatever respiratory complaints he had or did not have. He testified that he was honest with Dr. Paul in sharing his respiratory problems.

Petitioner testified that from time to time over the years, he underwent chest x-ray screening by NIOSH for black lung. He testified that after the chest x-ray, NIOSH would write to him and tell him what the chest x-ray revealed. Petitioner testified that he had those letters with him in his car at the time of arbitration. He testified that he did not know if he would need them at arbitration.

The Arbitrator concludes:

1. Petitioner failed to prove by a preponderance of the evidence that he sustained an occupational disease arising out of and in the course of his employment. In so concluding, the Arbitrator finds the B-readings by Drs. Meyer and Castle to be more persuasive. In particular the Arbitrator finds the testimony of Dr. Meyer to be insightful, informative and persuasive. His background and experience in radiology, B-reading and coal workers' pneumoconiosis were impressive and beyond that of Petitioner's physicians, Drs. Smith and Paul. Dr. Meyer testified to the training received in the B-reading course. Dr. Paul does not have that training. Drs. Meyer and Castle are both B-readers and have been recertified as same numerous times. Coal Worker's Pneumoconiosis is a diagnosis made by chest x-ray interpretation. Three B-readers interpreted the 2015 chest x-ray. Two of them found it to be negative for CWP.

   Petitioner testified that from time to time over the years, he underwent chest x-ray screening by NIOSH for black lung. He testified that after the chest x-ray, NIOSH would write to him and tell him what the chest x-ray revealed. Petitioner testified that he had those letters with him in his car at the time of arbitration. The Arbitrator reasonably infers that if those letters supported his claim they would have been submitted at arbitration; however, they weren't.

   The Arbitrator notes that over the years Petitioner's medical records have reflected treatment for upper respiratory infections and sinusitis. With these acute conditions, Petitioner complained of cough, sometimes with and sometimes without sputum production. Petitioner testified at arbitration that his breathing would become labored or he would cough up black sputum when he would get a cold. Petitioner continues to hunt from a ladder stand. He also testified that he works on an elliptical three or four times per week. The medical records which were put into evidence do not contain any complaints of shortness of breath. In the most recent treatment records from two months prior to arbitration, Petitioner denied shortness of breath. The Arbitrator gives more

weight to the medical entries than Petitioner's arbitration testimony as the latter may have been motivated to support his claim.

The Arbitrator did not find Dr. Paul's opinions regarding Petitioner's chronic bronchitis and COPD persuasive. Dr. Paul failed to mention their existence in his initial report. He acknowledged that Petitioner had no complaints of shortness of breath when he examined him. Petitioner was not taking any breathing medications. While the doctor testified that under the *AMA Guides to Impairment, Sixth Edition* Petitioner's pulmonary function testing would not be within normal limits; rather, it would be considered "mildly" abnormal based on the FEV1/FVC ratio, that was based upon a ratio of 74 and the *Guides* consider normal to be 75 or more. Other than the ratio, everything else about Petitioner's examination was normal. Dr. Paul took a history of Petitioner having four to five respiratory issues a year; however, he took no steps to obtain Petitioner's medical records to verify the accuracy of that history. The records from Logan Primary don't corroborate Petitioner's history to Dr. Paul.

Petitioner testified that he went to Logan Primary Care for bronchitis and that his doctor knew he was a miner. That, in and of itself, does not establish that mining was the cause of Petitioner's bronchitis. Petitioner could have deposed his primary care doctor but did not do so. While Petitioner further testified to current problems and difficulties with breathing, his testimony was not corroborated by any medical records or other witness. The more recent Logan Primary Care records suggest a fairly fit and active retiree who regularly works out at a gym and denied any shortness of breath.

The Arbitrator also notes that the date of accident/exposure herein is Petitioner's date of retirement from the mine. Petitioner did not associate his retirement with any specific breathing problems.

2. Petitioner failed to prove by a preponderance of the evidence that his current condition of ill-being was causally connected to his employment.

3. Petitioner failed to prove by a preponderance of the evidence that he suffered a timely disablement under Section 1(f) of the Occupational Diseases Act.

4. Petitioner's claim for compensation is denied and no benefits are awarded.

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STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

SHERI OAKLEY,
Petitioner,

vs. No: 13 WC 17321

CHRISTIAN HOME CARE SERVICES,
Respondent

ORDER ON REMAND FROM THE CIRCUIT COURT OF ST. CLAIR COUNTY

This matter comes before the Commission on remand from the Circuit Court of St. Clair County. In the underlying claim, the Commission approved a settlement of the instant claim on November 16, 2015. The settlement provided Petitioner be paid a total of $27,500.00, representing loss of 25% of the person-as-a-whole. The contract also provided that Respondent had or would pay all related, reasonable and necessary medical expenses incurred, or to be incurred by the Petitioner, known and unknown, that were causally related to the alleged accident of January 24, 2013.

Petitioner filed a petition for penalties under Sections 19(k) and 19(l), as well as for attorney fees under Section 16 of the Act. The Commission denied Petitioner's petition finding that the delay in payment of an outstanding medical bill of $77,572.50 was more based on confusion than obfuscation. On appeal to the Circuit Court of St. Clair County, the court held that the denial of penalties under Section 19(l) was against the manifest weight of the evidence and remanded the matter to the Commission to determine the appropriate penalties to be imposed under Section 19(l).

The bills in question were incurred in late 2014 and sent to Respondent in 2015. It appears from the Decision of the Circuit Court, that the bills remained unpaid in January 2018 and by March 7, 2018, $18,362.50 remained unpaid. Section 19(l) provides for a penalty for unreasonable delay of payment of medical bill in the amount of $30 per day up to a maximum penalty of $10,000. In this instance, the delay appears to be more than three years. Therefore, the Commission concludes that the maximum penalty of $10,000.00 under Section 19(l) is appropriate.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $10,000.00 as penalties under Section 19(l) for unreasonable delay of payment of medical bills.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $10,100.00. 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: APR 9 - 2019

Deborah L. Simpson

Barbara N. Flores

Marc Parker

DLS/dw
R-3/7/18
46

STATE OF ILLINOIS)
) SS
COUNTY OF LASALLE)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Andrea Jacobsen,
Petitioner,

vs. NO. 14 WC 17745

Jack Mabley Developmental Center,
Respondent.

ORDER

Petition for Penalties and Attorney fees under §19(k), §19(l), & §16, Motion for enforcement & payment of Agreed Order, and the case having been filed by Petitioner's attorney herein and due notice given, this cause came before Commissioner Gore and heard November 16, 2018, in Ottawa, Illinois. The Commission having jurisdiction over the persons and subject matter and after being advised in the premise finds:

1. This matter was timely and properly filed before the Commission for an accident date September 15, 2013, which arose out of and in the course of employment.

2. This matter came for before Arbitrator Falcioni who approved a compromise settlement August 25, 2017. Temporary total disability (TTD) was to be paid to Petitioner through date of approval of the settlement contract.

3. On March 8, 2018, the parties came before Commissioner Gore, and an Agreed Order was signed by the parties and Commissioner Gore, wherein, Respondent was to pay to Petitioner $661.54 for underpayment of TTD/TPD benefits; Respondent was to issue that underpayment within 30 days from that Order March 8, 2018.

4. Petitioner noted that despite numerous telephone calls, e-mails, and letters to Respondent's counsel, Respondent failed to pay that agreed amount per the Agreed Order.

5. Petitioner filed their Petition for Penalties and attorney fees on August 20, 2018, regarding that underpayment still due per the Agreed Order.

6. The matter came before Commissioner Gore, in Ottawa, Illinois, November 16, 2018.

7. Petitioner argued at that point it was 223 days since the Agreed Order and they still had not received a check for the underpayment of TTD/TPD and that Respondent's failure to submit the check to Petitioner was unreasonable and vexatious and Petitioner requested penalties and attorney fees, as well as, payment of the agreed amount due.

8. Respondent's attorney stated that he had attempted on several occasions via telephone and e-mail to advise his client to pay the disputed amount and he had not heard anything either way, as to why it was not paid, or if they were refusing to pay, or, any excuse as to why it had not been paid.

9. The Commission, thereafter, took the matter under advisement.

The Commission notes that Petitioner's petition was filed timely.

The Commission finds that the Respondent has not met their obligation under the Agreed Order of March 8, 2018, and, further, provided no explanation or reason for the delay in issuing the payment. The Commission finds Respondent's delay is clearly unreasonable and vexatious, and, therefore, warranting the remedy sought by Petitioner.

The Commission finds that Petitioner is entitled to §19(k) penalties, with a showing that a Respondent acted in an unreasonable and vexatious manner by not timely paying the $661.54 TTD/TPD underpayment amount per the Agreed Order; penalties assessed under this section being 50% of the amount due under this section, of $330.77.

Further, the Commission finds that Petitioner is entitled to §19(l) penalties, by not timely paying the award or amounts otherwise due, of $30 per day for 223 days (March 8, 2018, Commission and parties Agreed Order) through November 16, 2018, for penalties assessed under this section, of $6,690.00.

Further, the Commission finds that Petitioner's attorney is entitled to §16 attorney fees on the award of 20% for fees, assessed on the unpaid TTD/TPD, per the Agreed Order, under this section of $132.31.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the $661.54 underpayment of TTD/TPD per the March 8, 2018 Agreed Order.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner additional compensation of $330.77 as provided in §19(k) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner additional compensation of $6,690.00 as provided in §19(l) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to the attorney for the Petitioner legal fees in the amount of $132.31 as provided in §16 of the Act

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) 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.

DATED: APR 9 - 2019

Barbara N. Flores

Deborah L. Simpson

Marc Parker

DLG/jsf
11/16/18
045

STATE OF ILLINOIS)
) SS.
COUNTY OF DUPAGE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Charles Fournier,

Petitioner,

vs.

NO: 16 WC 26612

UPS,

Respondent.

19IWCC0186

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

The Commission corrects the decision of the Arbitrator to show that Petitioner's average weekly wage was $1,299.99 pursuant to the "Agreed Stipulation to Amend Average Weekly Wage" filed by the parties and granted by Commissioner Tyrrell on 6/18/18.

All else is otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed 1/8/18, with correction, is hereby affirmed and adopted.

19IWCC0186

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

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

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury pursuant to §8(j) of the Act; provided that Respondent shall hold Petitioner harmless from any claims and demands by any providers for which Respondent is receiving credit under this order.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $2,000.00. 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: APR 11 2019
o: 2/11/19
TJT/pmo
51

Thomas J. Tyrrell

Michael J. Brennan

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

FOURNIER, CHARLES
Employee/Petitioner

Case# **16WC026612**

16WC026611

UPS
Employer/Respondent

19IWCC0186

On 1/8/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.57% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1747 SEIDMAN MARGULIS & FAIRMAN LLP
STEVEN J SEIDMAN
20 S CLARK ST SUITE 700
CHICAGO, IL 60603

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

STATE OF ILLINOIS)
)SS.
COUNTY OF DU PAGE)

☐ 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)

19IWCC0186

Charles Fournier
Employee/Petitioner

v.

UPS
Employer/Respondent

Case # **16** WC **26612**

Consolidated cases: **16 WC 26611- N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gerald Granada**, Arbitrator of the Commission, in the city of **Wheaton**, on **December 5, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's 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 **Prospective Right Shoulder Medical Treatment**

FINDINGS

19IWCC0186

On the date of accident, **August 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 left arm condition of ill-being ***is*** causally related to the accident.

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

In the year preceding the injury, Petitioner earned $**74,759.88**; the average weekly wage was $**1,437.69**.

On the date of accident, Petitioner was **53** years of age, ***married*** with **0** dependent children.

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

Respondent shall be given a credit of $**55,590.00** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**55,590.00**.

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

ORDER

The Arbitrator finds Petitioner right shoulder condition is not causally related to his August 2, 2016 accident. All claims for benefits related to a right shoulder injury are denied.

To the extent that any unpaid balances exist for related left shoulder treatment rendered prior to November 14, 2017, Respondent is required to pay the treatment providers directly pursuant to Section 8 of the Act and pursuant to 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

12/29/17
Date

JAN 8 - 2018

19IWCC0186

FINDINGS OF FACT

This case involves a Petitioner alleging injuries sustained while working for Respondent on August 2, 2016. There is a consolidated companion claim under 16 WC 26611, which was not addressed at the hearing. Petitioner claims he injured both his shoulders in this accident and Respondent disputes the Petitioner's claims regarding the right shoulder/arm. The issues in dispute with regard to the Petitioner's right arm claim are: 1) accident, 2) causation, 3) medical expenses, 4) TTD and 5) prospective care.

Petitioner is a machine mechanic for Respondent, hired in September of 2015. (Tr. p.12) Petitioner claims while repairing a jam in conveyors that move packages on August 2, 2016, he injured his left and right shoulders. (Arb. Ex. 2, Tr. pp.13-14) Petitioner testified that on that date, he was loosening the nut of a bolt with a breaker bar with both his arms fully extended and as the nut released, both shoulders "popped." (Tr. pp.14-17) Petitioner claimed he was using a tool when his discomfort occurred, and not holding the belt being repaired. (Tr. pp.31-32) Petitioner testified that the incident occurred at about 9:00-9:30 p.m., and verified he sustained only a single instance of injury rather than multiple occurrences. (Tr. pp.30, 92) His work shifts start at 4:30 p.m. (Tr. p.30)

Petitioner further testified that at the time of the occurrence his supervisor, Rich Anderson, stood directly across from him, "about three, four feet" away. (Tr. pp.14, 31) Per Petitioner, after the nut broke loose and he felt his shoulders pop, he exclaimed and Mr. Anderson asked him if he was okay. (Tr. p.32)

Rich Anderson completed a "Incident Flash Report" concerning Petitioner's accident, submitted into evidence as Respondent's Exhibit 1. Petitioner testified he did not note any problems or errors in writing on the document. He further testified that he signed the report after it was completed, but "under protest" due to threat of termination and because Mr. Anderson had to leave for the day. (Tr. pp. 33-34, 43-44, 50-52) Petitioner testified he had not previously been reprimanded or otherwise disciplined, and acknowledged the existence of a "process" that involves the union for reprimands. (Tr. pp.52-53)

Following the incident, Petitioner finished his shift, went home, and was taken to Concentra Medical Center ("Concentra") by Robert Adlam the next day. (Tr. pp.17-18, 34-35, Px2, Rx4) He testified that he experienced more discomfort in his left shoulder than his right, rated at 4-5/10. (Tr. pp.18, 29) He resumed work under restrictions and next returned to Concentra on August 15, 2016. (Tr. p.16, Px2, Rx5) On that date, Petitioner testified he reported continued pain in both shoulders, and both were examined on that date. (Tr. pp.19, 27, 35-36)

Between the August 2, 2016 and August 15, 2016 examinations at Concentra, Petitioner left the country to Grenada and St. Lucia for his sister's wedding. (Tr. pp.25-26) Concerning physical activity, Petitioner testified he sat in the pool and ocean because he couldn't move his arms to float. (Tr. p.26) He did not take any mediation, or wear slings or assistive devices. (Tr. p.39) Petitioner brought a 35 inch luggage bag, took four flights on the trip, and claims the bag never left the ground while in his possession. (Tr. pp.40-41, 50) During the trip, Petitioner testified he avoided using his left arm and favored doing items with his right. (Tr. p.41) He did not notice any change in the condition of his right arm. (Tr. p.41)

Petitioner continued to follow up at Concentra through the end of August, leading to an MRI arthrogram of his left shoulder or September 1, 2016. (Tr. pp.19-20, Px2) It revealed a full-thickness rotator cuff tear with mild to moderate degenerative changes in the acromioclavicular joint and moderate tendinosis. (Px3, 9/1/16 report)

Subsequent to the MRI, Petitioner transferred his care to Dr. Howard Freedberg of Suburban Orthopaedics, commencing with an initial examination on September 6, 2016. (Px3) On that date, Petitioner provided a history of injuring both shoulders while breaking a bolt and holding tight to a wrench. He was diagnosed with bilateral rotator cuff tears, bicipital tenosynovitis, and degenerative joint disease in his shoulders. Arthroscopic surgery was recommended for the left shoulder, and an MRI ordered for the right shoulder. Petitioner received light duty restrictions from Dr. Freedberg. (Px3) On September 8, 2016, UPS informed Petitioner they could not accommodate those restrictions. (Tr. p.22)

The September 12, 2016, MRI of the Petitioner's right shoulder revealed multiple findings. These included: severe supraspinatus tendinopathy, moderate subscapularis tendinopathy, a chronic biceps tendon rupture, joint osteoarthritis, and a joint effusion. (Px3)

On September 15, 2016, Dr. Freedberg examined Petitioner after the right shoulder MRI was completed. He recommended right shoulder surgery, but not until after the left shoulder was repaired and postoperative rehabilitation completed. (Px3)

On December 16, 2016, Dr. Freedberg performed arthroscopic left shoulder surgery on Petitioner, consisting of labrum debridement, subacromial decompression, distal clavicle resection, rotator cuff repair and biceps tenodesis. (Px3, Tr. pp.22-23) Postoperatively, Petitioner attended physical therapy at Suburban Physical Therapy, starting on January 24, 2017, and ending on April 27, 2017. (Px3, Tr. p.23)

Upon the completion of physical therapy, Dr. Freedberg continued to recommend right shoulder surgery. (Px3) Petitioner remains under the care of Dr. Freedberg. He was last examined on November 14, 2017, and placed at maximum medical improvement for his left shoulder at that time. (Px3, Tr. p.24) Petitioner testified he was released to return to work for his left shoulder injury, but not for his right shoulder condition. (Tr. p.25) He currently takes no medication for the right shoulder and is pleased with the outcome of his left shoulder. (Tr. pp.27, 42)

Richard Anderson, Petitioner's Supervisor, testified on Respondent's behalf. Mr. Anderson recalled the repair when Petitioner was injured on August 2, 2016. (Tr. p.56) He testified that before Petitioner left on August 2, 2016, Petitioner said his shoulder "hurt a little bit" and was sore. He told Petitioner there was 24 hours to complete a report, so he could go home and see whether he improved by morning. If not, a report could be done then. (Tr. pp.57-58) Petitioner reported he had continued soreness the next morning, so the incident was called in and Respondent would get him to the clinic. Mr. Anderson wasn't certain, but recalled Petitioner notifying him of the injury about 9:00-10:00 p.m., but possibly as late as 11:00. (Tr. p.58)

Mr. Anderson testified about the protocol when notified of a work injury. He generates a report within 24 hours, inquires about the need for medical attention, secure photos if possible, and "call[s] it in" to his manager. (Tr. p.59) Mr. Anderson completed the Flash Report (Rx1), signed it and presented it to Petitioner for signature to demonstrate it was reviewed by both of them. (Tr. p.60) Mr. Anderson confirmed the two signatures on Respondent's Exhibit 1 were his and Petitioner's, and denied Petitioner either resisting to sign the report or telling him anything was inaccurate after reviewing the report together. (Tr. pp.60-61) Mr. Anderson denied telling Petitioner that he had to sign the report or be terminated, and said he didn't have authority to terminate Petitioner's employment due to "a whole lengthy process with the union." (Tr. p.61) If Mr. Anderson completed a false Flash Report, Mr. Anderson would be subject to discipline and/or termination. Mr. Anderson testified that he has never

been subject to such discipline. (Tr. p.62) Had Petitioner declined to sign the Flash Report, Mr. Anderson would have noted it "RTS," signifying "refused to sign." (Tr. pp.63, 65, 86) He testified to only an OSHA form that an employee could refuse to sign, because that's required by OSHA, and the consequence would be a prohibition from the employee doing the related job duties. (Tr. p.63)

Mr. Anderson also prepared a written statement of Petitioner's accident, submitted into evidence as Respondent's Exhibit 3. The document describes the repair, its location, and the incident in detail. It relates that Petitioner stood beside the motor of the conveyor belt to lift the frame and align the bolts to secure it with his arms fully stretched out. (Rx3) Mr. Anderson turned away and heard Petitioner say his left shoulder had popped. Mr. Anderson then saw Petitioner "rotating his left shoulder and arm trying to stretch it out." Early the following afternoon, Petitioner reported his left shoulder still bothered him and that arrangements would be made for Robert Adlam to take him to the clinic. The accident report was reviewed later that evening with Petitioner. The statement does not mention Petitioner disputing the Flash Report or signing the report under protest. Mr. Anderson testified the statement was prepared due to questions and concerns about the left shoulder injury after he returned from vacation. (Tr. p.64)

Mr. Anderson testified about the importance of reviewing Flash reports with employees. (Tr. p.71) After doing so, Mr. Anderson would ask employees involved to sign. He disagreed on cross examination that if an employee didn't sign one of the reports that he or she would be subject to discipline. Instead, it resulted in an "RTS" notation and a union steward or other union member could serve as a witness and then sign as an attestation of the review and declination to sign. (Tr. pp.71-73) Mr. Anderson testified that the use of signatures is something he does as a collaborative effort to validate the accuracy of the report in case it's questioned later. (Tr. pp.84-85) It's not required by UPS, and estimated half the reports aren't signed at all. (Tr. p.85) Mr. Anderson surmised that it is probably difficult for those individuals who do not seek signed Flash Reports to prove it was reviewed with the employee. (Tr. p.86) There is no reprimand for Mr. Anderson if an employee refuses to sign a Flash Report. (Tr. p.85)

The Flash Report describing Petitioner's accident relates, "Employee was lifting PD4-18SR discharge belt tail up to bolt it in. As he was trying to lift it his left shoulder popped and he felt pain." (Rx1, Tr .p.74) Mr. Anderson testified that Petitioner reported he hurt only one shoulder, not both. (Tr. pp.80-81)

Mr. Anderson testified upon re-direct examination that it may have been a few seconds to a full minute for the time he turned away from Petitioner at the moment of the accident. (Tr. pp.82) Prior to looking away, Mr. Anderson observed Petitioner using his hands to leverage a piece to align bolt holes with his hands and no tools. (Tr. p.83)

Respondent submitted a brief video clip into evidence as Respondent's Exhibit 2. It shows Petitioner, who identified himself as located in the middle of the footage, working on a belt, recoiling and grabbing his left shoulder with his right hand, then swinging his left arm in circles in a windmill fashion. (Rx2, see also Tr. pp.79, 90-91) Mr. Anderson testified he had not seen the video prior to trial and was not part of procuring it. (Tr. pp.76-78) The video is time stamped at 9:38 p.m. Petitioner testified that the video did not depict his accident. (Tr. pp.91, 93) He testified that the video was "Way after. Hours after" his accident happened. (Tr. p.93) Petitioner testified that two repairs were performed, with his injury occurring during the beginning of the first repair, which took three to four hours. He then worked three to four hours afterwards to finish." (Tr. p.97)

Mr. Anderson testified that the video depicted the incident and location he testified about, where Petitioner reported to him a left shoulder injury, as described in the Flash report, and described in the written statement identified as Respondent's Exhibit 3. (Tr. pp.98-99)

Dr. Freedberg testified via evidence deposition on November 9, 2017. (PX 6) . According to Dr. Freedberg, Petitioner provided a history that he heard a pop in both shoulders while using a "big wrench" at work to break a bolt. (Px6, p.9) Based upon that information, Dr. Freedberg opined that the conditions observed in his left and right shoulders are related to the work accident of August 2, 2016. (Px6, pp.15-16) Dr. Freedberg testified that Petitioner reached maximum medical improvement for his left shoulder and Petitioner could otherwise return to his regular work. (Px6, pp.19-20)

Respondent submitted Section 12 reports from Dr. Prasant Atluri as Respondent's Exhibits 6 and 7, dated October 19, 2016 and July 13, 2017, respectively. Dr. Atluri opined that Petitioner's left shoulder condition, a full-thickness rotator cuff tear, was plausibly related to the work accident of August 2, 2016. (Rx6, pp.5-6) Dr. Atluri diagnosed Petitioner with chronic impingement syndrome and a rotator cuff tear for the right shoulder. (Rx6, p.6) Concerning causation, Dr. Atluri noted that the conditions of both shoulders were similar and the right "may have" been aggravated. In an addendum dated July 13, 2017 after reviewing Respondent's Exhibit 2 among other items, Dr. Atlrui opined that Petitioner's "right shoulder condition is not related to the reported work injury." (Rx7, p.3) In so concluding the doctor reasoned that his belief of a possible relationship was predicated upon Petitioner's report of a pop in both shoulders and an acute injury. However, the medical records from Concentra, additional materials, and video reviewed reflected only behavior consistent with an aggravation of the left shoulder, not the right.

Petitioner was notified of the termination of TTD in writing on November 30, 2017. (Rx8) The basis was the opinions of Dr. Freedberg that the current prohibition from work was exclusively due to Petitioner's unrelated right shoulder condition. (Rx8)

CONCLUSIONS OF LAW

1. With regard to the issue of accident, the Arbitrator finds that the Petitioner met his burden of proof. In support of this finding, the Arbitrator relies on the testimony of the various witnesses and the medical evidence. In reviewing the evidence, the issue of accident is not really at issue as there is no dispute the Petitioner was working on August 2, 2016 when he injured himself while performing work related duties. In fact, the parties agreed that there is no dispute the Petitioner sustained an accident resulting in injuries to the Petitioner's left arm on the date in question. The main question in dispute is whether the Petitioner also injured his right arm as the result of his August 2, 2016 work accident.

2. With regard to the issue of causation, the Arbitrator finds that the Petitioner has met his burden of proof with regard to his left arm injuries. The Arbitrator further finds that the evidence does not support a finding of causation with regard to the Petitioner's right arm condition. In support of this finding, the Arbitrator relies on the testimony and the medical evidence presented at trial and notes that this finding turns on the question of credibility. The Arbitrator notes much conflicting evidence in that regard and finds the question of Petitioner's credibility too great to set aside. The following are examples of evidence that undermines Petitioner's credibility in this case.

a. The initial medical records, accident report and testimony of Petitioner's supervisor, Rich Anderson all indicate an initial complaint by Petitioner of injury to his left arm following the August 2, 2016 incident involving Petitioner attempting to loosen a bolt on a conveyor belt. Following Petitioner's initial visit to Concentra, where the records show only complaints regarding Petitioner's left arm, Petitioner then goes on vacation out of the country. After his return from vacation, he goes back to Concentra on August 15, 2016 and then indicates that he injured both his arms in the August 2, 2016 incident.

b. Petitioner testified that his supervisor, Rich Anderson, stood directly across from him at the time of the occurrence, only three to four feet away. Mr. Anderson rebutted this testimony when he testified that he did not observe the actual occurrence. Instead he observed Petitioner moments before and less than a minute or thirty second afterward. Further, Mr. Anderson never positioned himself in the proximity to him that Petitioner testified about of only a few feet. Mr. Anderson testified he heard Petitioner exclaim his left shoulder got hurt, then swing his left arm in a windmill fashion, as depicted in the video in Respondent's Exhibit 2.

c. Mr. Anderson prepared an incident report indicating Petitioner's injury to his left arm. Petitioner signed this report, but testified that he did so under protest and under threat of termination. Mr. Anderson testified that the Petitioner did not express any protest with regard to signing the report, and Mr. Anderson would have noted a refusal to sign on the report if this were the case. Furthermore, Mr. Anderson testified that he could not terminate Petitioner for not signing the report since there is a union process in place that governs the termination of employees.

d. Petitioner was seen by Dr. Rincy Panicker at Concentra on the day after the accident, and then subsequently on August 15, 2016. Dr. Panicker's report of August 15, 2016 unequivocally states that Petitioner did not complain of right shoulder discomfort on August 3, 2016, when seen. (Rx5) Petitioner attempts to discredit Dr. Panicker's comment through his testimony about the existence of two reports from August 3, 2016, issued by Concentra - emphasizing an area in the complaint section that notes right shoulder complaints. A subsequent report was generated that changes that the notations of "right" to "left." In analyzing the reports, the Arbitrator notes that neither report contains physical examination findings for the right shoulder, despite Petitioner's contention that both were examined. Both reports relate solely to left shoulder findings. The history of both reports list exclusively left shoulder complaints, despite the discrepancy in the later "injury history" portion of the document.

e. After reviewing the video evidence time stamped at 9:38 pm showing Petitioner stopping work, reaching for his shoulder and walking while doing a "windmill" with his left arm, Petitioner testified that the video did not depict his accident because Petitioner claimed there were two repairs with the first taking three to four hours. Petitioner says he was hurt at "at the beginning" presumably of the first repair, then worked another three to four hours. This contradicts prior testimony indicating Petitioner's accident occurred after 9:00 pm.

Based on the above, the Arbitrator concludes that the Petitioner's claims with regard to his right arm lack credibility. Accordingly, the Arbitrator finds that the Petitioner's current condition of ill-being in his right arm is not causally connected to his August 2, 2016 work accident. Therefore, all benefits being claimed for the Petitioner's right arm condition are denied.

2. In accordance with the Arbitrator's findings regarding the issue of causation, all other issues are rendered moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF KANE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Maria Alvarado, as wife and next best friend of Evaristo Alvarado, deceased,

Petitioner,

vs. NO: 12 WC 27144

Menards,

19IWCC0187

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 wages, 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 sole question on review is whether the Instant Profit Sharing payment of $7,717.76 that Decedent received prior to his death should be included in the calculation of his average weekly wage.

The evidence shows that Evaristo Alvarado (hereinafter "Decedent") was working at the Menards in Plano, Illinois at the time of his death on 3/27/12. Decedent's wife, Maria Alvarado (hereinafter "Petitioner") testified that her husband began working part time for the Respondent in June of 2004, and that he quit in June of 2005 only to return full time in August of 2005. (T.16). She indicated that he continued to work for Respondent thereafter until the date of his death. (T.16-17).

Petitioner testified that every February her husband would receive a check from Menards as part of its "Instant Profit Sharing" plan (hereinafter "IPS"). (T.22-23). She stated that the only thing she knew about it was that employees "... need[ed] to meet the hours they required to be

able to get the profit-sharing check." (T.23). She agreed with the records if they show her husband did not receive an IPS payment in 2005 given that he did not work enough hours to meet the eligibility requirements outlined in the profit-sharing program. (T.25-26). However, she agreed that her husband did receive IPS payments every year from 2006 through 2012, and that his payment increased every year during that period. (T.27). She agreed that these payments were included in her husband's yearly W-2 statements. (T.28).

Petitioner agreed that the last IPS payment her husband received was on 2/10/12, or about a month-and-a-half before he died, in the amount of $7,717.76. (T.28-29). She agreed that this figure, as well as the previous IPS payments, was reflected on the W-2 statement under "wages, tips and other compensation." (T.29-30). She also agreed that the $7,717.76 that her husband received in February 2012 represented about 15 percent of his total earnings in 2011, and that it was an important part of his total yearly earnings from Menards. (T.32). She indicated that she and Decedent counted on the yearly IPS payments, and that they expected to receive same if her husband and his unit met the requirements set forth in the IPS program. (T.32).

On cross examination, Petitioner testified that the IPS program was "... an incentive for all the employees that my husband was working. He left the house at 3:00 in the morning to be there before 5:00 in the morning so he can be there on time and put the hours in. He was very excited to work for Menards because they have that program. They make the hours." (T.34). She agreed that the program was also based upon the earnings of the group in which he worked, noting that "... they have this in the whole company. It's each department, each team, have their own profit hours to make up. I know that everybody gets the profit sharing check every year according to the hours put in in the department with the team." (T.34-36). She also agreed that she understood that the basis for the payment would be based upon the profit earned by the team, and not the individual. (T.36).

Respondent's HR coordinator, Kimberly Januszewski, testified that she is familiar with the compensation that is provided to the team members employed by Menards. (T.41). She noted that Decedent was a fleet mechanic at the Plano Distribution Center and that there were approximately 20 people in his department at the time. (T.41,46). She indicated that the mechanics division "... works on our fleet – trailers, motorized equipment, those types of pieces of equipment that we would use at the distribution center." (T.46-47).

Ms. Januszewski testified that Decedent's regular rate of pay was $16.10 per hour. (T.47). She noted that overtime is not mandatory and is offered at time-and-a-half after 40 hours worked, although she did add that an employee may be asked to work overtime during seasonal periods. (T.50). She also stated that Menards adds $2.50 per hour for work on the weekend, which would bring Petitioner's weekend hourly wage to $18.60. (T.52).

Ms. Januszewski was shown a Menard's Instant Profit Sharing booklet that referred to the program as "discretionary" and which stated that it was intended to encourage Team Members to contribute to the growth and success of the company. (T.57-58). She noted that discretionary meant that "[i]t can be removed at any time" and that "... Menards at any point in time can determine not to make payments to the program therefore making it ineligible." (T.58,61). She also stated that "[t]he unit has to maintain 100 percent profitability based on year end figures in

order to compensate at 100% percent profit sharing ability." (T.62). In addition, she indicated that the Team Member needs to be paid for hours worked on or after December 15th of the W-2 year in order to be eligible, and that "[t]hey have to achieve a thousand hours paid during the W-2 year, … and the unit needs to achieve the profit requirements for the I.P.S. program." (T.63-64). She noted that the IPS is paid as a percentage of profitability, "[s]o, for example, if a unit is only 80 percent profitable, then they receive 80 percent of that figure." (T.66). She indicated that if a unit is not profitable at all "… they do not receive Instant Profit Sharing." (T. 65-66). She acknowledged that this has occurred during the period she had worked for Menards, but that it does not happen often. (T.66).

When asked who determines the division of profit for IPS purposes, Ms. Januszewski testified that "… we have profit and loss statements that we receive at each unit that will give us an idea as to where we are in accordance to our profit levels but ultimately that's coming from our general office." (T.67). Ms. Januszewski also read the following disclaimer into the record from the program manual: "The Menards I.P.S. program is a discretionary program. Menards reserves the right to amend or cancel the I.P.S. program in whole or in part at any time without notice. Menards also reserves the right to reduce, modify, or withhold awards based on such factors as regulatory events, changes in business conditions, individual performance or any other reason. Menards also reserves the right to decide all questions and issues arising under the I.P.S. program and its decisions are final. The I.P.S. program is a statement of Menards' intentions and does not constitute a guarantee that any particular amount of compensation will be paid. It does not create a contractual relationship or any contractually enforceable rights between Menards and the employee." (T.73-74). Ms. Januszewski denied that the IPS program is based upon a measure of the volume or quality of the work performed by the Team Member. (T.74-75). She agreed that the IPS benefit is based on the profit earned collectively by the unit that the Team Member is assigned to. (T.75).

On cross examination, Ms. Januszewski testified that the IPS program document she referred to previously (PX7) has been in existence at least as long as she has been with the company. (T.76-77). She agreed that Menards referred to the IPS program as "partners in profit" in PX7. (T.86-87). She noted that all employees are also given a Team Member information booklet (PX6) that lists the IPS program in the Table of Contents under "Benefits." (T.79-80). She likewise agreed that the word "bonus" is not mentioned in the IPS program booklet admitted at PX7. (T.82). In addition, she agreed that the information booklet given to employees that was admitted at PX12 refers to the IPS program as "earnings." (T.83-84). She also agreed that the IPS program has been in existence continuously for over 40 years, since 1958. (T.85-86). She agreed that the IPS program is a way to encourage Menards' employees to make contributions towards the profitability of their unit, and that the goal of the program was to provide employees like Decedent with a personal stake in the growth and success of their work unit in the company. (T.88). She agreed that it is an incentive-based program, and that the IPS earnings are paid at least in part in consideration for the work performed by each Team Member, including the Decedent. (T.91-92). However, she noted that "… there are a multitude of factors that go into whether or not the Instant Profit Sharing is paid out and then at what percentage." (T.96).

Ms. Januszewski agreed that IPS earnings are not pension, retirement or 401(k) benefits and that they are included in the employee's yearly W-2 wage statement. (T.97). She indicated

that an individual receives his or her IPS earnings based on a formula, and that IPS earnings increase with the Team Member's length of service up to a maximum of 15 percent after six years. (T.102-103). She also once again agreed that payment of IPS earnings is conditioned upon meeting three requirements – a thousand hours of work for Menards during the W-2 year, working on or after 12/15, and the unit achieving the necessary profit levels. (T.107-108). In addition, she agreed that the yearly IPS earnings are conditioned at least in part upon the diligent work and cooperation of each employee. (T.108). She also agreed, at least in part, that each employee has to meet Menards' performance expectations to receive an IPS payment. (T.110-111). She likewise agreed that if a Team Member meets the eligibility requirement then one would expect to receive an IPS payment in accordance with PX7, PX12 and RX1. (T.111).

On re-direct examination, Ms. Januszewski indicated that an employee would not be excluded from the IPS program based upon a performance review. (T.129). She also noted that the IPS benefit is not based upon the volume or quality of an individual Team Member's work. (T.129).

Based on the above, and the record taken as a whole, the Commission modifies the decision of the Arbitrator to find that the Instant Profit Sharing payment that Decedent received from Respondent on 2/10/12 in the amount of $7,717.76 was essentially a bonus and should not be included in the calculation of his average weekly wage pursuant to §10 of the Act. The Commission notes that documents describing the IPS program clearly show that it was discretionary, and that Menards reserved the right to amend or even cancel the program in whole or in part without notice and in its sole discretion. (PX7). Furthermore, these documents explicitly show that Menards' intention to pay these benefits was not a guarantee, and that no contractually enforceable rights between Menards and its employees were created in the process. More importantly, the evidence shows that IPS payments were not tied to individual performance, but were instead dependent upon the profitability of the unit in which a Team Member worked, assuming an employee met the requisite number of hours worked. Thus, the circumstances in this claim differ from the one presented in the case relied upon by the Arbitrator, *Arcelor Mittal Steel v. Ill. Workers' Compensation Comm'n*, 961 N.E.2d 807, 356 Ill. Dec. 418 (1st Dist. 2011), and as such is distinguishable. It also matters not that the IPS payment represented an important component of Decedent's earnings package, or that he and his spouse had come to expect and rely upon it as part of their annual income. Instead, the issue is whether the payment was truly incentive-based pay which an employee would receive for specific work performed as a matter of contractual right, and the evidence shows that the IPS program in question was not.

Therefore, the Commission finds that the IPS payment received by Decedent was essentially a bonus and therefore should not be included in the calculation of wages. Thus, the Commission modifies the decision of the Arbitrator to find that Decedent's average weekly wage was equal to $821.24, based upon the parties' stipulation along these lines.

All else is otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay death benefits of $547.49 per week, until $500,000.00 has been paid or 25 years, whichever is greater,

19IWCC0187

as provided in §7(a) and §8(b)4.2 of the Act, for the reason that the injuries sustained caused the death of decedent on March 27, 2012 leaving surviving at the time of his death his widow, Maria Alvarado, and no minor children.

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; 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.

Bond for the removal of this cause to the Circuit court 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 Review in Circuit Court.

DATED: APR 11 2019
o:2/11/19
TJT/pmo
51

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
FATAL

ALVARADO, MARIA AS WIFE AND NEXT BEST FRIEND OF ALVARADO, EVARISTO DECEASED
Employee/Petitioner

Case# **12WC027144**

19IWCC0187

MENARDS
Employer/Respondent

On 1/26/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 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:

1228 KINNALLY FKAHERTY KRENTZ LORAN
MARK MASUR
2114 DEERPATH RD
AURORA, IL 60506

1296 CHILTON YAMBERT PORTER LLP
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CHICAGO, IL 60606

19IWCC0187

STATE OF ILLINOIS)
)SS.
COUNTY OF KANE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
FATAL

Maria Alvarado, as wife and next best friend of Evaristo Alvarado, deceased
Employee/Petitioner

v.

Menards
Employer/Respondent

Case # **12** WC **27144**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Barbara N. Flores**, Arbitrator of the Commission, in the city of **Geneva**, on **December 12, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

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

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

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

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

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

G. [x] What were Decedent's earnings?

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

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

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

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

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

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

N. [ ] Is Respondent due any credit?

O. [ ] Other _____

FINDINGS

On the date of accident, **March 27, 2012**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Decedent earned **$49,953.30**; the average weekly wage was **$971.32** as explained *infra*.

On the date of accident, Decedent was **56** years of age, ***married*** with **no** dependent children.

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

Respondent shall be given a credit of **$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.

The Arbitrator finds that Decedent died on **March 27, 2012**, leaving **1** survivor(s), as provided in Section 7(a) of the Act, including **his wife, Maria Alvarado**.

ORDER

As explained in the Arbitration Decision Addendum, the Arbitrator finds that Petitioner has established that the decedent, Evaristo Alvarado, earned $49,953.30 (inclusive of a $7,717.76 Instant Profit Sharing Program payment received for work performed in the year before his accident) resulting in an average weekly wage of $971.32.

Thus, Respondent shall pay death benefits, commencing March 27, 2012, of $647.55/week to the surviving spouse, Maria Alvarado, on her own behalf, until ***$500,000 has been been paid or 25 years***, whichever is greater, have been paid, because the injury caused the employee's death, as provided in Section 7 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

January 24, 2018
Date

JAN 26 2018

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION *ADDENDUM*
FATAL

Maria Alvarado, as wife and next best friend of Evaristo Alvarado, deceased
Employee/Petitioner

v.

Menards
Employer/Respondent

Case # **12** WC **27144**

Consolidated cases: **N/A**

FINDINGS OF FACT

The only issue in dispute between the parties relates to Petitioner's earnings and average weekly wage. Arbitrator's Exhibit[1] ("AX") 1. Specifically, whether a $7,717.76 Instant Profit Sharing Program payment made to the decedent, Evaristo Alvarado, in the year before his accident should be included in the calculations. AX1. The parties have stipulated to all other issues. *Id.*

Maria Alvarado (Mrs. Alvarado) testified that she was married to the decedent, Evaristo Alvarado (Mr. Alvarado), on July 8, 1978. Tr. at 14-15. She explained that the decedent was born on April 17, 1955 and he was 56 years of age at the time of his death on March 27, 2012. *Id.* Mr. Alvarado was employed by Menard's (Respondent) on March 27, 2012 when he was involved in a forklift accident at work resulting in his death. Tr. at 15-19; PX3. Mrs. Alvarado testified that she was married to Petitioner for 33 years and they had two children, Israel (date of birth January 28, 1978), and Jezebeth (date of birth November 1, 1987). Tr. at 19-21; PX4. Jezebeth was not enrolled as a student at the time of the Mr. Alvarado's death. *Id.*

Mr. Alvarado had been employed by Respondent for eight years. Tr. at 16. He began working, part-time, in June of 2004 and worked for approximately one year before leaving the company. *Id.* He then returned to work for Respondent, full-time, in August of 2005 and worked continuously until his death on March 27, 2012. *Id.* Mr. Alvarado was a member of Respondent's fleet mechanic unit at its Plano Distribution Center. Tr. at 41. The Plano fleet unit consisted of 20 employees who serviced, maintained, and repaired Respondent's fleet, including trailers, forklifts, and other motorized equipment. Tr. at 46-47.

Mr. Alvarado's payroll history for the pay periods from March 27, 2011 through April 10, 2012 reflect that Mr. Alvarado earned $16.10 per hour, with no increases. PX9. However, Respondent also offered its employees, including Mr. Alvarado, an opportunity to earn money under its IPS Program. PX7 and RX1. Mr. Alvarado received a yearly IPS payment on February 10, 2012 totaling $7,717.76 because he met the eligibility requirements in the 2011 calendar year. PX9. Previously, Mr. Alvarado had regularly received IPS Program payments as follows:

[1] The Arbitrator similarly references the parties' exhibits herein. Petitioner's exhibits are denominated "PX" and Respondent's exhibits are denominated "RX" with a corresponding number as identified by each party. The arbitration hearing transcript is denominated as "Tr." with the corresponding page number(s).

Year Paid	Hours Worked	Payment Amount
2012	2,479.61	$7,717.76
2011	2,366.95	$6,767.47
2010	2,263.61	$4,627.56
2009	1,570.55	$2,154.40
2008	1,121.34	$1,034.82
2007	1,279.77	$740.33
2006	1,103.15	$306.86
2005	659.39	$0

PX8.

Mrs. Alvarado testified that she and Mr. Alvarado counted on the yearly IPS payment, considering it to be an important part of Mr. Alvarado's yearly earnings. Tr. at 32-33, 111-113. She explained that they expected to receive the IPS payment if the eligibility requirements were met. *Id.* On cross-examination, Mrs. Alvarado testified that she understood that the IPS Program was an incentive program. Tr. at 35-36. She acknowledged that she was aware that the earnings were based on the achievements and profitability of the group/team such that no additional amount would be paid if those requirements were not met. *Id.*

Kimberly Januszewski (Ms. Januszewski) testified that she is employed by Respondent and has been so employed since August 5, 2004 as an HR Coordinator. Tr. at 39-40. In this position, she is involved in interviews, training, scheduling, team-member (i.e. employee) development, and team-member resources. Tr. at 40-41. Ms. Januszewski explained that she is familiar with the forms of compensation that Respondent provides to its employees. Tr. at 41. She testified that the decedent, Mr. Alvarado, was employed as a Fleet Mechanic at the Plano Distribution Center. *Id.*

Ms. Januszewski was presented with Petitioner's Exhibit 9, which reflects Petitioner's payroll history. Tr. at 42. She explained that the document is a computer-screen printout maintained in the usual course of business. *Id.* Ms. Januszewski also explained the abbreviations and references contained in the document. Tr. at 42-56. She testified that "BIPS" is Bonus Instant Profit Sharing and "BMAN" is Bonus Manual, which is an incentive provided in the form of a holiday merchandise credit check based on the years worked by the team-member with the company. *Id.* "BCMC" is a bonus merchandise credit check given to team-members for a "Fall Be Here Days Program" which means that fulltime team members were given $500 in the form of a merchandise credit check to ensure that Respondent had enough employees during a specific period. *Id.*

Respondent has an "Instant Profit Sharing" (IPS) Program, which is an incentive and formula-based program providing employees the opportunity to earn money if certain eligibility requirements are met. Tr. at 92-93, 102-103. Each "team member" (i.e., a Menards employee) was eligible to participate in the program if:

1. He/she achieved1,000 hours paid during the W-2 year; and
2. He/she was paid for hours actually worked on or after December 15 of the W-2 year; and
3. The Team Member's work unit achieved the profit requirements for the IPS Program.

PX7 and RX1. The amount that an employee was eligible to receive depended upon the employee's years of eligibility, which grew with his/her annual length of service, and the profits achieved by his/her unit. PX12. The percentage of available "IPS earnings" defined by Respondent as W-2 earnings plus 401(k) deferrals, starts at 2.5% in an employee's first year of eligibility and increases yearly until the 6th year of eligibility when he/she caps out at 15% of IPS earnings. PX12.

The earnings available to Mr. Alvarado and other employees are detailed in the 7-page pamphlet entitled "Menard's Instant Profit Sharing" was distributed to all employees, including Mr. Alvarado. Tr. at 59. This pamphlet reflects a statement of Respondent's intentions with regard to the IPS Program, and also details the payment of earnings to employees that meet the eligibility requirements. Tr. at 84, PX7 and RX1.

The IPS Program pamphlet refers to "A Menards Tradition… 'Partners in Profit[]'" and notes that the IPS Program has been in existence continuously since 1958. Tr. at 85-86, PX7 and RX1. The pamphlet notes that the IPS Program is John Menards' way of sharing his company's success with his employees. Tr. at 86, PX7 and RX1. The pamphlet refers to the IPS program as "a great company benefit and an outstanding financial program." Tr. at 87, PX7 and RX1.

The IPS Program provides for an annual taxable lump sum payment, which is included in the "wages, tips, other compensation" box of the employee's W-2 Wage Statement. Tr. at 97-99. IPS earnings are not considered to be pension, retirement, or 401(k) benefits. Tr. at 97. The IPS Program is also the first of 11 listed benefits reflected in Menards Team Member Information Booklet, a 16-page manual outlining Menards benefits, work procedures, and values given to all employees. PX6; Tr. at 78. The IPS Program benefits are listed benefits including paid vacations, 401(k), and group insurance. PX6.

Ms. Januszewski acknowledged that each employee's diligent effort and cooperation toward the success of their work unit and the company contributes to make the IPS Program possible and successful. Tr. at 90-91; PX7 and RX1. When Respondent refers to diligent effort, she explained that it refers to the hard work of its employees. Tr. at 91. Ms. Januszewski testified that IPS earnings are paid, in part, in consideration for the work performed by the team members of a unit, including Mr. Alvarado. Tr. at 91. She explained that the performance and work of individual members of a unit, in part, determines whether these individuals receive IPS earnings. Tr. at 92-93. Ms. Januszewski testified that the IPS program is a financial incentive for employees' hard work and cooperation. Tr. at 92. She acknowledged that each team member of a unit plays a role in whether the unit is productive and profitable. Tr. at 94. The harder each team member of a unit works, the more likely the unit will be profitable, the individual team member is to receive an IPS payment, and the more each team member can earn. Tr. at 96-97.

Ms. Januszewski testified that the IPS Program is Respondent's way of encouraging employees to contribute to the growth and success of the company. Tr. at 88; PX7 and RX1. The IPS Program is also a way to encourage employees to make contributions towards the profitability of their unit. Tr. at 88; PX7 and RX1. One goal of the IPS Program is to provide employees with a personal stake in the growth and success of their work unit. Tr. at 88; PX7 and RX1. Ms. Januszewski acknowledged that the IPS Program is Respondent's way of sharing the unit's success with eligible employees. Tr. at 88-89. She further testified that Respondent had the ability to reduce, modify, or withhold an individual's IPS payment based on the employee's performance and that each employee had to meet Respondent's performance expectations to receive the payment. Tr. at 109, 111; PX12, PX7 and RX1. However, Ms. Januszewski further acknowledged that unit profits are checked by management periodically and employees are encouraged to become more productive (i.e., work harder) if the unit is not producing as expected. Tr. at 123-124.

ISSUES AND CONCLUSIONS

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

In support of the Arbitrator's decision relating to Issue (G), what were the Decedent's earnings/average weekly wage, the Arbitrator finds the following:

Section 10 of the Act entitled "Compute Compensation Based on Average Weekly Wage" states the following in pertinent part:

> The compensation shall be computed on the basis of the "Average weekly wage" which *shall mean the actual earnings of the employee* in the employment in which he was working at the time of the injury during the period of 52 weeks ending with the last day of the employee's last full pay period immediately preceding the date of injury, illness or disablement *excluding overtime, and bonus* divided by 52; but if the injured employee lost 5 or more calendar days during such period, whether or not in the same week, then the earnings for the remainder of such 52 weeks shall be divided by the number of weeks and parts thereof remaining after the time so lost has been deducted. Where the employment prior to the injury extended over a period of less than 52 weeks, the method of dividing the earnings during that period by the number of weeks and parts thereof during which the employee actually earned wages shall be followed. Where by reason of the shortness of the time during which the employee has been in the employment of his employer or of the casual nature or terms of the employment, it is impractical to compute the average weekly wages as above defined, regard shall be had to the average weekly amount which during the 52 weeks previous to the injury, illness or disablement was being or would have been earned by a person in the same grade employed at the same work for each of such 52 weeks for the same number of hours per week by the same employer. ....

820 ILCS 305/10 (*emphasis* added).

The Appellate Court has addressed whether production bonuses should be included in calculating a claimant's average weekly wage. *Arcelor Mittal Steel v. Ill. Workers' Comp. Comm'n*, 2011 Ill. App. LEXIS 1154, 961 N.E.2d 807, 356 Ill. Dec. 418 (1st Dist. 2011). In *Arcelor*, the claimant's production bonus was provided "in consideration for work performed pursuant to his collective bargaining agreement and not as an extra benefit provided by employer gratuitously." *Arcelor Mittal Steel*, 2011 Ill. App. LEXIS 1154, ¶¶19-20. Ultimately, the court found that the production bonuses earned by claimant should be included in calculating the average weekly wage because they were not a "bonus" as contemplated in Section 10 of the Act. *Id.*, at ¶¶20-21. In so concluding, the court noted the following:

> We note a distinction between incentive-based pay, which an employee receives in consideration for specific work performed as a matter of contractual right, and a bonus, which an employee receives for no consideration or in consideration of overall performance at the sole discretion of the employer. See e.g., *Levkovitz v. Industrial Comm'n*, 256 Ill. App. 3d 1075, 1081, 628 N.E.2d 824, 828, 195 Ill. Dec. 360 (1993) ("There is nothing in the record to indicate claimant received these meals 'as consideration for work.' *** These meals appear to more closely resemble a 'bonus,' i.e., extra benefits given to the employee by the employer.").

Arcelor Mittal Steel, 2011 Ill. App. LEXIS 1154, ¶19.

There are similarities between the IPS Program payments at issue in this case and the production bonuses considered in *Arcelor*. The IPS Program payments in this case and the production bonuses in *Arcelor* were both considered an important part of the compensation packages offered to the employees. Both also required that the employee meet certain eligibility requirements, and both were paid as consideration for work performed by the employee, either in whole or in part.

In *Arcelor* the "[e]mployer had no discretion and was obligated to pay the production bonuses if earned by its employees; the production bonuses were 'strictly due.'" *Id.*, at 20. Here, the IPS Program pamphlet reflects provisional language suggesting that an employee may not receive a yearly IPS Program payment if the eligibility requirements were not met. Ms. Januszewski confirmed the intended discretionary nature of the IPS Program payments. She explained that Respondent had the ability to reduce, modify, or withhold an IPS payment based on the employee's performance. Further, IPS Program payments were tied to the profitability of the performance of the employee as well as the employee's unit as a whole, albeit for work performed inclusive of each individual employee's work. However, consideration only of the eligibility requirements necessary for Mr. Alvarado to receive the IPS payments is a red herring.

The evidence in this case reflects that Respondent never exercised any discretion in making Mr. Alvarado's IPS Program payments for the work that he performed, which contributed to Respondent's increasing profitability every year. Mr. Alvarado received ever-increasing IPS Program payments on a yearly basis because he met the eligibility requirements every year except his first year when he worked part-time. Mrs. Alvarado's testimony that she and her late husband expected the IPS Program payment as a part of his earnings every year is confirmed by the ever-increasing, yearly IPS Program payments earned by Mr. Alvarado from 2006 through 2012.

Stated differently, Respondent's IPS Program payments to Mr. Alvarado were mandatory when he met the eligibility requirements, they were not bonuses as contemplated by Section 10 of the Act. Mr. Alvarado historically received theses structured incentive payments pursuant to the IPS Program based on his ever-increasing work production. Mr. Alvarado always met the eligibility requirements between 2006 and 2012, and exceeded his contributions at work such that the IPS Program payments increased every year. There is little room for speculation given the evidence in this case as to whether Mr. Alvarado would receive such IPS Program payments every year up to the maximum allowed under the program. To the contrary, it would be speculative to conclude that the IPS Program payments made to Mr. Alvarado were discretionary bonuses (as contemplated in Section 10 of the Act) given that Respondent habitually paid ever-increasing amounts to Mr. Alvarado for meeting and exceeding his work performance since 2006.

Accordingly, the Arbitrator finds that the $7,717.76 IPS payment received by the decedent, Mr. Alvarado, should properly be included in his average weekly wage calculation. Therefore, pursuant to the stipulation of the parties if the foregoing finding was made, the decedent's average weekly wage is $971.32 resulting in $647.55 weekly death benefit amount payable to his widow, Maria Alvarado, commencing on March 27, 2012.

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

BRYAN POWELL,

Petitioner,

vs. NO: 17 WC 30011

AMERICAN COAL,

19IWCC0188

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of temporary total disability and medical expenses, including prospective medical treatment, 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 Decision of the Arbitrator is modified only the extent that the first sentence of the seventh page is stricken. The Commission finds it to improper to speculate as to what recommendations Dr. Gornet may or may not make in the future. The Commission leaves the Decision of the Arbitrator otherwise undisturbed.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $1,016.31 per week for a period of 51-1/7 weeks, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this

19IWCC0188

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 expenses under §8(a) of the Act as stated in the Decision of the Arbitrator.

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.

APR 16 2019

DATED:
TJT/mav
O: 03/05/19
42

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION

NOTICE OF 19(b) ARBITRATOR DECISION

POWELL, BRYAN
Employee/Petitioner

Case# **17WC030011**

AMERICAN COAL
Employer/Respondent

19IWCC0188

On 7/17/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0969 RICH RICH & COOKSEY PC
THOMAS C RICH
6 EXECUTIVE DR SUITE 3
FAIRVIEW HTS, IL 62208

2999 LITCHFIELD CAVO LLP
GREGORY KELTNER
220 S CENTRAL AVE
ST LOUIS, MO 63105-3527

19IWCC0188

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
19(b)

Bryan Powell
Employee/Petitioner

v.

American Coal
Employer/Respondent

Case # 17 WC 30011

Consolidated cases: n/a

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Mt. Vernon, on June 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. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ Is Petitioner entitled to any prospective medical care?
L. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On the date of accident, April 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 $45,733.98; the average weekly wage was $1,524.46.

On the date of accident, Petitioner was 41 years of age, married with 2 dependent child(ren).

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

Respondent shall be given a credit of $35,171.93 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $35,171.93.

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

ORDER

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibit 1, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given credit of amounts paid for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall authorize and pay for prospective medical treatment including, but not limited to, the treatment recommended by Dr. Matthew Gornet.

Respondent shall pay Petitioner temporary total disability benefits of $1,016.31 per week for 51 1/7 weeks, commencing June 14, 2017, through June 8, 2018, as provided in Sections 8(b) of the Act.

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

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

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

William R. Gallagher, Arbitrator
ICArbDec19(b)

July 13, 2018
Date

JUL 17 2018

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 April 20, 2017 (the correct date of accident was April 22, 2017, and the date was correct on the stipulation sheet). According to the Application, Petitioner slipped on a metal beam and sustained injuries to the neck, shoulders, back, elbows, knees, tailbone and body (Arbitrator's Exhibit 2). This case was tried in a 19(b) proceeding and Petitioner sought an order for payment of temporary total disability benefits and medical bills as well as prospective medical treatment. Respondent stipulated that Petitioner sustained a work-related accident on April 22, 2017, but disputed liability on the basis of causal relationship (Arbitrator's Exhibit 1).

The primary injuries Petitioner alleged that he sustained were to the neck and low back. Respondent disputed liability in regard to Petitioner's neck and low back conditions, but only in part, in regard to Petitioner's neck condition. Respondent stipulated that Petitioner's neck condition was related to the accident for treatment he received through November 13, 2017. Respondent disputed liability for any treatment provided to Petitioner for his neck condition subsequent to November 13, 2017, and for all treatment provided to Petitioner for his low back condition. Respondent also disputed liability for prospective medical treatment in regard to Petitioner's neck and low back conditions (Arbitrator's Exhibit 1).

In regard to temporary total disability benefits, Petitioner claimed that he was entitled to payment of temporary total disability benefits for 51 1/7 weeks, commencing June 14, 2017, through June 8, 2018 (the date of trial). Respondent agreed Petitioner was entitled to temporary total disability benefits of 38 5/7 weeks, commencing June 14, 2017, through March 12, 2018, but not entitled to temporary total disability benefits thereafter (Arbitrator's Exhibit 1).

Petitioner worked for Respondent as a belt maintenance worker. Petitioner testified that on April 22, 2017, he had been working on a muddy/wet surface for the entire day. When Petitioner stepped on a metal beam, he slipped and fell onto a concrete floor. Petitioner stated that when this occurred, his neck was snapped backward in his back was jarred. Petitioner stated that following the accident, he had headaches, nausea and a lack of range of motion of his neck. Petitioner said he also had some low back complaints; however, his head and neck symptoms were the primary complaints at that time.

Petitioner did not seek any medical treatment immediately following the accident; however, Petitioner stated that his symptoms gradually increased. On May 3, 2017, Respondent sent Petitioner to the ER of Harrisburg Medical Center.

According to the ER record, Petitioner sustained a fall and had pain in the head, neck and back. CT scans of Petitioner's head, cervical spine, thoracic spine and lumbar spine were ordered. The CT scan of Petitioner's head was normal; however, the CT scan of Petitioner's cervical spine revealed an annular disc bulge at C4-C5. The CT scan of Petitioner's lumbar spine revealed disc bulging at L3-L4, L4-L5 and L5-S1. The CT scan of Petitioner's thoracic spine revealed disc protrusions at T5-T6 and T7-T8. Petitioner was discharged and directed to follow-up with Dr. James Alexander (Petitioner's Exhibit 3).

On May 3, 2017, Petitioner was seen by Dr. Clayton Ford (Dr. Alexander's partner). Dr. Ford examined Petitioner's neck and diagnosed cervicalgia with a bilateral trapezius strain. Dr. Ford's record of that date also listed as one of Petitioner's complaints "lbp" or low back pain, but he did not examine Petitioner's lumbar spine. He did note that CT scans of all three levels of the spine were obtained and the CT scan of the lumbar spine revealed spondylosis (Petitioner's Exhibit 4).

At the direction of Respondent, Petitioner was examined by Dr. James Coyle, an orthopedic surgeon, on June 5, 2017. In connection with his examination of Petitioner, Dr. Coyle reviewed medical records provided to him by Respondent. At that time, Petitioner complained of headaches, neck pain, numbness in the ring and little fingers of his left hand, weakness of both arms and right sided low back pain. On examination, Dr. Coyle noted tenderness at C6-C7 on the left side. He ordered an MRI scan of Petitioner's cervical spine (Petitioner's Exhibit 5).

The MRI of Petitioner's cervical spine was performed on June 5, 2017. According to the radiologist, the MRI revealed disc bulges/protrusions at multiple levels (Petitioner's Exhibit 6).

Dr. Coyle reviewed the MRI and opined it revealed a left central disc protrusion at C5-C6 and a left sided disc herniation at C6-C7. Dr. Coyle's diagnosis was cervicalgia and bilateral upper extremity radiculopathy, multilevel disc protrusions and herniations, and onset of nausea and vomiting. In regard to causality, Dr. Coyle noted "Based on the history given and the mechanism of injury, his cervical and low back symptoms are due to his work injury of April 22, 2017." Dr. Coyle ordered a nerve block procedure at C6-C7 for diagnostic and therapeutic purposes (Petitioner's Exhibit 5).

Dr. Coyle again saw Petitioner on June 20, 2017, because of Petitioner's ongoing neck and upper extremity symptoms. Dr. Coyle opined Petitioner had disc herniations at C4-C5 and C6-C7, but noted it was difficult to tell which was more symptomatic. He ordered physical therapy (Petitioner's Exhibit 5).

Petitioner received physical therapy from June 26 through July 14, 2017, for his neck and upper extremity complaints. While Petitioner did not receive any physical therapy in regard to his low back, it was noted that Petitioner also had lumbar spine/low back pain (Petitioner's Exhibit 3).

When Dr. Coyle saw Petitioner on July 18, 2017, Petitioner continued to have neck and left upper extremity symptoms. At that time, Dr. Coyle recommended Petitioner undergo disc surgery and a fusion with metal plating at C6-C7 (Petitioner's Exhibit 5).

Dr. Coyle performed surgery on August 8, 2017. The procedure consisted of microscopic discectomy, bilateral foraminotomy, insertion of a spacer and metal plate (Petitioner's Exhibit 10).

Dr. Coyle continued to treat Petitioner following the surgery. When he saw Petitioner on September 18, 2017, he noted that Petitioner was doing well in regard to his cervical spine surgery, but Petitioner's chief complaint was low back pain, right sided paralumbar pain and gluteal pain. On examination, straight leg raising was positive on the left side and there was

lumbar spasm. Dr. Coyle opined Petitioner had experienced an exacerbation of low back pain and he prescribed medication (Petitioner's Exhibit 5).

Dr. Coyle saw Petitioner on November 2, 2017, and Petitioner's cervical spine condition had continued to improve. In regard to the low back, Petitioner advised that the medication did not help. Dr. Coyle ordered an MRI scan of Petitioner's lumbar spine (Petitioner's Exhibit 5).

The MRI of Petitioner's lumbar spine was performed on November 13, 2017. According to the radiologist, the MRI revealed disc bulges at L4-L5 and L5-S1 (Petitioner's Exhibit 6).

Dr. Coyle saw Petitioner on November 13, 2017, and reviewed the MRI. Dr. Coyle opined the MRI revealed disc protrusions at L3-L4, L4-L5 and L5-S1 with the most significant finding at L4-L5. He opined Petitioner had low back pain with intermittent lower extremity radiculopathy. He recommended Petitioner undergo some epidural steroid injections (Petitioner's Exhibit 5).

On December 2, 2017, Petitioner was evaluated by Dr. Matthew Gornet, an orthopedic surgeon. At that time, Petitioner complained of low back pain with radiation into both hips and right leg as well as neck pain going into both shoulders. Petitioner advised the neck surgery had relieved his arm symptoms, but it did not relieve his neck symptoms. Dr. Gornet reviewed diagnostic studies of both the cervical and lumbar spine. Dr. Gornet opined the MRIs of the cervical and lumbar spine revealed disc pathology at multiple levels. In regard to the cervical spine, Dr. Gornet opined that there were annular tears at C4-C5 and C5-C6, a disc protrusion at C3-C4 and a disc herniation at C4-C5. In regard to the lumbar spine, Dr. Gornet opined that there were annular tears at L3-L4, L4-L5 and L5-S1 (Petitioner's Exhibit 11).

Dr. Gornet ordered a CT scan of the cervical spine which was performed on December 2, 2017. It revealed healing of the fusion at C6-C7 and protrusions at C3-C4 and C4-C5. Dr. Gornet noted that the fusion performed by Dr. Coyle helped the radicular symptoms, but did not address the axial pain related to the other disc injuries. He indicated he would defer any further treatment in regard to the cervical spine to provide more time for the fusion to heal (Petitioner's Exhibit 11).

In regard to the low back, Dr. Gornet noted Petitioner had lumbar symptoms primarily at L4-L5 and L5-S1. He referred Petitioner to Dr. Kaylea Boutwell for epidural steroid injections (Petitioner's Exhibit 11).

Dr. Boutwell saw Petitioner on December 21, 2017, and January 4, 2018, and administered epidural steroid injections at L4-L5 and L5-S1, respectively. The injections only provided some temporary relief. When Dr. Gornet saw Petitioner on February 24, 2018, he indicated he would place Petitioner's low back treatment on hold pending further diagnostic tests on the cervical spine (Petitioner's Exhibits 11 and 13).

At the direction of Respondent, Petitioner was examined by Dr. Robert Bernardi, a neurosurgeon, on February 27, 2018. In connection with his examination of Petitioner, Dr. Bernardi reviewed medical records and diagnostic studies provided to him by Respondent as well as a surveillance video of Petitioner obtained on September 27 and October 11, 2017.

In regard to Petitioner's cervical spine, Dr. Bernardi opined Petitioner had multilevel cervical degenerative disc disease, C6-C7 disc protrusion, post C6-C7 discectomy/fusion and neck and bilateral non-radicular arm pain of uncertain etiology. In regard to Petitioner's low back, Dr. Bernardi opined Petitioner had multilevel lumbar degenerative disc disease and low back and bilateral non-radicular leg pain of uncertain etiology (Respondent's Exhibit 5; Deposition Exhibit 2).

In regard to causality, Dr. Bernardi opined that neither Petitioner's neck nor low back conditions were related to the accident of April 22, 2017. This was based on a number of reasons Dr. Bernardi described at length. Briefly, Dr. Bernardi noted Petitioner did not seek medical treatment until 12 days after the accident; Petitioner's complaints in regard to both the neck and low back varied considerably; the findings on the cervical and lumbar MRIs were degenerative and the etiology of Petitioner's various symptoms was uncertain. He also referenced the surveillance video of Petitioner in which Petitioner was observed walking two dogs, had a leash in each hand, walked at a fast pace, the dogs got away from him, etc. He indicated this suggested the possibility of malingering by Petitioner. Finally, Dr. Bernardi opined Petitioner was not in need of any further treatment or testing and could return to work without restrictions (Respondent's Exhibit 5; Deposition Exhibit 2).

The Arbitrator watched the aforementioned surveillance video of Petitioner walking the two dogs. The entire video was less than three minutes long. In the segment of September 27, 2017, Petitioner had a leash in each hand and briefly walked the dogs until they both got loose. Petitioner walked at what might be considered a faster than normal pace, but it was not jogging or running. In the video segment of October 11, 2017, Petitioner was accompanied by another individual, a woman, and they were each walking one of the dogs (Respondent's Exhibit 4). At trial, Petitioner testified that walking the dogs did not cause any change of his symptoms.

Petitioner was subsequently seen by Dr. Gornet on April 21, 2018. Dr. Gornet ordered an MRI and CT scan of the cervical spine. Only the MRI was performed, and it revealed some incomplete healing at C6-C7. Dr. Gornet also reviewed Dr. Bernardi's report. Among other things, Dr. Gornet noted that Dr. Bernardi's opinion that the neck and low back conditions were not related to the accident were contrary to that of Dr. Coyle. He also noted that he disagreed with Dr. Bernardi's opinion that Petitioner's symptoms were not consistent with the diagnostic studies and, further, Dr. Bernardi did not even consider the possibility that the fusion procedure had failed (Petitioner's Exhibits 11 and 14).

Dr. Gornet was deposed on April 9, 2018, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Gornet's testimony was consistent with his medical records and he reaffirmed the opinions contained therein. Dr. Gornet testified Petitioner sustained disc injuries at multiple levels of both the cervical and lumbar spine, all of which he causally related to the accident of April 22, 2017 (Petitioner's Exhibit 15; pp 7-9).

In regard to Petitioner's cervical spine, Dr. Gornet testified that the C6-C7 fusion performed by Dr. Coyle did not address significant radicular components. He recommended Petitioner undergo disc replacement surgery above the level where Dr. Coyle performed surgery, but noted Petitioner was still waiting to determine if the fusion had healed. In regard to the lumbar spine,

Dr. Gornet recommended further diagnostic testing and then proceeding with either disc replacement surgery or fusion/disc replacement surgery (Petitioner's Exhibit 15; pp 10-11).

Dr. Gornet also watched the video of Petitioner walking his dogs. He stated that this activity would not have aggravated Petitioner's symptoms (Petitioner's Exhibit 15; pp 12-13).

On cross-examination, Dr. Gornet said that if the cervical fusion was healed, Petitioner would need multilevel disc replacement surgery. If the fusion was not healed, Petitioner would then need both multilevel disc replacement surgery and a fusion (Petitioner's Exhibit 15; p 17).

Dr. Bernardi was deposed on May 25, 2018, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Bernardi's testimony was consistent with his medical report and he reaffirmed the opinions contained therein. Dr. Bernardi testified Petitioner had multilevel degenerative disc disease in both the cervical and lumbar spine which was not related to the accident of April 22, 2017 (Respondent's Exhibit 5; pp 20-21).

On cross-examination, Dr. Bernardi acknowledged that Petitioner had not sustained any injuries to his cervical or lumbar spine prior to April 22, 2017. Dr. Bernardi stated he disagreed with both Dr. Coyle and Dr. Gornet in regard to their reading of the MRIs of the cervical and lumbar spine. Dr. Bernardi further stated he would not have performed the fusion surgery that Dr. Coyle performed (Respondent's Exhibit 5; pp 33-34, 40-47).

At trial, Petitioner testified he still has neck and low back pain and has not been able to return to work. He has an appointment to be seen by Dr. Gornet on June 26, 2018. He wants to proceed with whatever treatment is recommended by Dr. Gornet.

Conclusions of Law

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

The Arbitrator concludes that Petitioner's current condition of ill-being in regard to his cervical and lumbar spine is causally related to the accident of April 22, 2017.

In support of this conclusion the Arbitrator notes the following:

There was no evidence Petitioner had any cervical or lumbar spine symptoms prior to the accident of April 22, 2017.

There was no dispute Petitioner sustained a work-related accident on April 22, 2017.

While Petitioner did not immediately seek medical treatment following the accident, Petitioner credibly testified that his symptoms gradually increased over time.

At the time Petitioner first sought medical treatment on May 3, 2017, he complained of pain referable to the head, cervical and lumbar spine as well as other areas of the anatomy. Even though Petitioner's primary complaints were in regard to his head and cervical spine, CT scans were ordered for Petitioner's head, cervical spine, thoracic spine and lumbar spine.

Dr. Coyle initially evaluated Petitioner at the direction of Respondent, but subsequently became a treating physician. Dr. Coyle opined that Petitioner's cervical and low back symptoms were related to the accident of April 22, 2017.

Dr. Gornet agreed with Dr. Coyle that Petitioner's cervical and lumbar spine symptoms were causally related to the accident of April 22, 2017. However, Dr. Gornet opined that fusion surgery performed by Dr. Coyle did not address the axial pain related to the other disc injuries.

Dr. Coyle and Dr. Gornet both reviewed diagnostic studies of Petitioner's cervical and lumbar spine and agreed they revealed disc pathology at multiple levels.

Respondent's second Section 12 examiner, Dr. Bernardi, opined that Petitioner's cervical and lumbar spine conditions were not related to the accident of April 22, 2017, an opinion contrary to both Dr. Coyle, Respondent's first Section 12 examiner, and Dr. Gornet.

In regard to the surveillance video, Dr. Bernardi and Dr. Gornet both watched the video. Dr. Bernardi opined it suggested Petitioner was malingering. Dr. Gornet opined it was not of any particular significance in regard to Petitioner's condition. The Arbitrator also watched the video and did not observe Petitioner engaging in any activity inconsistent with his claim of being disabled.

Given the preceding, the Arbitrator finds the opinions of Dr. Gornet and Dr. Coyle to be more persuasive than that of Dr. Bernardi in regard to causality.

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

The Arbitrator concludes that all the medical treatment provided to Petitioner was reasonable and necessary and that Respondent is liable for payment of the medical bills incurred therewith.

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibit 1, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit of amounts paid for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

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

The Arbitrator concludes Petitioner is entitled to prospective medical treatment including; but not limited to, the medical treatment recommended by Dr. Matthew Gornet.

In support of this conclusion the Arbitrator notes the following:

Dr. Gornet has continued to treat Petitioner and will likely recommend further surgeries on the cervical and/or lumbar spine.

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

The Arbitrator concludes Petitioner is entitled to temporary total disability benefits of 51 1/7 weeks, commencing June 14, 2017, through June 8, 2018.

In support of this conclusion the Arbitrator notes the following:

Petitioner has been disabled and receiving medical treatment for his work-related condition during the aforestated period of time.

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS
COUNTY OF WILLIAMSON)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ROBERT DEERE,
Petitioner,

vs.

THE AMERICAN COAL COMPANY,
Respondent.

No. 15WC 11627
19IWCC0185

ORDER

This matter comes before the Commission on its own Petition to Recall the Commission Decision to Correct Clerical Error pursuant to Section 19(f) of the Act. The Commission having been fully advised in the premises finds the following:

The Commission finds that said Decision should be recalled for the correction of a clerical/computational error.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Commission Decision dated April 8, 2019, is hereby recalled pursuant to Section 19(f) of the Act. The parties should return their original decisions to Commissioner Thomas J. Tyrrell.

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

Thomas J. Tyrrell

APR 16 2019

DATED:
TJT/jrc
051

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WILLIAMSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ROBERT DEERE,

Petitioner,

vs.

NO: 15 WC 11627
19IWCC0185

THE AMERICAN COAL COMPANY,

Respondent.

CORRECTED 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, exposure, arising out of and in the course of employment, causal connection, permanent disability, legal and evidentiary error, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

Findings of Fact and Conclusions of Law

The Commission adopts the Arbitrator's Statement of Facts in its entirety, however, the Commission views the evidence different from the Arbitrator. The Commission finds no reason to disturb the finding of the Arbitrator as it pertains to coal workers' pneumoconiosis, however, the Commission finds Petitioner contracted a disabling pulmonary occupational disease as a result of an exposure that arose out of and in the course of his employment under the Act. Therefore, the Commission vacates the Arbitrator's Conclusions of Law and substitutes the following:

Petitioner proved by a preponderance of the evidence that he sustained an occupational disease arising out of and in the course of his employment. In so concluding, the Commission finds the testimony of Dr. Paul to be credible and most persuasive with regard to the Petitioner's

condition of chronic obstructive pulmonary disease.

Petitioner testified he worked in the coal mine for 40 years and the last 38 being below ground. He testified in addition to coal dust, he was regularly exposed to and breathed silica dust, roof bolting glue fumes, diesel fumes and trowel on, a glue used to put tiles up on the wall. He testified he was exposed to coal dust on the date he retired. Petitioner's medical records reflected treatment for upper respiratory infections, sinusitis and coughs over the years. With these acute conditions, Petitioner complained of cough, sometimes with, and sometimes without, sputum production. Petitioner testified that when he would get a cold his breathing would become labored, or he would cough up black sputum beginning in the early-to-mid 1980's. (T, p. 29-30) Petitioner testified that since he left the mine, his breathing problems "pretty much stayed the same." (T, p. 30) He testified he cannot seem to take a deep breath when trying to do yard work or playing with his grandkids. (T, p. 31) He testified that his hobbies and activities of daily living are now affected. He testified he can no longer ride a bike, or run and or trek into the back woods when hunting. (T, p. 32)

The Commission agrees with the Arbitrator that Dr. Castle's and Dr. Meyer's interpretation of Petitioner's chest x-rays are more persuasive than those of Dr. Smith and Dr. Paul regarding the presence of coal workers' pneumoconiosis in Petitioner's lungs but would not go so far as to say, as the Arbitrator did, that Dr. Paul's opinion regarding Petitioner's chronic bronchitis and chronic obstructive pulmonary disease is not persuasive. To the contrary, Dr. Paul is board certified in allergy, asthma and immunology. Although, by his own admission, Dr. Paul is not a B-reader, the Commission recognizes Dr. Paul's long history of treating coal miners for coal mine-induced lung disease and equally long history of interpreting chest x-rays of coal miners, but those histories cannot be said to be the same as taking the B-reading course and passing the B-reading test. Dr. Paul's experience makes his opinion as credible as one can be without the requisite training that a B-reader possesses.

With respect to the chest x-ray interpretations of Petitioner's certified B-reader, Dr. Smith, the Commission notes that, as Dr. Meyer testified, there can be disagreement between B-readers concerning the presence of small opacities on a chest x-ray. Dr. Meyer disagreed with Dr. Smith's report. (Rx1, Exhibit B). As Dr. Meyer testified, one of the most important parts of the B-reader training and examination is making a distinction between a 0/1 and 1/0 film. (Rx1, pp. 35, 36)

Dr. Castle testified that he is a certified B-reader and he reviewed the chest x-ray dated November 12, 2015 and that there were no parenchymal abnormalities consistent with pneumoconiosis. Dr. Castle testified that Dr. Smith interpreted the same film and indicated that there were opacities throughout both lung fields classified as P/P with a profusion of 1/0. He testified that this meant that Dr. Smith also considered that the film may be negative. Dr. Smith did not testify.

The Commission finds it instructive to have testimony of a B-reader that explains the idiosyncrasies of B-reading and, more specifically, a positive and/or negative B-reading finding. For this reason, the Commission finds Dr. Meyer's and Dr. Castle's testimony helpful and more persuasive than the x-ray interpretation reports of Dr. Smith and Dr. Paul with regard to coal workers' pneumoconiosis.

The Commission disagrees with the Arbitrator, however, with respect to the evidence demonstrating pulmonary disease. The Commission is persuaded by Dr. Paul's explanation of his diagnoses of chronic bronchitis and chronic obstructive pulmonary disease. Petitioner was seen by Dr. Paul at the Central Illinois Allergy and Respiratory Service on November 12, 2015 and underwent what was referred to as a black lung evaluation. Dr. Paul testified that he noted in his report that the pulmonary function tests were within normal limits. He further testified that under the AMA Guides to Impairment, Sixth Edition, the pulmonary function testing would not be within normal limits; rather, it would be considered mildly abnormal based on the FEV1/FVC ratio. He testified that it would indicate an obstructive impairment which would be compatible with chronic bronchitis. Dr. Paul also testified that coal dust can cause chronic bronchitis and chronic bronchitis is one of the things that make up the chronic obstructive pulmonary disease syndrome. (Px1, pp. 13,14) Dr. Paul opined that the coal dust environment to which Petitioner was exposed caused his conditions of chronic bronchitis and chronic obstructive pulmonary disease. Dr. Paul also opined Petitioner has significant pulmonary impairment caused by coal dust. (Px1, p. 16)

Dr. Paul noted Petitioner had coughing and wheezing during upper respiratory infections which would hang on about two months and he would get these four or five times per year. Dr. Paul testified that amount of coughing, eight to ten months a year for a number of years, fulfills the definition of chronic bronchitis. Although Dr. Paul did not review Petitioner's medical records, those from Logan Primary Care Services, Inc., support regular visits for coughs that would, at times, linger. (Rx3, 3/15/00 -"cough never really resolved...cough worse at night...deep breath forces him to cough"; 1/17/01-- "cough" prescribed antibiotic for 10 days; 8/27/01- cough; prescribed antibiotic; 2/3/04-5-day history of upper respiratory symptoms, productive cough, Acute Bronchitis; 3/20/06-Assessment: Upper respiratory infection-off-work; 11/3/06-Subjective: nasal discharge, cough, sore throat, green sputum. Duration of symptoms: 2 months on and off. Prescribed antibiotic and cough medicine; 11/7/07- Throat inflamed. Assessment: Upper respiratory infection; 12/4/09- Diagnosis: Upper respiratory infection viral; 9/10/12- congestion, cough; 1/20/18- congestion, cough and sore throat, worsening. Prescribed antibiotic; 1/30/18: Respiratory: Positive for cough)

The Commission finds the records from Logan Primary Care Services, Inc. are not dispositive of Petitioner's entire medical history and do not contradict the history that Petitioner provided to Dr. Paul. Thus, by Dr. Paul's definition, Petitioner has chronic obstructive pulmonary disease.

The Commission notes that Dr. Castle performed a medical records review and concluded Petitioner did not suffer from any pulmonary disease or impairment occurring as a result of his occupational exposure to coal mine dust. Dr. Castle reviewed the Petitioner's medical records noting there was never a diagnosis made of chronic bronchitis or chronic obstructive pulmonary disease. Dr. Castle testified that a cough is not considered an objective determinate of pulmonary impairment. Dr. Castle also testified, however, that having pulmonary function tests within the range of normal does not mean your lungs are free of any long damage, injury or disease. (DepT, p. 62) Dr. Castle also testified there is no objective measure of a cough but that does not mean it is without importance, medically speaking. (DepT, p. 66)

Dr. Castle then testified that if he had taken a patient history he could have asked the right questions and figured out whether Petitioner was giving an accurate history to Dr. Paul and how it squared with his treating records, but at the time he issued his report and at the time of his testimony, he was without that information in his dataset. He conceded on cross-examination chronic bronchitis is a diagnosis determined by patient history and that chronic bronchitis is one of the chronic obstructive pulmonary diseases. Dr. Castle qualified his answer adding, "it is considered chronic obstructive pulmonary disease provided there is evidence of obstruction, and in the absence of obstruction it is simply bronchitis." (DepT, pp. 73-74)

The Commission notes that Dr. Castle was critical of the method Dr. Paul used in his determination of Petitioner's FEV1/FVC ratio. Dr. Castle opined that the Petitioner's FEV1/FVC 74% ratio, which proved Dr. Paul's theory that Petitioner had obstruction, was faulty. Given Dr. Paul's extensive experience, that he examined the Petitioner and took his own history, the Commission finds that Dr. Paul's testimony regarding Petitioner's FEV1/FVC ratio of 74% proving obstruction to be more persuasive than Dr. Castle's testimony because Dr. Castle did not perform his own pulmonary function tests, nor did he cite any studies to support his assertion that Dr. Paul's methodology to arrive at a FEV1/FVC ratio was incorrect, and most important, Dr. Castle did not examine Petitioner and did not have the opportunity to ask Petitioner's questions.

Petitioner testified that his complaints since leave mining on January 30, 2015 have remained stable. The Commission recognizes that although Petitioner's health has remained stable, since his mining career ended, the ill-effects of that career still linger.

The Commission, based on the evidence, finds Petitioner's employment as a coal miner exposed him to coal mine dust and other mining substances that resulted in him developing chronic obstructive pulmonary disease. The Commission finds the evidence supports a finding that Petitioner suffered a permanent partial disability as a result of his employment with Respondent. Thus, the Commission finds that an analysis under Section 8.1b(b) is warranted.

The Commission finds neither party submitted an impairment rating report or opinion into evidence under Section 8.1b(b)(i), thus no weight is given to the first factor.

With regard to subsection (ii) of Section 8.1b(b), the occupation of the employee, the Commission notes that the Petitioner is retired, but his occupation at the time of exposure was a coal miner; the Commission gives this factor some weight;

With respect to Section 8.1b(b)(iii), the Commission notes that the Petitioner was 62 years old at the time he retired, the same date as his last exposure. Given that the Petitioner is at the end of his career, and he has remained stable, the Commission gives this factor significant weight;

Under Section 8.1b(b)(iv), as it relates to Petitioner's future earning capacity, the Commission finds that Petitioner has not proven that his future earning capacity will be diminished. Petitioner testified that when he retired from working, he receives a pension, has a 401k and signed up for Medicare. The record is silent regarding any connection between his condition of ill-being and effect on his future earning capacity, thus the Commission gives this factor little weight;

With respect to the treating medical records as corroborative of Petitioner's disability under Section 8.1b(b)(v), the Commission notes Petitioner's treating medical records indicate Petitioner's condition has remained stable since he was last in a mine, but those same medical records indicate Petitioner's chronic bronchitis, characterized by Dr. Paul as chronic obstructive pulmonary disease, is an ongoing issue, to be indicative of Petitioner's disability, and assigns moderate weight to this factor.

The determination of permanent partial disability is not simply a calculation, but an evaluation of all five factors as stated in the Act. In making this evaluation of permanent partial disability, consideration is not given to any single enumerated factor as the sole determinant. Therefore, after reviewing the entire record, and applying §8.1b(b) of the Act, the Commission concludes Petitioner's forty-plus year career as a coal miner introduced him to exposures that resulted in injuries to his pulmonary system and thus he suffered a 10% loss of use of a person as a whole under Section 8(d)2 as the result of the January 30, 2015 work-related accident.

The Commission further modifies the Arbitrator's Decision to correct a scrivener's error in paragraph four, the fifth line on page four, from "1975" to "2015."

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 16, 2018, is hereby reversed and modified for the reasons stated herein, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $735.37 per week for a period of 50 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the loss of use of 10% of the person as a whole.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $36,900.00. 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: APR 16 2019
TJT/bsd
O: 2/5/19
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Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DEERE, ROBERT
Employee/Petitioner

Case# **15WC011627**

THE AMERICAN COAL COMPANY
Employer/Respondent

19IWCC0185

On 5/16/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.03% 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:

0755 CULLEY & WISSORE
KIRK CAPONI
300 SMALL ST SUITE 3
HARRISBURG, IL 62946

1662 CRAIG & CRAIG LLC
KENNETH F WERTS
115 N 7TH ST PO BOX 1545
MT VERNON, IL 62864

STATE OF ILLINOIS)
)SS.
COUNTY OF Williamson)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

ROBERT DEERE
Employee/Petitioner

v.

THE AMERICAN COAL COMPANY
Employer/Respondent

Case # 15WC 011627

Consolidated cases: N/A

19IWCC0185

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Herrin**, on **March 14, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ Other **Sections 1(d)-(f) of the Occupational Diseases Act**

FINDINGS

On **January 30, 2015**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner's earnings were **$63,921.33** and Petitioner's average weekly wage was **$1,229.26.**

On the date of accident, Petitioner was **62** years of age, ***married*** with **0** dependent children.

Petitioner claims no medical or TTD, TPD, or maintenance benefits.

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

Respondent *is* entitled to a credit of **$0** for any medical bills paid through its group medical plan for which credit is allowed under Section 8(j) of the Act.

ORDER

Petitioner failed to prove he has an occupational disease due to an occupational exposure on January 30, 2015. Petitioner's claim for compensation is denied and no benefits are awarded.

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

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

Signature of Arbitrator

May 11, 2018
Date

MAY 16 2018

Findings of Fact and Conclusions of Law

The Arbitrator finds:

Summary of the Medical and Depositions

Medical records of Logan Primary Care were admitted into evidence. Petitioner was seen on December 7, 1999, complaining of cough, cold, congestion, coughing up phlegm and eyes burning. His lungs were clear at the time. The assessment was that of an upper respiratory infection. (Respondent's Exhibit No. 3, p. 45). Petitioner was seen on March 15, 2000, with primary concern of a cough. He related that he was treated in December of 1999, and got better with medication, but his cough never really resolved. He had sinus drainage which was clear. The cough was non-productive and was described as a dry/tickle cough which was worse at night. When Petitioner attempted to take a deep breath, it forced him to cough. Examination of the lungs showed rate and depth were regular and unlabored on auscultation anteriorly and posteriorly. The diagnosis was sinusitis. (Respondent's Exhibit No. 3, p. 44). Petitioner was again seen on January 17, 2001, for congestion and sinusitis. According to the report he had sinusitis annually. His assessment remained that of sinusitis. (Respondent's Exhibit No. 3, pp. 42-43). Petitioner was seen on August 27, 2001, for an upper respiratory infection. He had no cough. Petitioner's lungs were clear to auscultation and percussion bilaterally. The diagnosis was upper respiratory infection. (Respondent's Exhibit No. 2, p. 39).

Petitioner was again seen at Logan Primary Care on February 3, 2004, for acute bronchitis. The physical examination of Petitioner's lungs showed they were clear to auscultation and percussion bilaterally. (Respondent's Exhibit No. 3, p. 36).

Petitioner was again seen at Logan Primary Care on March 20, 2006. At that time he was diagnosed with fatigue and an upper respiratory infection. (Respondent's Exhibit No. 3, p. 34). Petitioner was seen on November 3, 2006, for sinus congestion and cough. His lungs were clear to auscultation bilaterally. The assessment was sinusitis. (Respondent's Exhibit No. 3, pp. 32-33). Petitioner was seen on November 7, 2007, for fatigue and sore throat. His lungs were clear. The assessment was upper respiratory infection. (Respondent's Exhibit No. 3, p. 31). Petitioner was seen on December 4, 2009, for the flu. Physical examination of the lungs showed they were clear to auscultation bilaterally, with no wheezes, rhonchi or rales. The assessment was a viral upper respiratory infection. (Respondent Exhibit No. 3, pp. 29-30).

Petitioner was again seen at Logan Primary Care on September 10, 2012, for an upper respiratory infection. He had a non-productive cough. Physical examination of the

lungs showed they were clear to auscultation and percussion. (Respondent Exhibit No. 3, pp. 27-28).

Petitioner was seen at Logan Primary Care on July 22, 2013, for a kidney stone. On that date his lungs were clear to auscultation bilaterally with no wheezes, rhonchi or rales. (Respondent's Exhibit No. 3, pp. 25-26).

Petitioner's last day working for Respondent was January 30, 2015.

Petitioner signed his Application for Adjustment of Claim herein on March 27, 2015. (AX 2)

Petitioner saw Dr. Glennon Paul on November 12, 2015, at the request of his counsel. A written report followed. (Petitioner's Exhibit No. 1, Deposition Exhibit No. 2). According to the doctor's report, Petitioner was a non-smoker who was retired and didn't expect to go back to work. He was 63 years old and had worked in the coal mines for forty years until he retired in 1975. All of his work had been underground but he mostly worked at the face of the mine as a machine miner. His only problem with his lungs was that he would have coughing and wheezing whenever he had an upper respiratory tract infection which would "hang on" for about two months. He would get these four to five times per year and they had been ongoing for the last several years. Petitioner denied seeking medical treatment for it. Petitioner had a normal physical examination. His chest had normal inspiratory and expiratory effort with no chest wall deformities or dullness to percussion. Auscultation revealed no wheezes or rales. His CBC was normal. His pulmonary function studies were within normal limits. A chest-ray showed some fibronodular lesions through both lung fields to a mild to moderate degree. Dr. Paul's impression was simple type Coal Workers' Pneumoconiosis.

On November 24, 2015, and at the request of Petitioner's attorney, Dr. Henry K. Smith, board certified radiologist and B-reader, interpreted a chest x-ray of Petitioner dated November 12, 2015. Dr. Smith interpreted the chest x-ray as positive for pneumoconiosis, profusion 1/0 with P/P opacities in all lung zones. (Petitioner's Exhibit No. 2).

On February 23, 2016, and at the request of Respondent's counsel, Dr. Christopher Meyer, a B-reader, was asked to review a November 12, 2015 chest x-ray of Petitioner. He deemed the film over-exposed and unacceptable for ILO B-reading interpretation. It was a copy of a film and he noted the original analog examination might be of acceptable quality. (RX 1, Exhibit B)

On April 16, 2016, and at the request of Respondent's counsel, Dr. Christopher Meyer, a B-reader, reviewed a PA and lateral chest radiograph dated November 12, 2015, from Central Illinois Allergy and Respiratory. He interpreted the x-ray as negative for coal

workers' pneumoconiosis. Dr. Meyer further noted that he had reviewed a narrative summary and B-reading form prepared by Dr. Henry Smith regarding the same chest radiograph. Dr. Meyer expressed his disagreement with Dr. Smith's report wherein he found small opacities of size "p" with profusion of 1/0. His lungs were clear and there were no findings of coal workers' pneumoconiosis (cwp). (Respondent's Exhibit No. 1, Exhibit B).

On August 10, 2016, and at the request of Respondent's counsel, Dr. James R. Castle reviewed medical records and chest x-ray regarding Petitioner and issued a written report. Dr. Castle concluded that Petitioner did not suffer from any pulmonary disease or impairment occurring as result of his occupational exposure to coal mine dust. He found the pulmonary function study of November 12, 2015 to be entirely normal. He also reviewed the 11/12/15 chest x-ray of Petitioner and found no evidence of any parenchymal abnormalities consistent with pneumoconiosis. He further noted Dr. Smith's interpretation of a profusion of "1/0" stating that meant the doctor acknowledged the film could be negative for cwp. (Respondent's Exhibit No. 2, Exhibit C).

Deposition of Dr. Meyer

The deposition of Dr. Meyer was taken on September 30, 2016. Dr. Meyer has been board certified radiology since 1992. (Respondent's Exhibit No. 1, p. 8). Dr. Meyer has been a B-reader since 1999. (Respondent's Exhibit No. 1, pp. 20-21). Dr. Meyer was asked to take the B-reading exam by Dr. Jerome Wiot who was part of the original committee that designed the training program which is called the B-reader program. (Respondent's Exhibit No. 1, pp. 21-22). Dr. Meyer has recently been asked to have a more active academic role in the B-reader program. Dr. Meyer is on the American College of Radiology Pneumoconiosis Task Force which is engaged in redesigning the course, the exam and submitting cases for the B-reader training module and exam. Dr. Meyer testified that the faculty is typically experienced senior level B-readers. (Respondent's Exhibit No. 1, pp. 33-34). Dr. Meyer testified that radiologists have a 10% higher pass rate on the B-reading exam than other specialties. In Dr. Meyer's opinion radiologists have a better sense of what the variation of normal is. Dr. Meyer testified that one of the most important parts of the B-reader training and examination is making a distinction between a 0/1 and 1/0 film. (Respondent's Exhibit No. 1, pp. 35-36).

Dr. Meyer testified that the B-reader looks at the lungs to decide whether there are any small nodular opacities or any linear opacities and based on the size and appearance of those small opacities, they are given a letter score. (Respondent's Exhibit No. 1, p. 23). Dr. Meyer testified that specific occupational lung diseases are described by specific opacity types. Coal workers' pneumoconiosis is characteristically described by small round opacities. Diseases that cause pulmonary fibrosis, like asbestosis, will be described by small linear opacities. (Respondent's Exhibit No. 1, p. 29). The distribution of the

opacities is also described because different pneumoconioses are seen in different regions of the lung. Coal workers' pneumoconiosis is typically an upper zone predominant process. Idiopathic pulmonary fibrosis or asbestosis is a basilar or linear process. The last component of the interpretation is the extent of lung involvement or the so-called profusion. (Respondent's Exhibit No. 1, p. 24). Dr. Meyer testified that the profusion is basically trying to define the density of the small opacities in the lung. (Respondent's Exhibit No. 1, p. 31).

Dr. Meyer testified that at the request of Respondent's counsel, he reviewed a PA and lateral chest radiograph dated November 12, 2015, from Central Illinois Allergy and Respiratory. (Respondent's Exhibit No. 1, p. 41). Dr. Meyer testified that he first received a copy film which he judged to be unreadable for an ILO B-reading interpretation. Subsequently he received the original film for that date. He graded the subsequent original examination as quality 2. It was still a little over exposed but diagnostic. Dr. Meyer noted a wedged deformity of the thoracic spine but there were no findings of coal workers' pneumoconiosis. (Respondent's Exhibit No. 1, pp. 41-42).

On cross-examination Dr. Meyer acknowledged that an individual could have CWP pathologically. He was also asked about CT scans and their costs and risks of radiation. (Respondent's Exhibit No.1, pp. 42 – 47, 51- 52). Dr. Meyer was also asked about B-readings, including the reality that B-readers can disagree as to whether a film shows CWP or not. Dr. Meyer explained that it is important that the individual interpreting the film have ample experience in reading them to be able to sort out what is in the background and what is normal. (RX 1, pp. 47 – 51, 79 - 80) He agreed that medical records and pulmonary function studies would not change his opinion regarding what he might see on the x-ray. The x-ray is a piece of hard data and symptoms are symptoms and vary from person to person. He agreed that Category 1 CWP is an x-ray diagnosis. (RX 1, pp. 52-53) Dr. Meyer was also asked general questions about the nature of CWP. (RX 1, pp. 53 – 64, 66 - 67). He was also asked questions about progressive massive fibrosis. (RX 1, pp. 64-65)

Dr. Meyer testified that he does about 160 to 200 B-readings per month. He acknowledged that he is generally retained by the coal company rather than the coal miner. (RX 1, p. 67) The doctor was also asked about histoplasmosis, including where it can be found and how it appears on x-ray. (RX 1, pp. 67- 70, 74)

Dr. Meyer testified that one will find coal dust in all coal miner's lungs. The real question is when is the threshold achieved to result in there being enough coal to show up on an x-ray. (RX 1, p. 72) Dr. Meyer also testified that overexposure of a film makes it more difficult to appreciate the abnormalities of CWP. (RX 1, p. 72)

Dr. Meyer acknowledged that the first time he took the B-reader exam he failed it. (RX 1, p. 74) Dr. Meyer explained the circumstances surrounding the test result the first

time. (RX 1, pp. 87-88, 90 - 91) He testified that the opacities of CWP are found in the mid and lower lung zones. When asked if it can be found in themed and lower lung zones and not the upper lung zones on occasion, he responded, "Very rarely." (RX 1, pp. 77-78) Dr. Meyer was asked about the recent study by Laney and Petsonk. (RX 1, pp. 78, 80 - 85)

Dr. Meyer acknowledged that it is possible for a miner to have pneumoconiosis determined by pathology that was not appreciated on a radiographic study. It's also possible that a miner who has a split opinion on the existence of CWP can have it found on autopsy or biopsy. (RX 1, p. 87) He also acknowledged that there are studies showing that, at autopsy, as much as 50 percent of coal miners are found to have abnormalities of coal workers' pneumoconiosis when it might not have been apparent radiographically during life. (RX 1, p. 88) He also acknowledged that if a B-reading is negative that doesn't necessarily rule out that the miner might have the disease pathologically. (RX 1, p. 89)

On redirect examination Dr. Meyer testified that Petitioner has neither massive fibrosis or cor pulmonale. He had no evidence of bulla or hyperinflation. He further testified that the study by Laney and Petsonk did not address the early disease process. (RX 1, pp. 90 – 93) Dr. Meyer further testified that CWP is typically an upper-zone nodular disease and if a non-B-reader simply makes a diagnosis of pneumoconiosis one still doesn't know if it meets the technical criteria for the diagnosis because it isn't identified. (RX 1, p. 94)

Deposition of Dr. Paul

The deposition of Dr. Paul was taken on February 17, 2017. (PX 1) Dr. Paul was the Director of St. John's Respiratory Therapy and Clinical Assistant Professor of Medicine at the SIU Medical School. (Petitioner's Exhibit No. 1, p. 6). Dr. Paul was the senior physician at the Central Illinois Allergy & Respiratory Clinic. Those physicians specialize in allergy and pulmonary disease. They take care of patients with respiratory diseases, critical care, allergic diseases and some internal medicine problems. (Petitioner's Exhibit No. 1, p. 7). Dr. Paul is semi-retired and occasionally does black lung evaluations. He does not take any new patients. Dr. Paul supervises a DUI clinic's medical treatment program. (Petitioner's Exhibit No. 1, pp. 46-47). Dr. Paul is board certified in asthma, allergy and immunology. (Petitioner's Exhibit No. 1, p. 9). Dr. Paul testified that at the time he did his fellowship in 1970 to 1972, there were not any pulmonary fellowships developed. He testified that it was strictly in allergy, asthma and respiratory disease. (Petitioner's Exhibit No. 1, pp. 9-10). Dr. Paul is not an A-reader or a B-reader. He has never been board certified in pulmonary disease. (Petitioner's Exhibit No. 1, p. 46). Dr. Paul has seen hundreds of individuals at the request of Petitioner's counsel. (Petitioner's Exhibit No. 1, p. 46).

Dr. Paul testified that it was his understanding that Petitioner was a lifelong non-smoker. He worked for 40 years in the coal mines, all underground. (Petitioner's Exhibit No. 1, p. 11). According to Dr. Paul, Petitioner had coughing and wheezing during upper respiratory infections which would hang on about two months and he would get these four or five times per year. Dr. Paul testified that amount of coughing, eight to ten months a year for a number of years, fulfills the definition of chronic bronchitis. Dr. Paul testified that Petitioner had a negative methacholine challenge. (Petitioner's Exhibit No. 1, p. 12). Dr. Paul also testified that he recorded in his report that the pulmonary function tests were within normal limits. He testified that under the *AMA Guides to Impairment, Sixth Edition* the pulmonary function testing would not be within normal limits; rather, it would be considered mildly abnormal based on the FEV1/FVC ratio. He testified that it would indicate an obstructive impairment which would be compatible with chronic bronchitis. (Petitioner's Exhibit No. 1, p. 13). Dr. Paul also testified that Petitioner's chronic bronchitis was caused by coal dust exposure. He testified that Petitioner had coal workers' pneumoconiosis and COPD caused by the coal dust environment. Dr. Paul testified that in light of these diagnoses. Petitioner could not have any further exposure to the environment of a coal mine without endangering his health. (Petitioner's Exhibit No. 1, p. 15-16).

Dr. Paul testified that a person could have coal workers' pneumoconiosis and still have a negative chest x-ray. He testified that the gold standard for diagnosing pulmonary disease is pathologic review of the tissue itself. Dr. Paul testified that he had heard of studies that indicate that 50% or more of long term coal miners have coal workers' pneumoconiosis at autopsy even though during life it was never diagnosed radiographically. (Petitioner's Exhibit No. 1, p. 18). Dr. Paul testified that in order to have pneumoconiosis one must have, in addition to coal mine dust deposited in his lungs, a tissue reaction to it. That tissue reaction can be called scarring or fibrosis. The scarring of coal workers' pneumoconiosis cannot perform the function of normal healthy lung tissue. (Petitioner's Exhibit No. 1, p. 20). Dr. Paul testified that, by definition, if one has coal workers' pneumoconiosis, he would have some impairment in the function of the lung at the site of the scarring whether it could be measured by spirometry or not. (Petitioner's Exhibit No. 1, p. 21). A person could have radiographically significant coal workers' pneumoconiosis and normal pulmonary function testing, normal blood gases and normal physical examination of the chest. Coal workers' pneumoconiosis is considered to be a progressive disease. (Petitioner's Exhibit No. 1, p. 24).

Dr. Paul testified that Petitioner did not complain to him of shortness of breath. He was not taking any breathing medications when Dr. Paul saw him. Dr. Paul did not get a history from Petitioner of ever having taken breathing medications. Petitioner did not provide to Dr. Paul any past medical history of black lung. Dr. Paul did not review any treatment records regarding Petitioner. (Petitioner's Exhibit No. 1, p. 42). Dr. Paul's physical examination of Petitioner's chest revealed no sign of disease. Dr. Paul testified

that the FEV1/FVC ratio on the testing performed at his office was 74%. The forced vital capacity was normal at 109%, and the FEV1 was normal at 107%. Dr. Paul testified that under the *AMA Guides*, to be normal the FEV1/FVC ratio would need to be 75% or more. (Petitioner's Exhibit No. 1, p. 43). Petitioner's total lung capacity was normal. He had no restriction. He did not have an impairment in gas exchange. (Petitioner's Exhibit No. 1, p. 44).

Dr. Paul did not know the date of the chest x-ray he reviewed. He testified that the film quality was good. (Petitioner's Exhibit No. 1, p. 44). Dr. Paul testified that there were opacities present. He testified that Petitioner's chest x-ray had multiple different opacity types and they were all coal types. Dr. Paul did not remember what lung zones were involved. Dr. Paul did not give the film a profusion rating. (Petitioner's Exhibit No. 1, pp. 45-46).

Dr. Paul testified that Petitioner did not tell him that he left mining at the time he did due to a breathing problem. He also acknowledged that Petitioner did not tell him that he left mining when he did on the advice of a physician or that he was unable to perform the duties of his last job in the mine. (Petitioner's Exhibit No. 1, p. 46).

Deposition of Dr. Castle

The deposition of Dr. Castle was taken on June 8, 2017. Dr. Castle is a pulmonologist and is board certified in internal medicine and the subspecialty of pulmonary disease. (Respondent's Exhibit No. 2, p. 4). Board certification in pulmonary disease was first established in 1941. (Respondent's Exhibit No. 2, p. 32). Dr. Castle practiced in Roanoke, Virginia for 30 years. His practice was limited to pulmonary disease and chest disease, which encompassed critical care medicine. (Respondent's Exhibit No. 2, p. 7). Dr. Castle's practice included patients with occupational lung disease. He had some patients in his practice that had coal workers' pneumoconiosis. (Respondent's Exhibit No. 2, p. 8). Dr. Castle has been certified as a B-reader since 1985. (Respondent's Exhibit No. 2, p. 14).

Dr. Castle reviewed a chest x-ray dated November 12, 2015, from Central Allergy and Respiratory Service. Dr. Castle testified that there were no parenchymal abnormalities consistent with pneumoconiosis. He found no evidence of pneumoconiosis or any coal mine dust-induced lung disease on the chest x-ray. (Respondent's Exhibit No. 2, p. 28). Dr. Castle testified that there is no such thing as radiographically apparent pulmonary impairment. Dr. Castle testified that for a proper reading of a chest film for pneumoconiosis, the ILO classification sheet starts with the name of the individual, and the date of the film. He testified that the quality of the film is important. Then the reader determines whether or not there are any opacities, the type of opacities, the size of the opacities and the location of the opacities based upon side by side comparison with the

standard ILO films. (Respondent's Exhibit No. 2, p. 29). Dr. Castle noted that Dr. Henry Smith interpreted the same film and indicated that there were opacities throughout both lung fields classified as P/P with a profusion of 1/0. He testified that this meant that Dr. Smith also considered that the film may be negative. (Respondent's Exhibit No. 2, p. 31).

Dr. Castle testified that the pulmonary function study obtained on November 12, 2015, was valid and was entirely normal. He testified that there was no evidence of any physiologic abnormality of any cause including coal workers' pneumoconiosis and coal mine dust exposure. (Respondent's Exhibit No. 2, pp. 31-32). Dr. Castle concluded that Petitioner did not suffer from any pulmonary disease or impairment occurring as a result of his occupational exposure to coal mine dust. (Respondent's Exhibit No. 2, p. 32). Dr. Castle testified that Dr. Paul determined that Petitioner's FEV1/FVC ratio was 74%. Dr. Castle testified that in spirometry testing one is supposed to take the greatest forced vital capacity and the greatest forced expiratory volume in one second to determine what the FEV1/FVC ratio is. He testified that Dr. Paul did not do that. Dr. Castle testified that when the highest FEV1 and the highest FVC are used, Petitioner's FEV1/FVC ratio in the testing performed in Dr. Paul's office was 75%. He testified that this is exactly what was predicted for Petitioner. (Respondent's Exhibit No. 2, p. 26). Dr. Castle testified that the evidence did not indicate an obstruction. Dr. Castle testified that he is familiar with the *AMA Guides to the Evaluation of Permanent Impairment, Sixth Edition*. Employing Table 5.4 of the Guides, Petitioner would fall under Class 0 impairment. (Respondent's Exhibit No. 2, p. 27).

Dr. Castle also reviewed medical records. In his review of medical records of Petitioner, there was never a diagnosis made of chronic bronchitis or COPD. (Respondent's Exhibit No. 2, pp. 27-28). Dr. Castle testified that cough is not considered an objective determinate of pulmonary impairment. Dr. Castle testified that in his review of medical in this case there was no pathologic evidence of disease in Petitioner. From the objective testing performed on Petitioner, from a respiratory standpoint, he was capable of heavy manual labor. (Respondent's Exhibit No. 2, p. 28).

Dr. Castle agreed with the position taken by the American Thoracic Society that an older worker with a mild pneumoconiosis may be at low risk for working in currently permissible exposure levels until he reaches retirement age. He also testified that it is very unlikely for simple pneumoconiosis to progress once the exposure ceases. (Respondent's Exhibit No. 2, p. 32). Dr. Castle testified that to his knowledge, Petitioner had sufficient exposure to the environment of the coal mine to cause coal workers' pneumoconiosis in a susceptible host. He agreed that Petitioner's treatment records did not mention any evidence of pneumoconiosis but that alone would not rule it out. (Respondent's Exhibit No. 2, p. 34). Dr. Castle testified that it is true that one can have disease and have a negative chest x-ray. Dr. Castle testified that recent studies were shown as many as 50% of long term coal miners have pathological coal workers' pneumoconiosis that was not

appreciated by radiographic study during their lives. (Respondent's Exhibit No. 2, p. 40). Dr. Castle testified that coal workers' pneumoconiosis is basically an x-ray diagnosis except for the caveat about pathology. Dr. Castle described the abnormality of coal workers' pneumoconiosis as basically trapped coal dust in a part of the lung which ends up wrapped in scar tissue and can be accompanied by emphysema around it. (Respondent's Exhibit No. 2, p. 44). Dr. Castle testified that by definition, if a person has coal workers' pneumoconiosis, he would have an impairment in the function of his lungs at the site of the scarring. (Respondent's Exhibit No. 2, p. 45).

Dr. Castle acknowledged that one can have radiographically significant coal workers' pneumoconiosis and yet have normal spirometry and normal pulmonary function and even, possibly, no complaints. If they do have complaints, it is usually shortness of breath. (RX 2, p. 47) Dr. Castle, having reviewed Petitioner's medical records at Logan Primary Care did not see any evidence/documentation that Petitioner was having upper respiratory infections four or five times a year. (RX 2, pp. 72-73) He acknowledged that had he taken a patient history from Petitioner he could have asked the "right questions" to determine if Petitioner was giving an accurate history to Dr. Paul. As it stands, he relied upon the records. (RX 2, p. 73)

Dr. Castle charged $1,200.00 for his forensic review of medical films and $1,900.00 for his deposition. (PX 3)

Additional Medical Care

Petitioner was seen at Logan Primary Care on January 16, 2018, for hypertension. Petitioner reported being active and he was using the elliptical at John A. Logan three to four times a week. Petitioner did not have any shortness of breath. On physical examination, Petitioner's respiratory effort was normal and he had no respiratory disease. (Respondent's Exhibit No. 3, pp. 2-3). Petitioner was again seen on January 20, 2018, with an upper respiratory infection. His presenting symptoms included congestion, non-productive cough and a sore throat. His symptoms had been present for three days. The assessment was pharyngitis and a cough. The PA felt this was an acute condition that could be treated with medication. (Respondent's Exhibit No. 3, pp. 3-7). Petitioner was seen on January 30, 2018, for follow up on his hypertension. Petitioner reported that his acute pharyngitis was better, but he had minor cough. His review of systems was negative for shortness of breath and wheezing. (Respondent's Exhibit No. 3, pp. 7-9).

The Arbitration Hearing

Petitioner's case proceeded to arbitration on March 14, 2018. Petitioner was the sole witness testifying at the hearing. The issues in dispute were occupational disease, causal connection, Sections 1(d) through 1(f) of the Occupational Diseases Act, and the nature and extent of any injury.

Petitioner testified that he lives in Energy, Illinois. He was 65 years old at the time of arbitration and married to Teresa. Petitioner testified that he attended John A. Logan College for about two years but did not receive certificates or degrees. Petitioner further testified that he worked in the coal mine for 40 years with the first two years being above ground and the last 38 being below ground. Petitioner testified that in addition to coal dust, he was regularly exposed to and breathed silica dust, roof bolting glue fumes, diesel fumes and trowel on. Petitioner described trowel on as a glue used to put tiles up on the wall.

Petitioner's last date in coal mining was January 30, 2015, with Respondent at its Galatia mine. Petitioner was 62 years old on that date. His job classification was mine examiner. Petitioner testified that he was exposed to coal dust on that day. Petitioner testified that this was his last day working at Respondent because he retired. He testified that he had had enough. Petitioner has not looked for work or been employed since retiring from Respondent.

Petitioner testified that he started working for Ruttman in mine construction in 1975. That work was above ground. He was building the Monterey No. 1 mine. The first time he went to work underground was for Inland Steel Coal Company in 1977. He was hired as a shuttle car operator. Petitioner testified that the shuttle car would take the coal that was being cut from the face of the mine and transport it to the conveyor belt. He described this as a fairly dusty job. He worked in that position for one year. Then he became a continuous miner operator. He was actually operating the machine that cuts the coal from the face of the mine. Petitioner worked as a continuous miner operator for 15 years. He next worked as a laborer where he would fill in for anyone who was off and they kept putting him back on the continuous miner. Petitioner testified that he was temporarily assigned to the longwall. He worked in all positions on the longwall including shear operator, shield puller and even repairman. Petitioner testified that the longwall takes the place of the continuous miner. He described the longwall as a shear that runs along the face of the mine. It literally cuts the coal out of the wall. He testified that when that coal drops it is extremely dusty. Petitioner worked in that job for two to three years. Next Petitioner became a mine examiner. His duties were to check the belt lines, escapeways, working units, and ventilation to make sure there was enough air ventilating the faces. He had to make sure everything was up to regulation and code. He was walking all over the mine. He was doing the mine examiner job when he was exposed to the roof bolting glue fumes. As an examiner he was exposed to pretty much every

exposure in the mine. Petitioner was an examiner at Inland Steel for five or six years until he was laid off in July 2002. He was called back as a diesel scoop operator to take equipment out of the mine. His last day at Inland was May 27, 2003.

Petitioner went to work for Respondent in 2004 at the Millennium Portal in Galatia. He was hired in as an operator and then was put on the longwall for a period of time. He worked as an examiner for Respondent. He also ran diesel equipment for six months underground. He has not worked at any mine since his retirement.

Petitioner testified that he first noticed his breathing problems at work after he had been working on the continuous miner. He noticed that when he would get a cold or his breathing would become labored, he would cough up black sputum. He testified that it would have been somewhere early to mid-1980s when he first noticed his breathing problems. Petitioner testified that from the time he first noticed the breathing problems until he left the mines, it did not get any better. He testified that at times it got a little worse. He testified that his breathing problems have stayed pretty much the same since he left the mine. Petitioner does not take any breathing medications. Petitioner testified that he cannot seem to take a deep breath.

Petitioner testified that with yard work or playing with his grandkids he has to stop and rest. Petitioner testified that he has always been very active sports-wise. Petitioner testified that the last time he participated in sports would have been slow pitch softball approximately 20 years ago. While he was still working, he noticed the difference in his breathing ability and that he would get tired. Petitioner testified that he tries to stay active with his grandchildren. He testified that he quit bike riding and cannot run anymore. He tries to walk on the treadmill a little bit to keep himself in as good of shape as he can. Petitioner testified that he hunts. He testified that he did not use to hesitate to trek way back in the woods, but he cannot do that anymore. He tries to stay closer to the edge near the road. Petitioner testified that he deer hunts from a ladder stand. He testified that he killed a deer this past hunting season. Petitioner testified that he goes to John A. Logan College to work on an elliptical three or four times per week. He spends about 30 minutes there each time. He also does some light lifting. Petitioner testified that he spends quite a bit of time with his grandkids watching their sports. Petitioner testified that he lives on about eight acres. He mows the grass with a riding mower.

Petitioner testified that Dr. Mark Smith at Logan Primary Care was his family doctor until he retired a few years ago and now he sees Dr. Workman. He testified that he saw these physicians for breathing difficulties. He testified that when he would get bronchitis, he could not breathe and he would go to these doctors for treatment. He testified that the doctors were aware that he was a miner. Petitioner has never smoked. Petitioner takes medication for blood pressure. Petitioner testified when he treated with Dr. Smith and Dr. Workman at Logan Primary Care, he was honest with him in sharing

whatever respiratory complaints he had or did not have. He testified that he was honest with Dr. Paul in sharing his respiratory problems.

Petitioner testified that from time to time over the years, he underwent chest x-ray screening by NIOSH for black lung. He testified that after the chest x-ray, NIOSH would write to him and tell him what the chest x-ray revealed. Petitioner testified that he had those letters with him in his car at the time of arbitration. He testified that he did not know if he would need them at arbitration.

The Arbitrator concludes:

1. Petitioner failed to prove by a preponderance of the evidence that he sustained an occupational disease arising out of and in the course of his employment. In so concluding, the Arbitrator finds the B-readings by Drs. Meyer and Castle to be more persuasive. In particular the Arbitrator finds the testimony of Dr. Meyer to be insightful, informative and persuasive. His background and experience in radiology, B-reading and coal workers' pneumoconiosis were impressive and beyond that of Petitioner's physicians, Drs. Smith and Paul. Dr. Meyer testified to the training received in the B-reading course. Dr. Paul does not have that training. Drs. Meyer and Castle are both B-readers and have been recertified as same numerous times. Coal Worker's Pneumoconiosis is a diagnosis made by chest x-ray interpretation. Three B-readers interpreted the 2015 chest x-ray. Two of them found it to be negative for CWP.

   Petitioner testified that from time to time over the years, he underwent chest x-ray screening by NIOSH for black lung. He testified that after the chest x-ray, NIOSH would write to him and tell him what the chest x-ray revealed. Petitioner testified that he had those letters with him in his car at the time of arbitration. The Arbitrator reasonably infers that if those letters supported his claim they would have been submitted at arbitration; however, they weren't.

   The Arbitrator notes that over the years Petitioner's medical records have reflected treatment for upper respiratory infections and sinusitis. With these acute conditions, Petitioner complained of cough, sometimes with and sometimes without sputum production. Petitioner testified at arbitration that his breathing would become labored or he would cough up black sputum when he would get a cold. Petitioner continues to hunt from a ladder stand. He also testified that he works on an elliptical three or four times per week. The medical records which were put into evidence do not contain any complaints of shortness of breath. In the most recent treatment records from two months prior to arbitration, Petitioner denied shortness of breath. The Arbitrator gives more

weight to the medical entries than Petitioner's arbitration testimony as the latter may have been motivated to support his claim.

The Arbitrator did not find Dr. Paul's opinions regarding Petitioner's chronic bronchitis and COPD persuasive. Dr. Paul failed to mention their existence in his initial report. He acknowledged that Petitioner had no complaints of shortness of breath when he examined him. Petitioner was not taking any breathing medications. While the doctor testified that under the *AMA Guides to Impairment, Sixth Edition* Petitioner's pulmonary function testing would not be within normal limits; rather, it would be considered "mildly" abnormal based on the FEV1/FVC ratio, that was based upon a ratio of 74 and the *Guides* consider normal to be 75 or more. Other than the ratio, everything else about Petitioner's examination was normal. Dr. Paul took a history of Petitioner having four to five respiratory issues a year; however, he took no steps to obtain Petitioner's medical records to verify the accuracy of that history. The records from Logan Primary don't corroborate Petitioner's history to Dr. Paul.

Petitioner testified that he went to Logan Primary Care for bronchitis and that his doctor knew he was a miner. That, in and of itself, does not establish that mining was the cause of Petitioner's bronchitis. Petitioner could have deposed his primary care doctor but did not do so. While Petitioner further testified to current problems and difficulties with breathing, his testimony was not corroborated by any medical records or other witness. The more recent Logan Primary Care records suggest a fairly fit and active retiree who regularly works out at a gym and denied any shortness of breath.

The Arbitrator also notes that the date of accident/exposure herein is Petitioner's date of retirement from the mine. Petitioner did not associate his retirement with any specific breathing problems.

2. Petitioner failed to prove by a preponderance of the evidence that his current condition of ill-being was causally connected to his employment.

3. Petitioner failed to prove by a preponderance of the evidence that he suffered a timely disablement under Section 1(f) of the Occupational Diseases Act.

4. Petitioner's claim for compensation is denied and no benefits are awarded.

****

STATE OF ILLINOIS)
) SS.
COUNTY OF PEORIA)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Ashlee Sprenger,
Petitioner,
vs.

NO: 15 WC 21038

Peoria County Sheriff's Department,
Respondent.

19IWCC0189

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 20, 2018, is hereby affirmed and adopted.

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

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

DATED: APR 16 2019
o040419
BNF/mw
045

Barbara N. Flores

Deborah Simpson

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SPRENGER (RAUBA), ASHLEE
Employee/Petitioner

Case# **15WC021038**

PEORIA COUNTY SHERIFF'S DEPARTMENT
Employer/Respondent

19IWCC0189

On 8/20/2018, 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:

0564 WILLIAMS & SWEE LTD
JEAN A SWEE
2011 FOX CREEK RD
BLOOMINGTON, IL 61701

5354 STEPHEN P KELLY
ATTORNEY AT LAW
2710 N KNOXVILLE AVE
PEORIA, IL 61604

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

Ashlee Sprenger (Rauba)
Employee/Petitioner

v.

Peoria County Sheriff's Department
Employer/Respondent

Case # **15** WC **21038**

Consolidated cases: _____

19IWCC0189

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Peoria**, on **7/17/18**. 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 4/8/15, 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 $40164.80; the average weekly wage was $772.40.

On the date of accident, Petitioner was 36 years of age, *single* with 0 dependent children.

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

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

Respondent is entitled to a credit of $17,822.21 under Section 8(j) of the Act.

ORDER

Credits

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

Respondent is shall be given a credit of $17,822.71 for medical benefits that have been paid, and Respondent shall hold the 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.

Medical benefits

Respondent shall pay reasonable and necessary medical services, pursuant to the medical Fee Schedule, of $2,021.25 to Unity Point Methodist/Proctor, and $192.00 to Unity Point Health Care, as provided in Sections 8(a) and 8.2 of the Act.

Respondent is ordered to reimburse Petitioner in the amount of $1,061.87 for medical bills paid out-of-pocket.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $514.93/week for 3 2/7 weeks, commencing June 5, 2015 through June 28, 2015, as provided in Section 8(b) of the Act.

Permanent Partial Disability: Schedule Injury

Respondent shall pay Petitioner permanent partial disability benefits of $463.44/week for 32.25 weeks, because the injuries sustained caused the 15% 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.

Signature of Arbitrator

Aug. 14, 2018
Date

ICArbDec p. 2

AUG 20 2018

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ASHLEE SPRENGER (RAUBA), Petitioner	)	Case No.: 15 WC 021038
Vs.	)	
PEORIA COUNTY SHERIFF'S DEPT., Respondent	)	19IWCC0189

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 36-year old correctional officer, sustained an accidental injury that arose out of and in the course of her employment by Respondent on April 8, 2015. On that date, Petitioner was responding to an emergency call involving an inmate who required medical care for a seizure. When Petitioner received the call, she was immediately "pumped with adrenaline." Petitioner had been in the restroom and she ran out of the door, turned to grab her five-pound duty belt, then pivoted to the left to run out of the door. Petitioner testified that her knee twisted when she pivoted.

Petitioner testified that her adrenaline rush did not subside for some time after the incident. Petitioner said that she began experiencing left knee pain the following day and that it increased over the next several days.

On April 20, 2015, Deb Whetstone, Respondent's payroll supervisor, filled out a form 45 and stated that on April 8, 2015, Petitioner "tweaked" her knee while responding to a backup call and that she sustained left knee pain from the injury (Px2).

On April 21, 2015, Respondent referred Petitioner to IWIRC for an evaluation of her left knee pain. Dr. Stopka stated that Petitioner was authorized by the employer's representative to be evaluated for a medical condition to determine 1) if the medical conditional is work related and/or consistent with the reported mechanism of injury, 2) if treatment of the medical condition is indicated and direct indicated treatment, and 3) if worker is safe to perform job requirements. Dr. Stopka stated that Petitioner injured her left knee on April 8, 2015, while responding to a backup call when she grabbed her duty belt to put it on while running. Dr. Stopka stated that shortly after, she noticed left knee pain and that she was unsure whether she twisted her left knee while running or before she started to run. Petitioner described her symptoms as constant burning sensation around the entire knee that increases to a sharp pain while standing for long periods of time. Dr. Stopka ordered an x-ray of the left knee which was read as normal. Dr. Stopka stated that the assessment was left knee strain, no acute injury, mechanism described occurring at work does not correlate with current symptoms. Dr. Stopka stated that Petitioner should remain off work until released by her PCP (Rx1, page 1).

On April 22, 2015, Petitioner treated with her family doctor, Dr. Williams. Dr. Williams recorded a history that Petitioner injured her left knee two weeks ago while running a backup call at work. Dr. Williams stated that Petitioner had left knee pain going up and down stairs and that

she could hear a pop and feel a grind. Dr. Williams stated that Petitioner was a runner and had run marathons and half marathons. Dr. Williams stated that Petitioner felt like she had twisted her knee and did not feel it initially when it happened, but that she noticed the pain within 24 hours. Dr. Williams diagnosed an internal derangement of the knee, referred Petitioner to physical therapy, and released Petitioner to light duty beginning April 27, 2015 (Px3, page 2, 3). Dr. Williams stated, "The nature of her injury at work and PE could certainly be consistent with an internal derangement specifically medial meniscus tear. She was running to respond to an emergency and pivoted on a load bearing knee slightly flexed," (Px3, page 3).

On May 15, 2015, Dr. Williams stated that Petitioner had ongoing knee pain, that she had a pocket of fluid on her knee, and that it was more swollen. Dr. Williams ordered a MRI for May 7, 2015, to check for a meniscus tear (Px4, page 5).

On May 7, 2015, Petitioner underwent a MRI. The radiologist, Dr. Nathan, stated that Petitioner had a horizontal tear of the body and posterior horn medial meniscus with reactive MCL bursitis and marrow edema in the medial tibial plateau, large joint effusion without intra-articular loose body, and single focal cartilage fissure seen in the patella (Px5).

On May 18, 2015, Petitioner treated with Dr. Gibbons at Midwest Orthopedic Center. Petitioner completed a new patient/problem history form and stated that her date of injury was April 8, 2015 at work. Petitioner stated that her left knee twisted inward and hyperextended on that date and that she heard a pop (Px7, page 40). On May 18, 2015, Jeffrey Roberts, PA-C, stated that Petitioner had left knee pain for approximately six weeks after running at work. Mr. Roberts stated that Petitioner had a left knee medial meniscus tear and that she was interested in a left knee arthroscopy with partial medial meniscectomy (Px7, pages 31, 32).

On June 5, 2015, Petitioner underwent a left knee arthroscopy for a medial meniscus tear. In the body of the surgical report, Dr. Gibbons stated that there was an obvious large flap tear of the medial meniscus coming from the posterior third which he debrided back to about a 7mm peripheral rim. Dr. Gibbons' post-operative diagnosis was partial medial meniscectomy (Px6).

On June 15, 2015, Mr. Roberts stated that Petitioner was participating in a home exercise program and that her ecchymosis was resolving (Px7, page 8). On June 22, 2015, Mr. Roberts stated that on exam, palpation elicited very subtle medial and lateral joint line tenderness. Mr. Roberts stated that Petitioner may return to work in full capacity on June 29, 2015 (Px7, page 4, Rx2).

On August 24, 2015, Petitioner treated with Dr. Gibbons. Dr. Gibbons stated that Petitioner was status left knee arthroscopy. Dr. Gibbons stated that Petitioner had some pain in the lateral posterior knee, worse after extended activity. Dr. Gibbons stated that Petitioner had increased pain and stiffness post immobilization or when going up and down stairs. Dr. Gibbons stated that Petitioner was taking Ibuprofen, one or two daily. On exam, Dr. Gibbons noted that Petitioner had mild lateral joint pain tenderness on the left with good quadriceps activation. Dr. Gibbons stated that Petitioner could continue walking or biking as tolerated (Px7, page 2).

Dr. Michael Gibbons testified by deposition on April 2, 2018. Dr. Gibbons testified that he is a board certified orthopedic surgeon and that he has been practicing since 1995 (Px1, page 4). Dr.

Gibbons testified that he initially treated Petitioner in January, 2014, for her shoulder. Dr. Gibbons stated that Petitioner did not make any complaints of knee pain at that time. Dr. Gibbons stated that his office first treated Petitioner on May 18, 2015, for her left knee (Px1, pages 5, 6). Dr. Gibbons said that Petitioner filled out a new patient problem history form on May 18, 2015 which gave a history of an accident on April 8, 2015. Dr. Gibbons said that Petitioner felt a pop in her left knee on April 8, 2015, and that she had swelling in her knee 24-48 hours later (Px1, pages 6, 7). Dr. Gibbons said that Petitioner gave a history of having pain and swelling in her left knee approximately six weeks after she had been running at work. (Px1, pages 7, 8).

Dr. Gibbons testified that he reviewed the MRI films taken May 7, 2015. Dr. Gibbons stated that the MRI revealed a medial meniscus tear and some bone edema of the medial tibial plateau. Dr. Gibbons explained that a bone edema, or bone bruise, was usually a sign of some kind of stressful situation (Px1, pages 9, 10). Dr. Gibbons stated that during surgery on May 15, he found an obvious large flap tear of the medial meniscus and that he removed the flap that was torn (Px1, pages 11, 12). Dr. Gibbons stated that he last treated Petitioner on August 24, 2015. At that time, she had some pain in the lateral posterior part of her knee, worse after extending or straightening her knee. Dr. Gibbons stated that Petitioner had stiffness going up and down stairs and that this was consistent with the injury and surgery (Px1, pages 13, 14). Dr. Gibbons opined that Petitioner's history of accident, which included a running or twisting injury, was consistent with his diagnosis of medial meniscus tear. Dr. Gibbons stated that Petitioner had symptoms after the event which included pain and swelling and that these symptoms led to Petitioner requiring surgery. Dr. Gibbons explained that a twisting, or hyperextending, injury can cause some compression of the meniscus between the two bones in the leg, the upper leg (femur) in the lower leg (tibia). Dr. Gibbons stated that with enough force, it can tear the cushion, or meniscus, between the structures (Px1, pages 14, 15). Dr. Gibbons opined that because Petitioner had a tear in her meniscus, she has an increased risk of arthritis developing in the future (Px1, pages 15, 16).

On cross-examination, Dr. Gibbons opined that Petitioner was at maximum medical improvement on June 29, 2015, and that she had been released to return to full duty work (Px1, page 16). Dr. Gibbons opined that engaging in running activities could cause the complaints that Petitioner experienced on August 24, 2015 (Px1, page 17). Dr. Gibbons stated that the complaints on June 29, 2015 appeared to be normal complaints for the surgery Petitioner underwent (Px1, page 18). Dr. Gibbons testified that there was no way to know the date of the meniscus tear (Px1, pages 19, 20). On cross, Dr. Gibbons stated that there are lots of ways to tear a meniscus and that it did not have to be a twisting mechanism, however that is one of the common mechanisms of injury (Px1, pages 21, 22).

Petitioner testified that she had been an active runner for approximately 20 years prior to her accident. Petitioner said that years before her accident, she had engaged in running races, including marathons. Petitioner said that prior to her work accident, she ran approximately 20 to 30 miles each week.

Petitioner testified that prior to April 8, 2015, she had never experienced any left knee pain running, that she did not have any ongoing left knee pain, and that she had never treated for left

knee pain. Petitioner said that after her April 8, 2015, accident, she had increased pain running, walking, and working.

On May 4, 2012, at Respondent's request, Petitioner underwent a pre-employment physical at IWIRC. Petitioner passed the physical and there is no mention of left knee pain (Rx1, page 1).

Petitioner testified that the surgery on June 5, 2015, her left knee pain improved. Petitioner said that she was able to return to full work duties for Respondent on June 29, 2015.

At the time of Arbitration, Petitioner said that she continued to experience some ongoing left knee pain. Petitioner said she still experiences occasional pain in her left knee going up and down stairs, sitting for long periods of time, and that she had a sensation of her left knee popping when she would bend or squat.

Petitioner testified that she was insured through Respondent's group insurance plan. Respondent's health insurance paid for some of her left knee treatment.

Petitioner testified that she moved to Missouri a few years ago and that she stopped working for Respondent because she moved out of state. Petitioner testified that at the time of arbitration, she was employed at Boone County as an Account Specialist making $14.87 an hour working 40 hours a week.

Petitioner testified that while she was employed for Respondent, she would get paid extra to train correctional officers. Petitioner testified that she worked some overtime in the year preceding the accident. Petitioner said that some of the overtime was forced and that some overtime was voluntary. Petitioner said that forced overtime would occur if a co-worker would call in sick on the shift subsequent to hers.

Conclusions of Law

Accident

Respondent argues that the Petitioner did not have an accident as alleged for basically two reasons. First, they argue that she failed to report the accident to her employer or see medical attention for eleven days, which is essentially a credibility argument. Secondly, they argue that she provided different histories to her employer and initial medical providers. Again, this is a credibility argument. The Arbitrator is not persuaded by either of the Respondent's arguments.

The Petitioner testified that she was injured when she was responding to an emergency call for back up due to a prisoner having a seizure. She testified that when she got the call, she was in the rest room. She was not expecting the call. She quickly grabbed her duty belt and while she was turning to run to the scene while putting the belt on, she twisted on her left leg. She credibly acknowledged that she did not have immediate pain and that pain did not come on until her shift had ended. She also said that she began to notice minor pain and swelling that evening, and that those symptoms gradually worsened over the following days. Eventually, on April 19, she turned in an accident report.

The Petitioner was, at the time of the accident, a relatively young individual who was a competitive distance runner, training by running about 20 to 30 miles a week. It would certainly be reasonable for her to wait awhile before reporting her accident to her employer and beginning medical treatment. Given the relatively mild initial symptoms and her athletic background, she likely thought the problem might go away on its own. Her failure to report the accident under those circumstances does not hurt her credibility.

As for the second argument, the Arbitrator notes that her histories to her employer and her initial providers were consistent. On the Form 45 prepared by her employer on April 20, she said that she had "tweaked" her knee while responding to a call for back up help. When she was seen by IWIRK at her employer request the following day, she did not, as the Respondent contends, deny that her knee twisted on the date in question. Instead she honestly told the doctor that she was not sure whether she twisted the knee when running to answer the call or before she began to run. When she was seen the next day, the 22nd, by Dr. Williams, she said that she felt like she twisted her knee while running to answer the call. Again, she honestly said that she did not feel immediate symptoms but noticed pain 24 hours later. It was with that history that Dr. Williams provided a clear opinion on causation.

Finally, her initial exam findings were consistent with a recent injury. At IWIRK, she complained of pain increasing from 5 to 8 on a 10 point scale from the accident date forward. The examiner found diffuse tenderness in the knee. The next day, Dr. Williams found tenderness along the joint space, along with positive McMurray's and Grind tests. He concluded that she may have a meniscal tear. Her findings continued to be positive in her follow up's with Dr. Williams as well as when she was seen by Dr. Gibbons, her surgeon.

Based upon the evidence above, the Arbitrator finds that the Petitioner did sustain an accident involving her left knee arising out of her employment on April 8, 2015, as alleged.

Causation

Among the doctors giving opinions on causation, the Arbitrator feels Dr. Williams is the most persuasive. On his initial office note, he wrote that the Petitioner's running to respond to an emergency and pivoting on a load bearing knee slightly flexed certainly could be consistent with a medial meniscal injury. (PX 4) As stated above, she was pivoting and then running to respond to an emergency. Dr. Williams also noted that the Petitioner did not have immediate symptoms, yet he opined that a causal connection did exist. Finally, he, like the Arbitrator, notes that there was no history of prior similar knee problems for this person who had been a runner for the previous twenty years.

The Doctors at IWIRK did not feel causation was present, but it appears from their office note that their opinions were based upon what they felt was a basically negative exam, more consistent with a strain. The Arbitrator notes again the acute findings of Dr. Williams, along with the later findings of Dr. Gibbons which again were consistent with a recent injury.

The Arbitrator also notes that Dr. Gibbons opined that running or twisting could cause a torn meniscus. (PX 1 at 14)

The Arbitrator finds Dr. Williams' causation opinion is supported by the evidence, as concludes that the petitioner has proven that her injuries are causally related to her accident of April 8, 2015.

Average Weekly Wage

Not much evidence was offered to assist the Arbitrator in determining the Petitioner's average weekly wage. The parties did address overtime, and the Arbitrator believes the evidence established that the Petitioner's overtime was neither mandatory nor regular. In the 26 pay periods in which she worked, she was only paid overtime during 5 of those periods. The amounts varied. Accordingly, overtime will not be included. This makes the W-2 forms introduced by the Petitioner meaningless.

Respondent placed the Petitioner's pay stubs into evidence. They show that the Petitioner received pay for her regular hours worked as well as pay for holiday and personal time. They also show payments for other things which the Arbitrator cannot interpret. It would have been helpful for the Petitioner to have testified as to what the various pay categories meant. The Arbitrator could have then reached a conclusion as to whether they were to be properly included in the calculation of AWW.

It does appear that in the year preceding the accident, the Petitioner received two wage increases. During the first 12 pay periods, she was paid $762.60 per week. During the next 7 pay periods, she received $775.95. During the final 7 pay periods, she received $785.65.

When you average the amounts above, you come up with a wage of $772.40. It appears from the evidence presented, that this wage is the most equitable and reflects accurately what the Petitioner was paid excluding overtime in the year prior to her accident. The Arbitrator finds the above as the AWW.

Medical Bills

Having found that Petitioner's left knee meniscus tear and surgery is causally related to her accident on April 8, 2015, the Arbitrator orders Respondent to pay reasonable and necessary medical services, pursuant to the medical Fee Schedule of $2,021.25 to Unity Point Methodist/Proctor and $192.00 to Unity Point Health Care.

Respondent shall be given a credit of $17,822.71 for medical benefits that have been paid, and Respondent shall Petitioner hold harmless from any claims of any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent is also ordered to reimburse Petitioner in the amount of $1,061.87 for medical bills paid out of pocket (Px8).

TTD

As a result of her knee surgery, Petitioner was off work from June 5, 2015 until June 29, 2015 (Px9).

Having found accident and causation, the Arbitrator orders Respondent to pay TTD for 3 2/7 weeks commencing June 5, 2015, through June 28, 2015.

Nature and Extent

The Arbitrator finds that as a result of Petitioner's April 8, 2015 accident, she sustained a large flap tear of her medial meniscus requiring surgery.

Based on the above, as well as the credible record, the Arbitrator finds that the Petitioner sustained a 15% loss of use of her left leg as provided in Section 8(e) of the Act as a result of the April 8, 2015 accident. Pursuant to Section 8.1(b) of the Act, the Arbitrator, in determining the level of permanent partial disability, bases his decision 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.

With regard to (i), the parties did not offer into evidence a reported level of impairment pursuant to subsection (a). The Arbitrator therefore gives no weight to this factor.

With regard to (ii), Petitioner was employed as a correctional officer at the time of the injury and she returned to work as a correctional officer after her accident. Petitioner subsequently moved to Missouri and began working at Boone County as an Account Specialist for reasons unrelated to her work accident. The Arbitrator gives little weight to this factor.

With regard to (iii), Petitioner was 36 years old at the time of the injury. The Arbitrator finds that Petitioner may have to live and work with a disability for a longer period of time than an older individual with the same injuries. The Arbitrator gives some weight to this factor.

With regard to (iv), the Arbitrator finds that Petitioner was able to return to her prior work as a correctional officer making the same amount of money she did at the time of the injury. The Arbitrator gives little weight to this factor.

With regard to (v), the Arbitrator finds that Petitioner's testimony that she has continued to experience some ongoing left knee pain going up and down stairs, sitting for long periods of time, and that she has a sensation of knee popping when she bends or squats, is consistent with the medical records.

On August 24, 2015, Dr. Gibbons stated that Petitioner had increased pain and stiffness post immobilization or when going up and down stairs. Dr. Gibbons stated that Petitioner was taking Ibuprofen, one or two daily.

Dr. Gibbons testified that Petitioner was at an increased risk of arthritis developing in the future because of the injury with meniscus tear and removal. The Arbitrator therefore gives greater weight to this factor.

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

Michelle Roach,

Petitioner,

19IWCC0190

vs.

NO: 14 WC 40730

Chicago Transit Authority,

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 all issues, and being advised of the facts and law, reverses the Decision of the Arbitrator and finds Petitioner failed to prove she sustained an accident arising out of and in the course of her employment on December 1, 2014.

Findings of Fact

1. Petitioner was a full-time bus operator for Respondent on December 1, 2014. At the arbitration hearing, Petitioner testified she had driven her bus back to the garage after finishing her route on December 1, 2014. (Tr. at 22). Petitioner testified she parked the bus, got out and started to walk east toward the back of the bus when she noticed a servicer walk toward her bus to get inside. *Id.* at 23-25.

   Petitioner testified as she was walking in the garage, the servicer backed up the bus and hit her twice. *Id.* at 25. Petitioner testified the bus first stuck her back. *Id.* at 26. She testified she then turned around and put her hands up to block the bus when it struck her again. *Id.* Petitioner testified she then went to the side of the bus and kicked it to alert the servicer she had been hit. *Id.* at 27.

   Petitioner testified the servicer kept going and pulled his bus away. *Id.* at 28-29. Petitioner

testified she then got on a bus driven by a coworker named Vince Carter. *Id.* at 29-30. She stated Mr. Carter drove his bus forward so Petitioner could reach the servicer and inform him she had been hit. *Id.* Petitioner testified she informed the servicer he had hit her and then reported it to her on-duty manager. *Id.* at 30-31.

2. In the Employee Report of Injury filled out and signed by Petitioner on December 1, 2014, Petitioner claimed injury to her right arm, right rib and both hands after being struck on the right side by a bus. (Rx 5). Petitioner did not indicate any low back injury.

3. Vincent Carter, a fellow bus operator for Respondent, testified at hearing that on December 1, 2014, he was pulling his bus into the garage and saw Petitioner get hit at least twice by another bus that was backing up. (Tr. at 6-7). Mr. Carter testified the bus he was pulling in was stopped when he witnessed the accident. *Id.* at 21. He testified Petitioner then got on his bus and he told her to talk to a manager. *Id.* at 10.

4. Respondent's Exhibit 6 includes an Employee Interview Record signed by Mr. Carter on December 2, 2014. This document indicated Mr. Carter did not recall anything specific in regard to the December 1, 2014 accident.

   Respondent's Exhibit 6 also contains a Report to Manager form completed by Mr. Carter. In describing the accident, Mr. Carter wrote: "I don't recall anything specific but something happened."

5. Luis Rivas, who was a bus servicer for Respondent on December 1, 2014, also testified at hearing. Mr. Rivas testified the bus he was operating on December 1, 2014 did not hit Petitioner. (Tr. at 30). Mr. Rivas identified himself in Respondent's Exhibit 2's surveillance video as the man who approached the bus, got onto the operator seat, backed the bus up and then pulled forward. *Id.* Mr. Rivas testified he followed procedures at that time, including honking the horn to signal he was reversing. *Id.* at 31. He testified the bus also had automatic rear flashing lights and beeped when in reverse. *Id.* at 31-32.

   Mr. Rivas testified that when he pulled the bus up to the service station, Petitioner irately approached him. *Id.* at 32. He testified Petitioner first said, "You almost hit me," but then changed her statement and said, "You know you hit me, right?" *Id.* Mr. Rivas testified Petitioner then said, "You hit me two to three times." *Id.* at 32-33.

   Mr. Rivas testified Petitioner wanted him to apologize, but he was not sure why because he had clearance on the bus all the way around and had seen her in the mirror. *Id.* at 33. Mr. Rivas testified he nevertheless apologized if he had gotten close to Petitioner, and Petitioner said she would not bring it up to management because she was "not that type of person." *Id.* Mr. Rivas was never subject to any discipline from management for the alleged accident. *Id.* at 35.

6. Respondent's Exhibit 4 is the accident report filled out and signed by Mr. Rivas on December 2, 2014. In the report, Mr. Rivas wrote that on December 1, 2014, he took control of a bus that needed serviced and put it in reverse. Mr. Rivas indicated that while

twisting the wheel and honking the horn, he saw Petitioner on the right-side mirror with clearance to proceed forward. Mr. Rivas claimed Petitioner then reappeared as he went to refuel and first claimed he almost hit/hit her before thereafter claiming he hit her twice with the bus. Mr. Rivas stated Petitioner sought an apology and told him she should tell the manager, but she was not that type of person.

7. Respondent's Exhibits 1 to 3 contain surveillance video footage of the alleged December 1, 2014 accident.

   Respondent's Exhibit 1 is the garage surveillance view of the alleged accident. It first shows the top of someone's head, presumably Petitioner, walking closely along the left side of a parked bus. Petitioner is then briefly blocked from view by the bus. The bus, driven by Mr. Rivas, then begins to back up as another bus, driven by Mr. Carter, pulls into the garage. Mr. Rivas puts the bus in reverse, turns it slightly and pulls forward out of view. As the bus moves, Petitioner appears from the area where Mr. Rivas' bus left and walks to Mr. Carter's stopped bus. Petitioner does not show any visible signs of injury while walking to Mr. Carter's bus. She then gets on Mr. Carter's bus, and Mr. Carter drives forward with Petitioner standing in the front of his bus.

   Respondent's Exhibit 2 shows Mr. Rivas walk onto the bus as Petitioner is seen walking along the side of the bus toward the back. Petitioner is then blocked from view behind the bus as Mr. Rivas begins to back out. The video does not have an angle showing Petitioner being hit; however, Petitioner reappears on the side of the bus and kicks it as Mr. Rivas pulls away. Several seconds later, as Mr. Rivas is servicing the bus, Petitioner reappears and speaks with Mr. Rivas. There is no sound on the video to hear what is being said. Petitioner has no visible injury and appears to be walking and standing normally.

   Respondent's Exhibit 3 is the surveillance video from Mr. Carter's bus. It shows Petitioner walking sideways along the back of Mr. Rivas' bus. Petitioner walks approximately half way across the bus while the bus appears to be in reverse. Petitioner then briefly turns with her back toward the bus and walks back in the direction in which she came. The video does not clearly show Petitioner making actual contact with the bus.

8. This matter proceeded to hearing on November 16, 2017. In the Decision issued on December 14, 2017, the Arbitrator found Petitioner sustained an accident arising out of and in the course of her employment but her current condition of ill-being was not causally related to said accident. Nevertheless, the Arbitrator awarded loss of use of 1% MAW in permanent partial disability, total temporary disability benefits from December 2, 2014 to January 29, 2015, and medical benefits up to January 29, 2015.

Conclusions of Law

Following a careful review of the entire record, the Commission respectfully finds the Arbitrator erred in determining Petitioner proved she sustained an accident that arose out of and in the course of her employment on December 1, 2014. In so finding, the Commission hereby reverses the Decision of the Arbitrator and denies all benefits.

The Commission was presented with a substantial amount of conflicting evidence regarding Petitioner's alleged accident. Petitioner testified she was hit twice by the reversing bus. (Tr. at 23-26). She testified the bus first struck her back, and she then turned around and put her hands up to block the bus before it struck her again. *Id.* at 26.

The treatment records corroborate Petitioner's testimony insofar as showing Petitioner reported the accident to her doctors and told them her injury had occurred from being hit by a reversing bus. However, the Employee Report of Injury Petitioner filled out on the accident date said she was struck on the right side and did not indicate any low back injury. (Rx 5).

Mr. Rivas' testimony and his accident report also conflict with Petitioner's version of the accident. Mr. Rivas denied hitting Petitioner with a bus on December 1, 2014. (Tr. at 30). Mr. Rivas testified that when he pulled the bus into the service station, he was approached by Petitioner, who was irate. *Id.* at 32. He testified Petitioner first said, "You almost hit me," but then changed her statement and said, "You know you hit me, right?" *Id.* Mr. Rivas testified Petitioner then said, "You hit me two to three times." *Id.* at 32-33. The Report to Manager form prepared by Mr. Rivas on the accident date is consistent with his testimony. *See* Rx 4.

While Mr. Rivas' testimony suggested no accident occurred, Mr. Carter's testimony corroborates Petitioner's version of the accident. Mr. Carter testified he saw Petitioner get hit at least twice by the bus. (Tr. at 6-8). However, the Commission finds Mr. Carter's testimony to be discredited by his Employee Interview Record and Report to Manager forms. The Employee Interview Record signed by Mr. Carter on December 2, 2014 indicated Mr. Carter did not recall anything specific in regard to the alleged accident. (Rx 6). Thereafter, in his Report to Manager, Mr. Carter wrote: "I don't recall anything specific but something happened." *Id.* Because Mr. Carter's testimony conflicts with his two reports that were prepared immediately following the accident, the Commission does not find Mr. Carter to be a persuasive witness on Petitioner's behalf.

Moreover, the surveillance video in Respondent's Exhibit 3 does not clearly show the bus making actual contact with Petitioner. Respondent's Exhibit 3 shows Petitioner walk sideways half way across the back of Mr. Rivas' bus, turn with her back facing the bus and then walk back in the direction she came. It does not clearly show Petitioner being hit and could just as easily show Petitioner getting out of the way before she is hit. It also does not show Petitioner having any visible injuries or difficulty moving after the alleged hit. As Respondent's Exhibit 3 could very easily just show Petitioner ***almost*** getting hit, the Commission finds it notable that Mr. Rivas testified Petitioner first exclaimed, "You almost hit me." *See* Tr. at 32-33; Rx 4.

Additionally, Petitioner testified that after she was hit the first time, she turned toward the bus with her hands up to block it. (Tr. at 25). The Commission puts great weight on the fact that this alleged action does not occur on the surveillance video in Respondent's Exhibit 3.

The surveillance videos in Respondent's Exhibits 1 and 2 also fail to show the bus making direct contact with Petitioner. Respondent's Exhibit 1 shows Petitioner walking normally and calmly with no visible signs of a recent accident, and Respondent's Exhibit 2 also shows Petitioner

standing normally and walking with no apparent injury.

In considering all witnesses' testimony and all surveillance footage, the Commission finds the totality of the evidence supports a finding that Petitioner failed to prove she was actually hit by the reversing bus. Petitioner's testimony that she was hit two times is directly contradicted by Mr. Rivas' testimony and not clearly corroborated by the surveillance videos. The surveillance videos do not show the bus making actual contact and Petitioner is seen walking normally after the alleged accident. Although Mr. Carter's testimony supports Petitioner's version of the accident, his testimony is fatally weakened by his two accident reports in which he indicated he did not see anything specific occur.

For these reasons, the Commission finds Petitioner failed to prove a compensable accident occurred, and as a result, denies Petitioner's claim for all benefits. The Decision of the Arbitrator is reversed accordingly.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator dated December 14, 2017, is hereby reversed as stated herein.

IT IS FURTHER ORDERED that Petitioner failed to prove she sustained an accident that arose out of and in the course of her employment on December 1, 2014.

IT IS FURTHER ORDERED that Petitioner is denied all benefits under the Illinois Workers' Compensation Act, including but not limited to, permanent partial disability benefits, temporary total disability benefits and payment of medical expenses related to the December 1, 2014 alleged accident.

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

APR 17 2019

DATED:

Deborah L. Simpson

Stephen J. Mathis

DLS/met
o: 2/21/19
46

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

Michelle Roach,
Petitioner,

19IWCC0191

vs.

NO: 15 WC 22754

Chicago Transit Authority,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, temporary disability, permanent disability, 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 December 14, 2017, is hereby affirmed and adopted.

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

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

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

DATED: APR 17 2019
o2/21/19
DLS/rm
046

Deborah L. Simpson

Deborah L. Simpson

Stephen J. Mathis

Stephen J. Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

19IWCC0191

ROACH, MICHELLE
Employee/Petitioner

Case# **15WC022754**

14WC040730

CHICAGO TRANSIT AUTHORITY
Employer/Respondent

On 12/14/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.46% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0293 KATZ FRIEDMAN ET AL
KEITH SPARKS
77 W WASHINGTON ST 20TH FL
CHICAGO, IL 60602-2983

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

19IWCC0191

Michelle Roach
Employee/Petitioner

v.

Chicago Transit Authority
Employer/Respondent

Case # 15 WC 22754

Consolidated cases: 14 WC 40730

An *Application for Adjustment 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 Luedke** Arbitrator of the Commission, in the city of **Chicago, Illinois**, on **November 16, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. 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. ☒ 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 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 **6/8/15**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the **6/8/2015** injury, Petitioner earned **$56,789.72**; the average weekly wage was **$1,092.11.**

On the date of the **12/1/14** accident, Petitioner was **33** 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 **$1,332.11** for other benefits, for a total credit of **$1,332.11**

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

ORDER

Because the petitioner did not prove an accident compensable under the Act, benefits are denied.

The employer is ordered to pay medical bills from Concentra for treatment on June 8, 2015 and psychiatric counseling bills from Integrated Behavioral Medicine pursuant to the fee schedule.

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

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

Robert E. Lindsay 12-14-17

Signature of Arbitrator Date

DEC 14 2017

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

The arbitrator finds the petitioner did not suffer a compensable psychological injury on June 8, 2015. The fact that the petitioner was allegedly struck by a ricocheting water bottle does not add a physical aspect to this claim. The petitioner testified during cross-examination while viewing the video entered as *R1* in 15 WC 22754 that the video did show a shield up and that the assailant had to throw the bottle over the shield and did not strike the petitioner on a direct hit. The arbitrator finds this is a mental/mental claim and is to be evaluated pursuant to *Pathfinder Co. v. Industrial Com. 62 Ill. 2d 556 (1976).* The arbitrator finds this incident not to be extraordinarily stressful on an objective basis. Because of the arbitrator's decision regarding accident and medical expenses all other issues are moot.

J. Has Respondent paid all appropriate charges for all reasonable and necessary medical services?

The arbitrator notes the respondent sent the petitioner to Concentra Medical Center and Integrated Behavioral Medicine as a result of the June 8, 2015 occurrence. These bills are entered as part of *P7.* The arbitrator orders the respondent to pay bills from Concentra for treatment on June 8, 2015 and Integrated Behavioral Medicine pursuant to the fee schedule.

STATE OF ILLINOIS)
) SS.
COUNTY OF PEORIA)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

STACY ASH,
Petitioner,

vs.

No: 03 WC 43923,
03 WC 49089
15 IWCC 612

BLOOMINGTON PUBLIC SCHOOLS,
Respondent

ORDER

This matter comes before the Commission on Petitioner's Motion to Compel Compliance With Order. A hearing was held before Commissioner Luskin on December 11, 2018 in Peoria. The parties were represented by counsel, and a record was taken.

Petitioner filed two separate claims, 03 WC 43923 and 03 WC 49089 alleging accidental injuries to her lower back on June 26, 2003 and April 21, 2003, respectively. On February 2, 2007, an Arbitrator denied compensation in 03 WC 43923, finding that accident caused no permanent injury. Also on that date, the Arbitrator issued another opinion finding Petitioner proved the accident on April 21, 2003 caused the current condition of ill-being of her lower back and awarded her 125 weeks of permanent partial disability benefits representing the loss of the use of 25% of the person-as-a-whole.

Petitioner filed a petition for relief under §8(a) of the Act. On August 10, 2015, the Commission issued an opinion ordering Respondent to authorize and pay for implantation of a trial spinal cord stimulator recommended by Petitioner's treating doctor, Dr. Benyamin. In the decision the Commission found that Petitioner was "entitled to additional medical treatment in the form of a trial spinal cord stimulator and the medical expenses related thereto."

At the instant hearing, Petitioner testified that she went to Dr. Benyamin about the spinal cord stimulator in November 2016. The delay between the Commission Decision on the 8(a) petition and that presentation to Dr. Benyamin was due to Dr. Benyamin's current treatment for a cervical condition. Dr. Benyamin wanted to wait until after he completed treating Petitioner's cervical condition before addressing her lumbar issues. Dr. Benyamin wanted an MRI prior to implantation of the stimulator. Respondent has thus far refused to authorize or pay for the MRI.

On cross, Petitioner agreed that in February 2014 she was a passenger in a vehicle that was struck in the rear. Thereafter, she mostly had neck pain and jaw-pain, but she also had an increase in her lower back pain. She had physical therapy which treated for both her neck and back. She also agreed that Dr. Vales, her primary care physician, had referred her to Dr. Taimoorazy for the spinal cord stimulator, but Petitioner chose to go to Dr. Benyamin because he was her pain doctor. Dr. Vales "was fine with that." Dr. Benyamin had recommended a lumbar spinal cord stimulator prior to the 2014 motor vehicle accident. However, a separate cervical cord stimulator also has been recommended after that accident.

Petitioner submitted into evidence records of Dr. Benyamin from October 14, 2015 through December 4, 2018. On October 14, 2015, Petitioner was referred to Dr. Benyamin on referral from Dr. Vales. She was involved in a motor vehicle accident in February 2014 and had had neck pain, jaw pain, headaches, and blurred vision. Physical therapy had not been beneficial. She had been found not to be a surgical candidate and pain management was recommended. Dr. Benyamin administered numerous injections in Petitioner's cervical spine. In the course of his treatment of Petitioner's neck, on July 7, 2016, Dr. Benyamin noted that he would contact Petitioner's lawyer "about the low back and stimulator approval." On November 23, 2016 Petitioner presented to Nurse Practitioner, Elizabeth Madlem to discuss low back pain. She noted that the last imaging of the lumbar spine was in 2013. Ms. Madlem noted that Petitioner's low back symptoms progressed since she was last treated for her lower back and felt it was "pertinent to order a new lumbar spine MRI." Based on the MRI they would determine whether a spinal cord stimulator was indicated.

Petitioner also submitted records from Dr. Vales. On September 3, 2015, he noted that Petitioner "was recently cleared for a pain similar (sic) for her low back through the disability, and this dates back to a work injury in 2003. They have referred her to Dr. Benyamin for that." Dr. Vales would have preferred Dr. Taimoorazy, "but we may not be able to get around that referral without the risk of getting it withdrawn. So for now, the neck is the priority. We will get her in with Dr. Taimoorazy and go from there."

In its motion, Petitioner requests the "Commission compel Respondent to order the MRI so the spinal cord stimulator trial may be carried out as the commission ordered, and the appropriate attorney fees and penalties to be ordered paid to Petitioner for the necessary enforcement of this order." As the Commission has explained in the past, we do not have any powers to "enforce" an order or "compel" the actions of parties. The Commission can only issue orders and awards and impose penalties when certain condition are met. In the case now before us, the record is a little unclear about whether Dr. Benyamin actually recommended an MRI prior to placement of the lumbar cord stimulator. The record indicates that a nurse practitioner recommended such a study and Petitioner testified that Dr. Benyamin recommended the MRI. In any event, the Commission now orders Respondent to authorize and pay for any prospective treatment recommended by Dr. Benyamin for treatment of her lower back related to her work injury in 2003. In addition, the Commission notes that Petitioner's request for penalties and fees is premature because we do not know what any prospective procedures would cost. If after the issuance of this order, Petitioner believes that Respondent's actions warrant the imposition of penalties and fees, it can pursue such a petition in the future.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent authorize and pay for any and all prospective treatment recommended by Dr. Benyamin for treatment of her lumbar spine condition caused by her work related accident on April 21, 2003.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $17,00.00. 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: APR 17 2019

Deborah L. Simpson

Barbara N. Flores

Marc Parker

DLS/dw
R-12/11/18
46

STATE OF ILLINOIS)
) SS.
COUNTY OF KANE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Maria DeJesus Hermosillo,

Petitioner,

vs. NO: 16 WC 5431

Unistaff,

19IWCC0192

Respondent.

DECISION AND OPINION ON REMAND

This matter coming before the Commission on an order from the Circuit Court of Cook County dated June 22, 2018; the Commission being fully apprised in the premises, reverses its prior decision entered on December 11, 2017 as to the issue of accident pursuant to the directions of the circuit court order and awards benefits as outlined below.

Procedural History

On November 15, 2016, this matter proceeded to arbitration pursuant to Section 19(b) of the Act before Arbitrator Gerald Granada on the following issues: 1) accident, 2) causal relationship, 3) medical expenses, 4) prospective medical care, and 5) temporary total disability benefits. Arbitrator Granada issued his decision on December 22, 2016 finding Petitioner failed to prove she sustained an accident on January 11, 2016 which arose out of her employment and found all other issues moot.

On January 5, 2017, Petitioner filed a timely Petition for Review before the Commission. Both parties filed briefs and presented oral arguments before the Commission on October 11, 2017. On December 11, 2017, a majority of the Commission affirmed and adopted the December 22, 2016 decision of the Arbitrator pursuant to Section 19(e) of the Act. Commissioner Coppoletti dissented finding Petitioner proved her accident arose out of and the course of her employment.

19IWCC0192

On January 3, 2018, Petitioner filed a timely review before the Circuit Court of Cook County. On June 22, 2018, the circuit court entered its order reversing the Commission finding Petitioner proved she sustained injuries which arose out of and in the course of her employment. The circuit court remanded the matter to the Commission for further proceedings consistent with its order.

Findings of Fact

At trial Petitioner testified via an interpreter she was employed by Respondent and had been so for approximately five months. T. 11. While so employed, Petitioner was sent to various locations, and on January 11, 2016 she was working at Power Packing in Batavia. T. 12. While on her break at approximately 2 p.m., Petitioner proceeded to the parking lot in order to relocate her car to a space closer to the entrance. T. 14. Petitioner identified Petitioner's Exhibit 7 (PX7), a photograph of the parking lot and placed an X noting the original position of her car. T. 16-17. Petitioner explained she moved her car due to the fact one of her carpool companions was elderly, and she was afraid she might fall. T. 17-18.

Petitioner testified as to the weather conditions explaining it was cold with approximately one to two inches of snow on the ground. T. 18-19. Petitioner marked on PX7 the area where she repositioned her car along with the location of her fall. T. 20-21. As to the parking policy, Petitioner testified she was instructed by Respondent as to where and where not to park. T. 23-24.

Petitioner testified she fell to the ground striking her neck and lumbar spine. T. 27-28. Petitioner further explained she attempted to break her fall with her left hand. T. 28-29. After falling she experienced pain in her neck as well as her left hand. T. 30-31. Petitioner testified she immediately reported the injury to personnel at Power Packing and further completed two accident reports, one on January 11, 2016 (RX3) and one the following day (RX4). T. 31. Both RX3 and RX4 were identified and read into the record by the translator. T. 33-39.

Following her fall, Petitioner obtained treatment with Dr. Johnston at Dreyer Occupational Health who obtained x-rays and released Petitioner to return to work with restrictions. A job was provided within the restrictions. T. 40-42. Petitioner presented to Dreyer Clinic on two further occasions January 13 and 20, 2016. T. 41-42.

Thereafter on February 1, 2016, Petitioner sought a second opinion with Dr. Rivera, a chiropractor, who provided physical therapy and authorized Petitioner off work as of February 5, 2016. T. 43-44. Dr. Rivera referred Petitioner to Dr. Chhadia who initially evaluated Petitioner on February 29, 2016 regarding her left hand. T. 48. Dr. Chhadia recommended physical therapy and medications which improved Petitioner's pain. *Id.* Petitioner testified she continues to experience pain in her wrist to the base of her thumb, and given such, Dr. Chhadia is recommending surgery which Petitioner desires to undertake. T. 50.

Petitioner testified Dr. Chhadia referred her to Dr. Novoseletsky for treatment for her back and neck. T. 51. On August 23, 2016 Petitioner underwent an injection to her neck which improved her pain. *Id.* Thereafter, Petitioner underwent two further injections to her neck on September 21, 2016 and October 5, 2016 which also temporarily improved her pain. T. 52. On October 18, 2016, Petitioner underwent an injection to her back which temporarily improved her pain, but her pain subsequently returned extending into her left leg. T. 52-53. Petitioner testified she desires to undergo further treatment with Dr. Novoseletsky. T. 53.

Petitioner testified Dr. Novoseletsky released her to return to work with restrictions on October 10, 2016 which she presented to Respondent. T. 54-55. To date, no job offer has been tendered. T. 55.

On cross-examination, Petitioner testified a worker helped her up after her fall, but she did not identify the person in the accident report. T. 64; 69. Petitioner confirmed she slipped on snow and ice. T. 72.

Mr. David Dudzinski was called to testify on behalf of Respondent. Mr. Dudzinski testified he was currently employed by Respondent in the capacity of director of sales. T. 83. One of his clients is Power Packing, and as such, he has visited the location on numerous occasions. T. 84. Mr. Dudzinski identified Respondent's Exhibit 6 (RX6), a photograph of the plant and marked the employee entrance. T.86-87. Mr. Dudzinski testified both customers and visitors parked in the lot. T. 88.

On cross-examination, Mr. Dudzinski testified the account, Power Packing, designated certain parking areas for employees to utilize. T. 93-94. Mr. Dudzinski reviewed PX7 stating the areas marked by Petitioner specifically the X and Δ were designated employee parking areas. T. 94. Mr. Dudzinski testified the general public could also park in the employee areas. T. 95-96.

The medical records of Dreyer Medical Clinic were offered into evidence as Petitioner's Exhibit 1 (PX1). On January 11, 2016, Petitioner presented for treatment providing a history of slipping on ice injuring her left hand and head. Petitioner complained of pain in her left wrist as well as her neck. X-rays evidenced a possible tiny triquetral fracture. Petitioner was provided a wrist splint and released to return to work with a ten-pound restriction.

On January 13, 2016, Petitioner presented for follow-up with continued complaints of head, neck, and left wrist pain with an additional onset of low back pain. Petitioner was diagnosed with 1) minor closed head injury; 2) resolving cervical strain; 3) left wrist sprain; and 4) lumbar sacral strain due to her fall. The wrist splint was discontinued, and work restrictions were continued. Petitioner was advised to return for follow-up on January 20, 2016. PX1.

On January 15, 2016, Petitioner returned to the clinic due to her ongoing pain. Her diagnoses were continued. New anti-inflammatory medication was provided, and work

restrictions were continued. On January 20, 2016, Petitioner presented for evaluation complaining of pain in her neck, back, and left wrist along with paresthesia over her thumb. Physical therapy was recommended, and her work restrictions were continued. PX1.

The medical records of Dr. Gabriel Rivera of RNS Physical Therapy were offered into evidence as Petitioner's Exhibit 2 (PX2). On February 1, 2016, Petitioner sought treatment complaining of pain in her neck, mid-back, and lumbar spine as well as left wrist due to a fall on ice. Dr. Rivera diagnosed sprains of Petitioner's cervical and lumbar spine as well as the left wrist. Physical therapy was recommended and instituted beginning on February 1, 2016 and ending on August 8, 2016. During her treatment, Dr. Rivera recommended MRIs for her lumbar and cervical spine which were completed on February 6, 2016 (PX3). Dr. Rivera authorized Petitioner off-work as of February 8, 2016 pending an evaluation with an orthopedic physician. PX2.

The medical records of Suburban Orthopaedics - Drs. Ankur Chhadia and Dmitry Novoseletsky were offered into evidence as Petitioner's Exhibit 4 (PX4). Petitioner presented to Dr. Chhadia on February 29, 2016 with complaints of cervical and lumbar pain with numbness extending into the left upper extremity as well as both lower extremities, left greater than right. Petitioner also complained of left wrist pain with constant numbness and tingling. Dr. Chhadia diagnosed "hand and wrist contusion, dequervains tendonitis, DJD aggravation of thumb CMC base," recommended physical therapy as well as MRIs of her hand and wrist, authorized Petitioner off-work, and applied a long thumb spica brace. Dr. Chhadia referred Petitioner to his associate, Dr. Novoseletsky, regarding her cervical and lumbar spine complaints. PX4.

MRIs of the left hand and wrist were completed on March 7, 2016 evidencing mild osteoarthritis of the MCP and IP joints and a possible tear of volar radio-ulnar ligament, respectively. On March 14, 2016, Dr. Chhadia re-evaluated Petitioner and reviewed the MRIs diagnosing "hand and wrist contusion, dequervains tendonitis, TFCC tear, DJD aggravation of thumb CMC base and wrist joint." Dr. Chhadia recommended continued splinting, physical therapy, and authorized Petitioner off-work. On April 11, 2016, Dr. Chhadia's diagnoses and recommendations remained the same, and he provided an injection to Petitioner's thumb. PX4.

On May 12, 2016, Petitioner underwent an EMG/NCV evidencing bilateral carpal tunnel syndrome as well as chronic C6-C7 radiculopathy. On May 27, 2016, Dr. Chhadia evaluated Petitioner and reviewed the EMG diagnosing bilateral carpal tunnel syndrome along with her previous diagnoses. Dr. Chaddia recommended surgical intervention including "left hand carpal tunnel release and thumb carpometacarpal joint resection with ligament reconstruction and tendon interposition." Petitioner's immobilization, physical therapy, and off-work status were continued. Dr. Chhadia evaluated Petitioner on two subsequent occasions, June 29, 2016 and August 5, 2016 wherein she voiced consistent complaints and the same diagnoses and recommendations were provided. PX4.

In the interim, Dr. Novoseletsky evaluated Petitioner who complained of increased neck pain and sporadic lumbar pain. Dr. Novoseletsky diagnosed "cervical radiculopathy, foraminal stenosis, IDD, and facet syndrome regarding the neck and sacroiliitis, IDD, spondylosis, and radiculitis regarding the lumbar spine" and recommended continued physical therapy, an EMG, a sacroiliac injection (SIJ), and authorized Petitioner off-work. On April 7, 2016, Dr. Novoseletsky evaluated Petitioner who complained of worsening neck and lumbar pain. The same diagnoses and recommendations were made pending authorization of the recommended treatment. On May 5, 2016, Dr. Novoseletsky again evaluated Petitioner whose condition remained unchanged from her prior evaluation and provided the same recommendations. Dr. Novoseletsky also authored a report in rebuttal to Dr. Lieber's independent medical evaluation report opining Petitioner's fall aggravated her pre-existing degenerative conditions in her neck, lumbar spine, and wrist causing her current need for treatment. PX4.

On May 20, 2016, Dr. Novoseletsky evaluated Petitioner following her EMG study and recommended a cervical epidural steroid injection (CESI) and continued to recommend the SIJ injection. The same recommendations were made during Petitioner's June 1, 2016, July 11, 2016, and August 11, 2016 appointments. On August 23, 2016, Petitioner underwent the CESI and on September 21, 2016 a cervical medial branch block. During Petitioner's September 23, 2016 follow-up appointment, Dr. Novoseletsky recommended an additional medial branch block which was subsequently performed on October 5, 2016. On October 10, 2016, Dr. Novoseletsky evaluated Petitioner who advised of a decrease in her neck complaints following the injections. Dr. Novoseletsky continued to recommend the SIJ injection and additional cervical injections if Petitioner's neck pain returned. Petitioner was released to return to work with restrictions. PX4.

On March 3, 2016, Petitioner was evaluated by Dr. Lawrence Lieber pursuant to Section 12 of the Act at the request of Respondent. Dr. Lieber diagnosed Petitioner with degenerative cervical disc disease, low back pain, and left-hand pain and opined no causal relationship existed between Petitioner's alleged injury and her current symptomology. Dr. Lieber placed Petitioner at maximum medical improvement and released her to return to full duty work. RX2.

On April 8, 2016, a Utilization Review was issued regarding physical therapy treatment finding six units approved and all other therapy denied. RX5.

Conclusions of Law

A. Accident

To obtain benefits under the Act, an employee must prove her injury arose out of and occurred during the course of her employment. "In the course of" speaks to time, place, and circumstances of the injury. See *e.g. Caterpillar Tractor Company v. The Industrial Commission*, 129 Ill. 2d 52, 57, 541 N.E.2d 665 (1989) ("This Court has recognized that accidental injuries sustained on an employer's premises within a reasonable time before and after work are generally deemed to arise in the course of the employment"). Under certain circumstances, the employer's premise extends to an employer-provided parking lot. See *e.g.*

DeHoyos v. The Industrial Commission, 26 Ill. 2d 110, 113, 185 N.E.2d 885 (1962) ("Whether or not the employer owned the parking lot is immaterial; for if the employer provides a parking lot which is customarily used by its employees, the employer is responsible for the maintenance and control of the parking lot"). Further, "slips or falls on an employer-provided lot when hazardous conditions are present are generally compensable. [citations omitted]." *Morse-Harvey v. The Industrial Commission*, 345 Ill. App. 3d 1034, 1038, 804 N.E.2d 1086 (2004). "This court has repeatedly held that "when an employee slips and falls, or is otherwise injured, at a point off the employer's premises while traveling to or from work, his injuries are not compensable.' [citations omitted]. Prior decisions of this court have noted two exceptions to this general rule." *Illinois Bell Telephone Company v. The Industrial Commission*, 131 Ill. 2d 478, 483-84, 546 N.E.2d 603 (1989). A claimant's injury can be deemed to occur "in the course of" the employment 1) if the injury is sustained in a parking lot maintained or controlled by the employer, or 2) if the employee's presence is required while performing her job duties and she is exposed to a common risk to a greater degree than the general public. *Id.*

In the present matter, the parking-lot exception applies. Petitioner established she slipped and fell in an employer-provided parking lot. Petitioner testified she parked in the lot adjacent to the employer's building in a specific designated area. T. 22; 27. Mr. David Dudzinski testified on behalf of Respondent and confirmed Petitioner was advised to park in a designated area. T. 94. (Petitioner was an employee of the Respondent, Unistaff, working on the premise of Power Packing. T. 11-12). See *Suter v. Illinois Workers' Compensation Commission*, 2013 IL App (4th) 130049WC. Petitioner's injury occurred in the course of her employment.

Petitioner is also required to establish her injury "arose out of" her employment. "'Arising out of' the employment refers to the origin or cause of a claimant's injury. [citation omitted]. For an injury caused by a fall to arise out of employment, a claimant must present evidence which supports a reasonable inference that the fall stemmed from a risk associated with her employment. [citation omitted]." *Suter* at ¶ 39. Did Petitioner confront a hazard? The overwhelming evidence establishes Petitioner slipped on snow and/or ice. Petitioner testified there existed one to two inches of snow on the ground where she fell. T. 19; 72. Petitioner testified underneath the snow was ice. T. 72-73. The arbitrator commented on the photographs offered into evidence as the same did not evidence any hazard or defect, but there is absolutely no evidence as to when the photographs were taken. As such, no reasonable inference can be made from the photographs as to the non-existence of a hazard. Further, the photographs show green grass and trees budding with leaves which is indicative of a season other than winter. Petitioner's undisputed and credible testimony is she sustained injury when she slipped and fell on snow and/or ice. The fact that the general public also utilized the lot is immaterial as Petitioner was exposed to an employment risk - snow and/or ice, therefore a neutral risk analysis as employed by the arbitrator is inapplicable. Petitioner's injury arose out of her employment.

B. Causal Relationship

The Commission finds the Petitioner proved a causal relationship between her accident of January 11, 2016 and her neck, lumbar spine, and left wrist conditions and subsequent need for treatment. "[T]he Commission is not bound by the arbitrator's findings and may properly determine the credibility of witnesses, weigh their testimony and assess the weight to be given to the evidence. [citation omitted]." *R.A. Cullinan and Sons v. The Industrial Commission*, 216 Ill. App. 3d 1048, 1054, 575 N.E.2d 1240 (1991). The "interpretation of the testimony of medical witnesses is particularly within the province of the Industrial Commission. [citation omitted]." *A.O. Smith Corporation v. The Industrial Commission*, 51 Ill. 2d 533, 537, 283 N.E.2d 875 (1972).

The Commission affords greater weight to the opinions of Dr. Chhadia and Dr. Novoseletsky over those of Dr. Lieber. Since her fall, Petitioner has voiced consistent complaints of pain involving her neck, lower back, and left wrist. The diagnostic tests specifically the MRIs and EMG evidence objective findings which correlate to Petitioner's subjective complaints of pain. The lumbar MRI evidences a herniated disc at the L4-L5 level; the cervical MRI evidences C6-C7 stenosis which correlates with the EMG finding of chronic C6-C7 radiculopathy; the hand/wrist MRIs evidence a TFCC tear and arthritis. Dr. Novoseletsky opined Petitioner's pre-existing degenerative conditions were aggravated by her fall necessitating her medical treatment. Moreover, the injections provided substantial relief regarding Petitioner's neck pain and temporary relief for her lumbar pain.

Dr. Lieber opines no causation between Petitioner's "alleged" injury and her conditions. Dr. Lieber provides no basis for this opinion instead merely states his opinion as an absolute. From his report, it can be inferred he does not believe Petitioner's fall occurred. As Petitioner unquestionably sustained a fall, the Commission affords little weight to Dr. Lieber's opinion.

The Commission awards the reasonable and necessary medical expenses incurred through the date of the hearing specifically as follows: 1) RNS-Physical Therapy in the amount of $12,316.43; 2) Suburban Orthopaedics in the amount of $18,388.00; 3) Ashton Center for Day Surgery in the amount of $14,532.00; and 4) Oak Brook Anesthesiologists in the amount of $3,125.00. The Respondent shall pay the medical expenses pursuant to Sections 8 and 8.2 of the Act.

C. Temporary Total Disability Benefits

The Commission awards temporary total disability benefits for a period of 40 and 2/7 weeks from February 8, 2016 through November 15, 2016. "The factors to be considered in determining whether a claimant has reached maximum medical improvement include: (1) a release to return to work; (2) the medical testimony concerning the claimant's injury; (3) the extent of the injury; and (4) 'most importantly,' whether the injury has stabilized. [citations omitted]." *Mechanical Devices v. Industrial Commission (Johnson)*, 344 Ill. App. 3d 752, 760, 800 N.E.2d 819 (2003). "Once an injured employee's physical condition has stabilized, the

employee is no longer eligible for TTD benefits because the disabling condition has become permanent. [citation omitted]." *Id.* at 759.

Petitioner has not reached maximum medical improvement and is in need of ongoing medical care. Petitioner was released to return to work with restrictions on October 10, 2016 by Dr. Novoseletsky, but no job was offered by Respondent.

D. Medical Expenses/Prospective Medical Care

Section 8(a) of the Illinois Workers' Compensation Act entitles a claimant to recover medical expenses which are reasonable, necessary, and causally related to an accident. *820 ILCS 305/8(a)* (West 2010); *Zarley v. The Industrial Commission*, 84 Ill. 2d 380, 418 N.E.2d 718 (1981). The same standard applies to prospective medical care. *Homebrite Ace Hardware v. The Industrial Commission*, 351 Ill. App. 3d 333, 814 N.E.2d 126 (2004). Petitioner sustained an injury to her neck, lumbar spine, and left wrist on January 11, 2016 resulting in the following diagnoses: 1) cervical spine- cervical radiculopathy, foraminal stenosis, IDD, and facet syndrome; 2) lumbar spine - sacroiliitis, IDD, spondylosis, and radiculitis; and 3) left wrist- CTS, dequervains tendonitis, TFCC tear, DJD aggravation of thumb CMC base and wrist joint. Dr. Novoseletsky recommends further treatment for Petitioner's lumbar spine, specifically injections. Dr. Chhadia recommends further treatment for Petitioner's left wrist, specifically left-hand carpal tunnel release and thumb carpometacarpal joint resection with ligament reconstruction and tendon interposition. The Commission awards prospective medical care as recommended by Drs. Chhadia and Novoseletsky. The Respondent shall provide and pay for such treatment.

IT IS THEREFORE ORDERED BY THE COMMISSION that its decision of December 11, 2017 is hereby vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 22, 2016 is hereby vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner proved she sustained an accident on January 11, 2016 which arose out of and occurred in the course of her employment with Respondent.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's current conditions of ill-being are causally related to her injury sustained on January 11, 2016.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $234.33 per week for a period of 40-2/7 weeks, representing February 8, 2016 through November 15, 2016 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

19IWCC0192

a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay the reasonable, necessary and causally related medical expenses incurred in the care and treatment of Petitioner's neck, lumbar spine, and left wrist conditions pursuant to Sections 8(a) and 8.2 of the Act. The Commission specifically awards the following medical expenses: 1) RNS-Physical Therapy in the amount of $12,316.43; 2) Suburban Orthopaedics in the amount of $18,388.00; 3) Ashton Center for Day Surgery in the amount of $14,532.00; 4) Oak Brook Anesthesiologists in the amount of $3,125.00. Respondent shall be given a credit for all medical benefits that have been paid and Respondent shall hold Petitioner harmless from any claims from 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 shall provide and pay for the medical treatment as recommended by Drs. Chhadia and Novoseletsky, pursuant to §8(a) 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.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $57,900.00. 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: APR 18 2019
LEC/maw
r02/06/19
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L. Elizabeth Coppoletti

L. Elizabeth Coppoletti

Stephen J. Mathis

Stephen J. Mathis

D. Douglas McCarthy

D. Douglas McCarthy

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WILLIAMSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Felicia Tally-Glispie,

Petitioner,

vs. NO: 16WC 38949

SOI/Warren G. Murray Center,

19IWCC0193

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 1, 2018, is hereby affirmed and adopted.

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

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

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

DATED: APR 18 2019
o030519
042

Thomas J. Tyrrell

Michael J. Brennan

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

TALLY-GLISPIE, FELICIA
Employee/Petitioner

Case# **16WC038949**

SOI/WARREN G MURRAY CENTER
Employer/Respondent

19IWCC0193

On 10/1/2018, 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 2.32% 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:

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

OCT 1 - 2018

DONALD A. PARRIA, Acting Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)SS.
COUNTY OF WILLIAMSON)

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☐ 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)

FELICIA TALLY-GLISPIE
Employee/Petitioner

v.

SOI/WARREN G. MURRAY CENTER
Employer/Respondent

Case # 16 WC 38949

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Herrin**, on **8/9/18** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

19IWCC0193

FINDINGS

On the date of accident, 10/11/16, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $57,859.36; the average weekly wage was $1,112.68.

On the date of accident, Petitioner was 47 years of age, *single* with 1 dependent children.

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

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

Respondent is entitled to a credit of $ any benefits paid through group under Section 8(j) of the Act.

ORDER

The Arbitrator finds that Petitioner suffered a lumbar strain as a result of the October 11, 2016 injury. The treatment recommending by Dr. Gornet is denied.

Respondent is ordered to pay all reasonable and necessary medical bills from October 11, 2016 to July 18, 2017 pursuant to the Act directly to the medical providers. Respondent is not responsible for the MRI Spectroscopy charges.

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

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

Signature of Arbitrator

9/28/16
Date

ICArbDec19(b)

OCT 1 - 2018

The Arbitrator finds the following facts:

The issue in this case is future medical.

At the time of the injury, Petitioner was a 47 year old employee of the State of Illinois at Murray Development Center.

On October 11; 2016 Petitioner sustained an injury while assisting in the redirection of an aggressive patient. (Rx. 1)

On October 18, 2016, Petitioner began treating with SSM Health St. Mary's in Centralia. (Px. 3) Petitioner had complaints of low back pain. (Id.) Petitioner was diagnosed with low back pain (contusion and sprain). (Id.) Petitioner was given an order for physical therapy and told to follow up in two weeks. (Id.)

Petitioner returned to SSM Health on November 11, 2016. (Id.) At this visit, Petitioner reported that she had been doing physical therapy but that it had not been helping. (Id.) Petitioner was told to discontinue physical therapy and to follow up with an orthopedist. (Id.)

On January 9, 2017 Petitioner began treating with Dr. Matthew Gornet. (Px. 4) Petitioner was referred to Dr. Gornet by her attorney, Thomas C. Rich and her attorney's office made the appointment for her to see Dr. Gornet. (T-9, 14)

Petitioner reported that she has low back pain predominately on her right side since the October 2016 incident. (Id.) Dr. Gornet ordered an MRI of the lumbar spine. (Id.)

The lumbar MRI was performed on January 9, 2017. (Px. 5) Dr. Matthew Ruyle read the film as showing central protrusions at L3-4, L4-5 and L5-S1 without significant canal stenosis. (Id.)

After reviewing the MRI, Dr. Gornet recommended lumbar steroid injections and placed Petitioner on light duty work. (Px. 4) Petitioner received epidural steroid injections by Dr. Helen Blake on January 17, 2017 and January 31, 2017. (Px. 8)

Petitioner returned to Dr. Gornet on March 2, 2017. (Px. 4) At this visit, Petitioner reported some relief from the injections. (Id.) Dr. Gornet recommended facet injections with Dr. Boutwell. (Id.)

Petitioner received facet injections with Dr. Boutwell on April 13, 2017 and May 18, 2018. (Px. 7)

On May 10, 2017 Respondent had Petitioner examined by Dr. Michael Chabot pursuant to Section 12. (Rx. 2) Dr. Chabot opined that Petitioner suffered a back contusion and

sacroiliac strain. (Id.) Dr. Chabot opined that Petitioner did not need additional facet injections.

Petitioner returned to Dr. Gornet on June 9, 2017. (Px. 4) Petitioner reported that the facet injections only gave temporary relief. (Id.) Dr. Gornet recommended a lumbar CT scan and MRI spectroscopy of the lumbar spine. (Id.)

Petitioner next saw Dr. Gornet on September 23, 2017. (Px. 4) Petitioner had a non productive discrogram at L4-5 and L5-S1 performed on July 17, 2018. (Px. 7) Pettioner had a lumbar CT scan performed on July 18, 2017 which showed annular disc bulges at L3-4 and L4-5 with no central canal or foraminal stenosis. (Px. 6) After reviewing the studies, Dr. Gornet recommended spinal fusion at L5-S1. (Px. 4)

Dr. Chabot issued an addendum to his Section 12 Report on March 4, 2018. (Rx. 3) Dr. Chabot testified via evidence deposition. (Rx. 4) Dr. Chabot noted that Petitioner had a non productive discogram at L4-5 and L5-S1. (Id. at 10) He testified that the discogram showed minimal changes at L4-5 and no real abnormalities at L5-S1. (Id. at 11)

Dr. Chabot testified that an MRI spectroscopy of the lumbar spine is not an FDA approved procedure. (Id. at 12) Further, an MRI lumbar spectroscopy has never been confirmed or validated as an alternative for a discogram. (Id.)

Dr. Chabot also noted that the facet injections Petitioner received did not provide significant benefit. (Id. at 13) Because the facet injections did not provide relief, Dr. Chabot stated that this means the facets were not the primary source of her complaints. (Id. at 13) He further stated that because the discogram failed to reproduce her symptoms at L4-5 and L5-S1, then those two disc levels were not the source of her complaints. (Id.) Moeover,Dr. Chabot testified that Petitioner did not suffer anything more than a strain from this incident and that Petitioner does not need the fusion at L5-S1 recommended by Dr. Gornet. The Arbitrator finds Dr. Chabot opinions to be more credible than Dr. Gornet's.

THEREFORE, the Arbitrator finds that Petitioner has failed to meet her burden of proof to show by a preponderance of the evidence that any surgical treatment and MRI Spectroscopy recommended by Dr. Gornet is reasonable and necessary and therefore, denies awarding Dr. Gornet's proposed surgical treatment and bills for MRI Spectrosopy.

STATE OF ILLINOIS)
) SS.
COUNTY OF LAKE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

LEANARD PAYNE,

Petitioner,

vs.

NO: 10 WC 16857

19IWCC0194

DUNNET BAY CONSTRUCTION,

Respondent.

DECISION AND OPINION ON REMAND

This matter comes before the Commission on remand from the Circuit Court of the 18th Judicial Circuit, DuPage County. Per the Remand Order, dated October 9, 2018, Judge Paul Fullerton reversed the Commission's March 29, 2018 Decision. Judge Fullerton found the Commission's Decision, finding that Petitioner, Leanard Payne, failed to prove that his low back condition was causally related to the April 21, 2010 work accident, was against the manifest weight of the evidence. The matter was remanded to the Commission for further findings of fact as to when Petitioner reached maximum medical improvement (MMI) for his low back condition and to determine what compensation Petitioner is entitled to pursuant to the Act, for his lumbar sprain/strain.

Procedurally, this matter was arbitrated on August 25, 2016 and September 19, 2016, before Arbitrator Anthony Erbacci. The Arbitrator issued his Decision on November 1, 2016. The Arbitrator found a causal relationship between Petitioner's left knee and left foot sprains and the April 21, 2010 work accident. By their respective Briefs on Review, the parties did not dispute the issue of causal connection relative to Petitioner's left lower extremity; their primary dispute was causal connection for Petitioner's current low back condition. The Arbitrator did not find that Petitioner's current condition of ill-being, as it pertained to the lumbar spine, was causally related

to the April 21, 2010 accident. Any compensation, by way of medical expenses, temporary total disability (TTD) benefits and permanent partial disability (PPD) benefits was limited to Petitioner's left knee and left foot. The Commission affirmed and adopted the Decision of the Arbitrator on March 29, 2018.

Petitioner appealed to the Circuit Court of the 18th Judicial Circuit, DuPage County. Judge Fullerton noted that three of Petitioner's treating physicians, Dr. Frank Phillips, Dr. Scott Rubinstein, and Dr. Artelio Watson as well as Respondent's Section 12 examiner, Dr. Sean Salehi, found causal connection between Petitioner's lumbar spine condition and the April 21, 2010 work accident. Judge Fullerton further indicated that while Dr. Salehi was unable to state with a reasonable degree of medical certainty that the April 2010 accident resulted in a permanent exacerbation of a pre-existing condition, he did believe that Petitioner sustained a lumbar strain, or at most, a temporary exacerbation of a pre-existing condition. Judge Fullerton stated that Dr. Salehi opined that Petitioner reached MMI within three months from the accident date. Dr. Salehi also noted that the pain Petitioner experienced was not attributed to disc degeneration shown in the 2008 and 2010 MRIs.

The one opinion against causal connection in this claim was that of Dr. Kevin Walsh, another Section 12 examiner hired by Respondent. Dr. Walsh's opinion was based upon the lack of low back complaints by Petitioner immediately after the accident. Judge Fullerton was not persuaded indicating that Dr. Walsh's conclusion did not discuss why the opinions of Dr. Phillips, Dr. Rubinstein, Dr. Watson, and Dr. Salehi, were unfounded or unsupported. Thus, Judge Fullerton found that the Commission's Decision on causal connection for Petitioner's low back condition was against the manifest weight of the medical evidence and reversed the Commission's Decision in that regard.

Based upon the directive from the Circuit Court, the Commission is required to find that Petitioner's lumbar sprain/strain was causally related to the April 21, 2010 accident. Per the Circuit Court's Remand Order dated October 9, 2018, the Commission must now determine whether Petitioner reached MMI as well as make further findings of fact on the issues of medical expenses, TTD and PPD.

In determining whether a claimant has reached MMI, a court may consider factors such as a release to return to work, medical testimony or other evidence concerning the claimant's injury, the extent thereof, and, most importantly, whether the injury has stabilized. *Mech. Devices v. Indus. Comm'n*, 344 Ill. App. 3d 752, 760 (4th Dist. 2003). The Commission is not persuaded by Dr. Salehi's arbitrary MMI date which, according to Dr. Salehi, was three months following the accident date. The Commission instead finds that Petitioner reached MMI on the date of Dr. Salehi's evaluation of Petitioner and his Section 12 report or October 28, 2010. As of October 28, 2010, Dr. Salehi could not causally relate Petitioner's lumbar spine condition to his work accident and found Petitioner sustained a lumbar strain, or at most, a temporary exacerbation of a pre-existing condition.

Petitioner, in his Statement of Exceptions to the Arbitrator's denial of causal connection for the lumbar spine, argued that the MMI date should be May 27, 2011. At that time, Petitioner had refused to proceed with back surgery and instead completed a functional capacity evaluation (FCE). The March 21, 2011 FCE demonstrated that Petitioner could perform within the medium physical demand level. In light of Petitioner's refusal to proceed with surgery and the FCE Dr. Watson, Petitioner's pain doctor, determined that Petitioner was at MMI on a conservative level for his back as of May 27, 2011. (T.30; T.38; PX4; PX7, pg. 15; RX12).

Notwithstanding this, the Circuit Court, relying on Dr. Salehi's Section 12 opinion, determined that Petitioner only suffered a back sprain/strain. The Commission finds that the October 28, 2010 MMI date is appropriate for this diagnosis. Petitioner's symptoms, treatment, and recommendations after October 2010 are unrelated to a lumbar sprain/strain, and therefore, unrelated to the April 21, 2010 work accident. Accordingly, in terms of Petitioner's diagnosis of a lumbar sprain/strain, the Commission finds that Petitioner reached MMI for his work-related condition on October 28, 2010.

Regarding medical expenses and TTD benefits, the Commission awards benefits through October 28, 2010. Respondent disputed liability on the basis that Petitioner's low back condition was unrelated to the April 21, 2010 accident. Having now determined that Petitioner sustained a lumbar sprain/strain as a result of the April 21, 2010 accident, the Commission awards medical expenses through October 28, 2010, the date of Dr. Salehi's Section 12 examination.

Relative to TTD, the Commission finds that Petitioner is entitled to TTD from April 22, 2010 to October 28, 2010. Again, Respondent disputed liability for TTD on the basis that Petitioner's low back condition was unrelated to the April 21, 2010 accident. Respondent further failed to demonstrate that it was able to accommodate any release to light duty work. Having found that Petitioner sustained a lumbar sprain/strain as a result of the April 21, 2010 accident, per the Circuit Court's Order, the Commission awards Petitioner TTD from April 22, 2010 through October 28, 2010, the date of Dr. Salehi's Section 12 examination.

The Commission further awards Petitioner three-percent (3%) loss of use of the person as a whole for the lumbar sprain/strain he sustained as a result of the April 21, 2010 accident. Any evidence of diminished work capacity, continued disability or need for further treatment subsequent to the MMI date of October 28, 2010 is unrelated to the April 21, 2010 work accident.

The Commission affirms all else relative to the left lower extremity.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner temporary total disability benefits of $1,077.35 per week for 27 1/7 weeks, commencing April 22, 2010 through October 28, 2010, that being the period of temporary total incapacity for work under Section 8(b) of the Act.

19IWCC0194

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall be given a credit of $28,011.10 for temporary total disability benefits previously paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner all reasonable, necessary, and related medical expenses through October 28, 2010, pursuant to Sections 8(a) & 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $664.72 per week for a period of 19.143 weeks, for the reason that the injuries sustained caused a 5% loss of use of Petitioner's left leg and 5% loss of use of Petitioner's left foot, as provided in Section 8(e) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $664.72 per week for a period of 15 weeks, for the reason that the injuries sustained to Petitioner's lumbar spine caused a 3% loss of use of the 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 the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $24,000.00. 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: APR 18 2019

MEP/pm
D: 4-9-19
049

Maria Elena Portela
Maria E. Portela

Thomas J. Tyrrell
Thomas J. Tyrrell

Deborah L. Simpson
Deborah L. Simpson

STATE OF ILLINOIS)
) SS.
COUNTY OF)
SANGAMON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JEFFREY SIMS,

Petitioner,

vs.

NO: 17 WC 25254

19IWCC0195

STATE OF ILLINOIS,
JACKSONVILLE CORRECTIONAL CENTER,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses and permanent partial disability (PPD) benefits, and being advised of the facts and applicable law, reverses the Decision of the Arbitrator and finds that Petitioner, Jeffrey Sims, sustained an accident that arose out of and in the course of his employment with Respondent on December 18, 2016. The Commission awards Petitioner all reasonable and necessary medical expenses related to the December 18, 2016 accident. As to PPD benefits, the Commission awards Petitioner one percent (1%) loss of use of the person-as-a-whole.

So that the record is clear, and there is no mistake as to the intentions or actions of the Commission, we have considered the record in its entirety. We have reviewed the facts of the matter, both from a legal and a medical/legal perspective. The Commission has considered all the testimony, exhibits, pleadings and arguments submitted by the parties.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission makes the following findings:

19IWCC0195

1. The Petitioner, Jeffrey Sims, filed an Application for Adjustment of Claim on August 20, 2017. Per the Application, Petitioner was a 51-year old, married male with no dependents under the age of 18. Petitioner alleged injury to his head, neck, back and body while working on December 18, 2016.

2. The Petitioner has been employed as a correctional officer at the Jacksonville Correctional Center since January 2002. At the time of the accident, he was assigned to Tower 4 where he observed the parking lot and inmates.

3. On December 18, 2016, Petitioner slipped on ice as he was returning from his "chow break" located in the gatehouse. To get to the gatehouse he had to leave the tower, walk across the parking lot, and then walk on the sidewalk. T.12, T.13. As he was returning from chow break, he exited the gatehouse, walked down a long sidewalk, turned left and then started to walk towards the parking lot. He lost his footing before he got to the parking lot. T.21. Petitioner testified that everything was covered in snow and ice. T.13.

4. Petitioner testified on cross-examination that there was only one way to get into the chow hall. T.20. The path to the gatehouse was open to the general public. *Id.* On re-direct examination, Petitioner testified that the pathway is located in a secure area of the prison. He can eat in the break room or any other room where they are assigned to eat. T.22.

5. An Employer's First Report of Injury was completed on December 19, 2016. Per the report, Petitioner slipped on ice and fell while returning to his assignment from chow break. The fall was the result of the snow and ice. RX.1.

6. Petitioner testified that he hit his tailbone, left shoulder and the back of his head on the ground. T.13. He noticed that his head and shoulder started to hurt. T.13. He reported the incident and completed his shift. He sought medical treatment the next day. T.14.

7. Petitioner presented to Passavant ER on December 19, 2016. It was noted that he fell on ice and landed on his shoulder and back and hit the back of his head. The CT scan of the head and cervical spine was normal. The x-ray of the left shoulder was normal. The impression was a contusion of the head and left shoulder and a cervical strain. He was taken off work until December 21, 2016. PX.1. Petitioner has an outstanding medical bill from Passavant totaling $250.00. PX.3.

8. Petitioner testified that his shoulder and tailbone worked itself out after a couple of weeks. However, his headaches would start from the back of his head and go around to the front of his temple. T.16.

9. Petitioner was seen at the Springfield Clinic on August 29, 2017 for a backache and thigh pain. Petitioner indicated that he fell in December and has since had a lot of left thigh pain.

Examination of the lateral thigh revealed tenderness in the outer aspect. The neck was within normal limits. He was to return as needed. PX.2.

10. Petitioner testified that he still works for the prison earning the same rate of pay. T.17. He gets a headache every now and then that starts from the back of his head and goes around to his temple. He will sometimes stay in a dark area and take over-the-counter Tylenol. T.18. Some weeks he has no headaches and some weeks he may have a few headaches. T.19. He experienced headaches around his eyes and sinus pressure prior to the accident, but it was nothing like what he now experiences. *Id.*

11. The Arbitrator found that Petitioner was exposed to a neutral risk and that he failed to establish that he was exposed to the risk of falling snow and ice to a greater degree than that of the general public. He failed to prove that the risk of falling on snow and ice while walking in a public lot was qualitatively or quantitatively increased due to his job duties. Therefore, Petitioner's claim for compensation was denied.

To obtain compensation under the Act, a claimant bears the burden of showing, by a preponderance of the evidence, that he has suffered a disabling injury which arose out of and in the course of his employment. *Sisbro, Inc. v. Indus. Comm'n*, 207 Ill. 2d 193, 203, 797 N.E.2d 665, 671, 278 Ill. Dec. 70 (2003). The "arising out of" component is primarily concerned with causal connection and is satisfied if the claimant shows 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.* A risk is incidental to the employment where it belongs to or is connected with what an employee has to do in fulfilling his or her duties. *Caterpillar Tractor Co. v. Indus. Comm'n*, 129 Ill. 2d 52, 58, 541 N.E.2d 665, 133 Ill. Dec. 454 (1989).

However, a risk-analysis is unnecessary if the injury occurred on the employer's premises due to an unsafe or hazardous condition. Our Supreme Court has held that accidental injuries sustained on the employer's premises within a reasonable time before or after work arise "in the course of" employment. *Archer Daniels Midland Co. v. Indus. Comm'n*, 91 Ill. 2d 210, 215, 437 N.E.2d 609, 62 Ill. Dec. 921 (1990). Further, where the injury was due to the dangerous condition of the employer's premises, courts have consistently approved an award of compensation. *Id.* at 216. See also *Hiram Walker & Sons, Inc. v. Indus. Comm'n*, 41 Ill. 2d 429, 244 N.E.2d 179 (1968) (holding that claimant's fall in employer's ice-covered parking lot was compensable); *Caterpillar Tractor Co v. Indus. Comm'n*, 129 Ill. 2d 52, 62, 541 N.E.2d 665, 133 Ill. Dec. 454 (1989) (suggesting that an injury is causally related to the employment if the injury occurs "as a direct result of a hazardous condition on the employer's premises"); *Mores-Harvey v. Indus. Comm'n*, 345 Ill. App. 3d 1034, 1040, 804 N.E.2d 1086, 281 Ill. Dec. 791 (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."); *Suter v. Ill. Workers' Comp. Comm'n*, 2013 IL App (4th) 130049WC, ¶ 40, 998 N.E.2d 971, 376 Ill. Dec. 261 (where the claimant slipped on ice in a parking lot furnished by her employer shortly after she arrived at work, the claimant was entitled to benefits under the Act "as a matter of law").

The fact that the walkway in the case at bar was also used by the general public is immaterial to the issue of compensability as Petitioner's injury was caused by a hazardous condition on the employer's premises.

As noted in *Mores-Harvey*, 345 Ill. App. 3d at 1040:

> [w]hether a parking lot is used primarily by employees or by the general public, the proper inquiry is whether [**9] the employer maintains and provides the lot for its employees' use. If this is the case, then the lot constitutes part of the employer's premises. *The presence of a hazardous condition on the employer's premises that causes a claimant's injury supports the finding of a compensable claim.* (Emphasis added.)

If the employer allows both its employees and members of the general public to use the parking lot and contemplates that its employees will traverse the parking lot, a hazardous condition on the parking lot that causes a claimant's injury is compensable, regardless of whether the employer restricts or dictates its employees' use of the lot. *Archer Daniels Midland*, 91 Ill. 2d at 216; *Mores-Harvey*, 345 Ill. App. 3d at 1040; *Suter*, 2013 IL App (4th) 130049WC, ¶ 40. The hazardous condition on the employer's premises renders the risk of injury incidental to employment without having to prove that she was exposed to the risk of that hazard to a greater extent than are members of the general public. *Archer Daniels Midland*, 91 Ill. 2d at 216; *Mores-Harvey*, 345 Ill. App. 3d at 1040; *Suter*, 2013 IL App (4th) 130049WC, ¶ 40.

In the present case, it was undisputed that the walkway where Petitioner fell was on the employer's premises and that the walkway and parking lot were covered in snow and ice. Petitioner's testimony that he slipped and fell on the ice was not rebutted by the Respondent and was bolstered by the Employer's First Report of Injury and the contemporaneous medical record. The Commission finds that the injury was caused by the snow and ice which represented a dangerous condition or defect on the employer's premises. As there was a hazardous condition on the employer's premises, a neutral risk analysis was not warranted. Petitioner's injury is a compensable claim.

The Commission further finds that Petitioner's injury would also have been compensable under the personal comfort doctrine. The personal comfort doctrine is relevant to the determination of whether an employee's injury occurred "in the course of" his employment. *Circuit City Stores, Inc. v. Ill. Workers' Comp. Comm'n*, 391 Ill. App. 3d 913, 921, 909 N.E.2d 983, 990 (2009). "According to the personal-comfort doctrine, an employee, while engaged in the work of his or her employer, may do those things that are necessary to his or her health and comfort, even though personal to himself or herself, and such acts will be considered incidental to the employment." *Illinois Consolidated Telephone Co. v. Indus. Comm'n*, 314 Ill. App. 3d 347, 350, 732 N.E.2d 49, 52, 247 Ill. Dec. 333 (2000). "If the injury occurs within the time period of employment, at a place where the employee can reasonably be expected to be in the performance of his duties and while

he is performing those duties or doing something incidental thereto, the injury is deemed to have occurred in the course of employment." *Eagle Discount Supermarket v. Indus. Comm'n*, 82 Ill. 2d 331, 338, 412 N.E.2d 492, 496, 45 Ill. Dec. 141 (1980).

In the present case, the Petitioner was injured during his lunch hour, and Illinois courts have recognized eating as an act of personal comfort. *Karastamatis v. Indus. Comm'n*, 306 Ill. App. 3d 206, 211, 713 N.E.2d 161, 165, 238 Ill. Dec. 915 (1999). Our Supreme Court has noted, however, that in lunch hour cases, "the most critical factor in determining whether the accident arose out of and in the course of employment is the location of the occurrence." *Eagle Discount Supermarket*, 82 Ill. 2d at 339, 412 N.E.2d at 496. In addition, if the employee "voluntarily and in an unexpected manner exposes himself to a risk outside any reasonable exercise of his duties, the resultant injury will not be deemed to have occurred within the course of the employment." *Id.* at 340, 412 N.E.2d 497.

In this case, Petitioner was injured while returning from the chow hall that was located on the employer's premises. To return to his work station Petitioner had to traverse the walkway and parking lot which were covered in snow and ice. There is no evidence that Petitioner voluntarily and in an unexpected manner exposed himself to a risk outside any reasonable exercise of duty. The Commission therefore finds that Petitioner's injury would also have been compensable under the personal comfort doctrine.

As to the nature and extent of Petitioner's injury, the Arbitrator did not consider the five factors under Section 8.1(b) of the Act as she considered the issue of nature and extent moot. The Commission having found accident and causal connection in this claim, and taking into consideration the following five factors listed under Section 8.1(b) of the Act, awards Petitioner one percent (1%) loss of use of the person as a whole:

(i) Impairment Rating: The Commission gives no weight to this factor as an impairment rating was not offered into evidence.

(ii) Occupation of Injured Employee: The Commission gives this factor no weight as there is no evidence in the record that Petitioner's injury has any significant effect on his occupation.

(iii) Petitioner's Age: Petitioner was 51-years old on the accident date. The Commission gives no weight to this factor as there is no evidence in the record that Petitioner's age has any significant effect on his occupation.

(iv) Petitioner's Future Earning Capacity: Petitioner testified that he currently earns the same rate of pay. Therefore, the Commission gives no weight to this factor.

(v) Evidence of Disability: The Commission gives this factor some weight as evidence of his disability was corroborated by the medical records. The records demonstrate that

Petitioner sustained a contusion to the head and left shoulder and he sustained a cervical strain. While the majority of his symptoms resolved on their own, Petitioner testified that he still experiences occasional headaches.

Considering the foregoing factors, with no single enumerated factor being the sole determinant of disability, the Commission awards one percent (1%) loss of use of the person as a whole.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on July 18, 2018, is hereby reversed for the reasons stated above.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner all reasonable and necessary medical expenses pursuant to Sections 8(a) & 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $775.18 per week for a period of 5 weeks, as provided in Section 8(d)2 of the Act, for the reason that the injuries sustained caused one percent (1%) loss of use of the person as a whole.

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

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

DATED: APR 18 2019

Maria Elena Portela
Maria Portela

MEP/tdm
O: 4/8/19
049

Thomas J. Tyrrell

Deborah L. Simpson
Deborah Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SIMS, JEFFREY
Employee/Petitioner

Case# **17WC025254**

STATE OF ILLINOIS/DEPT OF CORRECTIONS
Employer/Respondent

19IWCC0195

On 7/18/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 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:

2333 WOODRUFF JOHNSON & EVANS
JAY JOHNSON
4234 MERIDIAN PKWY SUITE 134
AURORA, IL 60504

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

6079 ASSISTANT ATTORNEY GENERAL
BRADLEY DEFREITAS
500 S SECOND ST
SPRINGFIELD, IL 62706

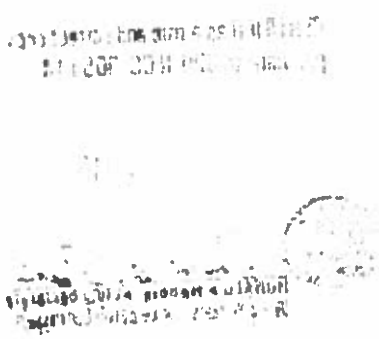
0498 STATE OF ILLINOIS
ATTORNEY GENERAL
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601-3227

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

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

JUL 18 2018

Illinois Workers' Compensation Commission



19IWCC0195

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

JEFFREY SIMS
Employee/Petitioner

v.

STATE OF ILLINOIS/DEPARTMENT OF CORRECTIONS
Employer/Respondent

Case # 17 WC 25254

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 **Springfield**, 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. ☐ 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 **December 18, 2016**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did 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 **$78,000.00**; the average weekly wage was **$1,500.00**.

On the date of accident, Petitioner was **51** years of age, ***married*** with **0** dependent children.

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

ORDER

As explained in the Arbitration Decision, Petitioner failed to prove by a preponderance of the evidence that he sustained an accident which arose out of and in the course of his employment on December 18, 2016. All benefits are denied.

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

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

Signature of Arbitrator

July 6, 2018
Date

STATE OF ILLINOIS)
) ss
COUNTY OF SANGAMON)

19IWCC0195

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

JEFFREY SIMS
Employee/Petitioner

v.

Case #: **17 WC 25254**

STATE OF ILLINOIS/DEPARTMENT OF CORRECTIONS
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner filed an Application for Adjustment of Claim alleging an injury to his head, neck, and back arising out of and in the course of his employment with Respondent. At issue is accident, medical bills, temporary total disability, and nature and extent of the injury. The Arbitrator notes that Respondent stipulated that all issues flow from the issue of accident and are otherwise not disputed.

On December 18, 2016, Petitioner was 51 years old, married, and had no dependent children. He was employed by Respondent as a Correctional Officer and had been so employed since January 2002. On the day in question, he was assigned to Tower 4 at Jacksonville Correctional Center. His duties included observing the parking lot, observing the inmates while they were in the yard, and making sure everything stayed secure.

Petitioner testified that at the time of his fall he was on his "chow break". He had been relieved at the tower, went on his break in the dietary area of the gatehouse building, and was on his way back to the tower when he "slipped on some ice and busted my tail". He testified that to get from the tower to the gatehouse he walked across the parking lot, got onto the sidewalk, and then walked into the building. He testified, "Everything was covered in snow and ice; the parking lot, the sidewalks, just everything". When he fell, he landed on his tailbone, left shoulder, and the back of his head. He reported the incident right away to his Shift Commander and finished his shift that day.

Petitioner testified that when he woke up the next day his shoulders and neck were sore and he had a headache. He decided to get checked out and went to Passavant Hospital. He was examined and taken off work for two days. He denied having prior problems or having prior headaches to this extent, and denied any subsequent injuries to these affected areas. He returned to work and sought no further treatment for approximately seven months. He testified that during

that time his tailbone and shoulder "took care of themselves", but the headaches continued. They originated in the back of his head and came around to the front of his temple. Because of the continued headaches, he went to his family physician, Dr. Malcott. He was put on a course of oral steroids, which caused his heart rate to shoot way up and he had to discontinue the medication. He has not sought medical treatment for his injuries since that time.

Petitioner testified that he continues to work at the prison and is earning the same salary as he did at the time of his fall. Currently, he continues to have headaches "every now and then", which start at the back of his head and come around to his temple. He takes over the counter medication as needed. As to the frequency of the headaches, he stated, "Some weeks you don't experience it at all, and then the next week you might have two or three episodes; and sometimes you might have one or two a week for a little bit and then it goes away again." He testified that prior to the accident he had headaches off and on, mostly from sinus pressure, but never had them in the back of his head that throbbed.

On cross-examination, Petitioner testified that the path he took to and from his lunch break was open to the public, as it was the only way for people to go in or out of the prison. When he fell, he was closer to the gatehouse than the tower. He testified he came out of the gatehouse and walked down a long walk, then turned left to go toward the parking lot, which is where he fell. He acknowledged that, despite his reported ongoing headaches, he has not returned to the doctor.

Following the accident, Petitioner presented to the emergency room at Passavant Area Hospital on December 19, 2016. He reported a history of the accident consistent with his testimony and complained of headache and pain in his left shoulder and head/neck. He underwent left shoulder x-rays, CT scan of the head, and CT scan of the cervical spine, which were all normal. Assessment was contusion and strain of the head and left shoulder. He was instructed to remain off work until December 21, 2016, and to follow up with his primary physician as needed. PX1.

The next medical treatment, as Petitioner testified, was August 29, 2017, when he presented to Nurse Practitioner Amber Wright at Springfield Clinic, with complaints of backache and thigh pain. The note states, "According to the patient he recalls falling back in December. He has had a lot of pain in the left thigh since this occurred. He has tried OTC treatment without relief so far." His primary complaint was left thigh pain and burning that "comes and goes". He was started on a tapering dosage of Prednisone for the backache and instructed to return as needed. PX2.

CONCLUSIONS OF LAW

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

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

To obtain compensation under the Illinois Workers' Compensation Act, a claimant must show by a preponderance of the evidence that he suffered a disabling injury arising out of and in the course of his employment. 805 ILCS 305/2; *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill.2d 193, 201 (2003); *Metropolitan Water Reclamation District of Greater Chicago v. Illinois Workers' Compensation Comm'n*, 407 Ill.App.3d 1010, 1013 (1st Dist. 2011); *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill.2d 52, 57 (1989). Both elements must be present at the time of the claimant's injury in order to justify compensation. *Illinois Bell Telephone Co. v. Industrial Comm'n*, 131 Ill.2d 478, 483 (1989).

An injury "arises out of" one's employment if its origin is in a risk connected with or incidental to the employment so that there is a causal relationship between the employment and the accidental injury. In order to meet this burden, a claimant must prove that the risk of injury is peculiar to the work or that he or she is exposed to the risk of injury to a greater degree than the general public. *Orsini v. Industrial Comm'n*, 117 Ill.2d 38, 45 (1987). There are three categories of risk to which an employee may be exposed: (1) risks distinctly associated with the employment; (2) risks that are personal to the employee; and (3) neutral risks which have no particular employment or personal characteristics. *Illinois Institute of Technology Research Institute v. Industrial Comm'n*, 314 Ill.App.3d 149, 162 (1st Dist. 2000).

The Arbitrator finds that Petitioner's injuries were not the result of an employment related risk nor a personal risk. Rather, the risk was neutral.

Injuries resulting from a neutral risk generally do not arise out of the employment and are compensable under the Act only where the employee was exposed to the risk to a greater degree than the general public. Such an increased risk may be either qualitative, such as some aspect of the employment which contributes to the risk, or quantitative, such as when the employee is exposed to a common risk more frequently than the general public. *Springfield Urban League v. Illinois Workers' Compensation Comm'n*, 990 N.E.2d 284, 290 (4th Dist. 2013).

The Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that his accident arose out of his employment. Specifically, he did not establish that he was exposed to the risk of falling on snow and ice to a greater degree than that of the general public. In fact, he testified that "everything was covered in snow and ice; the parking lot, the sidewalks, just everything" and further testified that the area in which he fell was the only way for people to go in or out of the prison. Petitioner failed to prove that his risk of falling on snow and ice while walking in a public parking lot was quantitatively or qualitatively increased.

Based on the foregoing and the record in its entirety, the Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that he sustained an accident on December 18, 2016, that arose out of and in the course of his employment with Respondent. All other issues are rendered moot and the Arbitrator makes no findings regarding same. All benefits are denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF MCLEAN)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MARY BUCKLEY,

Petitioner,

vs.

NO: 16 WC 32369

19IWCC0196

MOLLY MAIDS,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses, temporary total disability (TTD) benefits and permanent partial disability (PPD) benefits, and being advised of the facts and applicable law, reverses the Decision of the Arbitrator and finds that Petitioner sustained an accident that arose out of and in the course of her employment with Respondent on September 21, 2016. The Commission also finds that Petitioner's left shoulder condition is causally related to the September 21, 2016 accident. The Commission further finds that Petitioner is entitled to all reasonable and necessary medical expenses related to the September 21, 2016 accident, as well as TTD benefits from November 22, 2016 through February 22, 2017. As to PPD benefits, the Commission awards twelve-and-a-half percent (12.5%) loss of use of the person as a whole.

So that the record is clear, and there is no mistake as to the intentions or actions of the Commission, we have considered the record in its entirety. We have reviewed the facts of the matter, both from a legal and a medical/legal perspective. The Commission has considered all the testimony, exhibits, pleadings, and arguments submitted by the parties.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission makes the following findings:

1) Petitioner testified that on September 21, 2016, she worked full-time for Respondent as a maid. (T.10). She had worked for Respondent for nearly 12 years. (T.10). Her duties as a maid included mopping, vacuuming, sanitizing kitchens and bathrooms, dusting mini-blinds, ceiling fans, cobwebs, baseboards and doorframes as well as unloading and reloading the car with supplies. (T.10).

2) In describing her injury at work on September 21, 2016, Petitioner testified "I was dusting the levers of the mini-blinds, and I was holding the bottom of the mini-blind so I could get a good wipe on it; but then it started coming loose, and I reached up too quick, and that's when it had popped." (T.11). At the time of her injury, Petitioner's left arm was in an upright position, above shoulder height. (T.11). On cross-examination Petitioner confirmed that the activity of reaching up is what caused her shoulder injury; she did not have anything in her left hand when she was reaching up. (T.20).

3) After the accident, Petitioner noticed that her left arm hurt and was tingling. It also felt numb and heavy. (T.12). Petitioner informed Kelly Wright, texted her boss and was sent to the occupational health clinic. (T.12).

4) Petitioner presented to the occupational health clinic on September 21, 2016. (T.12; PX2; RX1). Petitioner complained of pain from the left shoulder down to her left elbow. The history noted that Petitioner had injured her left shoulder about one hour prior, "while reaching to hold miniblinds while dusting." She exhibited positive Hawkins' test, as well as tenderness and limited range of motion. Petitioner was diagnosed with a left shoulder strain, left shoulder tendinitis and rotator cuff syndrome. She was allowed to return to work with restrictions and was told to use a sling for support. (PX2; RX1). Petitioner returned to work for Respondent. (T.12).

5) Petitioner testified that she did not have any left shoulder problems prior to September 21, 2016. (T.16).

6) On September 21, 2016, Petitioner also presented to Advocate Bromenn Medical Center for evaluation. The hospital record noted that Petitioner, a right-hand dominant woman, was complaining of left shoulder pain. Petitioner had reported that she was working as a housekeeper. While cleaning the mini-blinds, the mini-blinds started falling, and she reached to catch them with her left arm when she experienced burning pain in her left shoulder. At this appointment, Petitioner denied tingling, numbness or weakness. Examination revealed tenderness to palpation in the left shoulder. Range of motion could not be tested due to pain. There was no gross deformity and gross sensation was intact throughout the upper trunk. X-rays of the left shoulder revealed no obvious fracture, dislocation or misalignment. (PX1).

7) Petitioner returned to the occupational health clinic a week later, on September 28, 2016. Her pain complaints persisted and Petitioner now reported tingling and numbness from her left shoulder to her fingers. (PX2).

8) Petitioner completed an MRI of the left shoulder on September 30, 2016. The impression indicated a severe partial tear versus a complete tear of the supraspinatus tendon at the insertion. (PX2; PX3). On October 6, 2016, the occupational health physician referred Petitioner to an orthopedic specialist. (PX2).

9) On November 22, 2016, Petitioner consulted with Dr. Lawrence Li, a board-certified orthopedic surgeon, at Orthopedic & Shoulder Center. (T.13; PX4; PX5, pg. 5). Dr. Li's evidence deposition was taken on March 6, 2017. His testimony was consistent with his medical records. (PX5). The history recorded stated: "She works for Molly Maid and was cleaning blinds. She saw the blinds were going to fall and reached up to keep it from falling. She did this with her [l]eft arm and developed severe pain." Dr. Li reviewed the MRI and noted a full thickness tear of the supraspinatus tendon.

10) At this appointment, Petitioner checked off symptoms of tingling, numbness, stiffness, weakness, giving way, swelling, popping and locking. During the actual shoulder exam there was no swelling noted, but strength testing was a four out of five and Neer and Hawkins' tests were positive. Additionally, examination of the left elbow demonstrated full range of motion, positive Tinel's at the cubital tunnel and decreased sensation over the ulnar nerve distribution. (PX4).

11) Dr. Li diagnosed Petitioner with a left shoulder full thickness rotator cuff tear "as a result of trying to catch falling blinds." Petitioner was also diagnosed with left cubital tunnel syndrome. Petitioner was told to wear a sling for two months and she was taken off work. Dr. Li administered an injection, medication was prescribed and physical therapy was ordered. Petitioner commenced physical therapy at Dr. Li's office on November 28, 2016. (T.13-14; PX4).

12) By December 21, 2016, therapy had improved Petitioner's range of motion and function but her pain persisted. She also had tingling and numbness in the ulnar nerve distribution. Dr. Li recommended proceeding with left arthroscopic rotator cuff repair. He also wanted to continue monitoring Petitioner's cubital tunnel syndrome. (PX4).

13) Petitioner proceeded with surgery on January 10, 2017. Dr. Li performed a left shoulder arthroscopy with rotator cuff repair, arthroscopic subacromial decompression, extensive debridement of anterior, superior and posterior labral tears and excision of the distal clavicle. (T.14; PX4). Dr. Li's post-operative diagnoses were left shoulder rotator cuff tear, subacromial impingement and AC joint dysfunction. (PX5, pg. 10). Petitioner completed her post-op physical therapy at Dr. Li's office. (T.14; PX4).

14) Dr. Li released Petitioner to light duty work on February 10, 2017. Petitioner was not allowed to use her left arm. Petitioner followed-up with Dr. Li on February 15, 2017. Dr. Li administered a cortisone injection, recommended further physical therapy and instructed Petitioner to continue to use the CPM machine and Game Ready Vasopneumatic compression therapy. (PX4).

15) In regard to causal connection, Dr. Li testified "It's my opinion to a reasonable degree of medical certainty that the act of suddenly reaching up as quickly as she could to stop the blinds aggravated her shoulder and any possible underlying degenerative tears in her rotator cuff worse and permanently aggravated that condition." (PX5, pg. 12). Dr. Li described the injury as a traction injury – a pulling-type mechanism. "So she's suddenly distracting her arm, raising it up as fast as she could in the hope of catching this falling blind. And when the rotator cuff is put on traction, it can tear further." (PX5, pgs. 12-13). On cross-examination, Dr. Li clarified that the acceleration of Petitioner's arm as she reached for the falling blinds is what caused the tear. He added, "[E]ven if she never touched the mini blind, it wouldn't matter." (PX5, pg. 27).

16) On re-direct, Dr. Li explained that his intra-operative findings suggested an actual physical tearing versus degenerative tearing because he saw actual separation between the part of the tendon that was torn and the bone. (PX5, pg. 32).

17) Respondent sent Petitioner for a Section 12 examination with Dr. Stephen Weiss on November 15, 2016. Dr. Weiss was board-certified in orthopedic and arthroscopic surgery. (RX2; RX4, pg. 6). Dr. Weiss' evidence deposition was completed on March 29, 2017. His testimony was consistent with the findings and opinions contained in his Section 12 report. (RX4). Dr. Weiss noted that Petitioner denied any prior difficulties with her left shoulder. Dr. Weiss stated that on September 21, 2016, Petitioner was dusting with her right hand when the blind started to fall off the bracket. "She pushed the blind against the window with her right hand and was reaching up with her left hand to put it back into place when she felt a sudden, sharp pain in her left shoulder." Dr. Weiss stated in his Section 12 report that he agreed with the MRI findings but he did not see any evidence of an acute finding. (RX2; RX4, pg. 24). Examination revealed tenderness to palpation over the rotator cuff insertion. He diagnosed Petitioner with manifestation of severe rotator cuff tendinopathy. (RX2).

18) Dr. Weiss opined that Petitioner's condition was degenerative and pre-existing "as she was simply reaching overhead when she developed pain in the left shoulder." Dr. Weiss believed that this magnitude of force was insufficient to have caused the partial tear noted on the MRI. (RX2). However, on cross-examination, Dr. Weiss acknowledged that if Petitioner had a degenerative tear of that magnitude, then a non-forceful activity could have easily become symptomatic. (RX4, pg. 33). As of the date of the Section 12 examination, Dr. Weiss believed that light duty restrictions, an injection, an intensive rehabilitation program and arthroscopy would be appropriate. (RX2).

19) Petitioner confirmed that she was off work from November 22, 2016 through February 22, 2017. (T.14). Petitioner returned to work on February 23, 2017. She worked one-handed. (T.15). Petitioner was released full duty on March 22, 2017 and she returned to work for Respondent. (T.15). Petitioner worked for Respondent until May 5, 2017.

20) As of the date of arbitration, Petitioner was working for Big Money Bingo Hall and Charity Hall as a cook at the concession stand. (T.16). Petitioner still noted stiffness and pain in her left shoulder. She also described not having the full range for reaching, especially

overhead. (T.16-17). Petitioner continued to take ibuprofen once a day as well as a pain medication and an anti-inflammatory. (T.18). She also used ice and performed her home exercises. (T.19).

The Commission is not bound by the Arbitrator's findings. Our Supreme Court has long held that it is the Commission's province "to assess the credibility of witnesses, resolve conflicts in the evidence, assign weight to be accorded the evidence and draw reasonable inferences from the evidence." *City of Springfield v. Indus. Comm'n,* 291 Ill. App. 3d 734, 740 (4th Dist. 1997) (citing *Kirkwood v. Indus. Comm'n*, 84 Ill. 2d 14, 20 (1981)). Interpretation of medical testimony is particularly within the province of the Commission. *A. O. Smith Corp. v. Indus. Comm'n,* 51 Ill. 2d 533, 536-37 (1972).

The Commission disagrees with the Arbitrator's finding that Petitioner failed to prove that she sustained an accident that arose out of and in the course of her employment with Respondent on September 21, 2016. The Commission reverses the Arbitrator's Decision in its entirety.

The Arbitrator indicated that the parties did not dispute that Petitioner's injuries were sustained in the course of her employment. However, the parties disputed the issue of whether Petitioner's injuries arose out of her employment. The Arbitrator indicated that Petitioner injured herself in the process of raising her left arm above her head to prevent a mini-blind from falling. Petitioner had nothing in her left hand or arm and she did not come in contact with the mini-blind at the time of her injury. The Arbitrator deemed the act of raising one's arm a neutral risk and found that nothing by way of Petitioner's employment contributed to the risk of raising her arm, either on a qualitative or quantitative basis. (Arbitrator's Decision, pg. 6).

Petitioner relies on *Mytnik v. Ill. Workers' Comp. Comm'n*, 2016 IL App (1st) 152116WC, in support of her position that the risk she encountered was necessary in the performance of her job. Petitioner testified that cleaning mini-blinds was a regular part of her job duties, and on the accident date, she had to raise her left arm quickly to prevent the mini-blind from breaking loose and falling. Petitioner argues that this act was part of her employment, and a risk beyond what the general public encounters. (Petitioner's Brief, pg. 2).

An employee's injury is compensable under the Act only if it "arises out of" and "in the course of" the employment. *Univ. of Ill. v. Indus. Comm'n*, 365 Ill. App. 3d 906, 910 (1st Dist. 2006); *O'Fallon Sch. Dist. No. 90 v. Indus. Comm'n*, 313 Ill. App. 3d 413, 416 (5th Dist. 2000). Both elements must be present to justify compensation. *First Cash Fin. Servs. v. Indus. Comm'n*, 367 Ill. App. 3d 102, 105 (1st Dist. 2006). The phrase "in the course of" refers to the time, place, and circumstances of the injury. *Ill. Inst. of Tech. Research Inst. v. Indus. Comm'n*, 314 Ill. App. 3d 149, 162 (1st Dist. 2000). Accidental injuries sustained on an employer's premises within a reasonable time before and after work are generally deemed to arise in the course of one's employment. *Caterpillar Tractor Co. v. Indus. Comm'n*, 129 Ill. 2d 52, 57 (1989). As noted by the Arbitrator, the parties did not dispute that Petitioner's injuries were sustained in the course of her employment.

Turning to the second requirement and the dispositive issue in this case: For an injury to "arise out of" one's employment, its origin must be in some risk connected with, or incidental to,

the employment so as to create a causal connection between the employment and the accidental injury. *Caterpillar Tractor Co. v. Indus. Comm'n*, 129 Ill. 2d 52, 58 (1989).

To determine whether an employee's injury "arose out of" his or her employment, Illinois courts have recognized three categories of risk to which an employee may be exposed: (1) risks distinctly associated with the employment; (2) risks personal to the employee; and (3) neutral risks that have no particular employment or personal characteristics. *First Cash Fin. Servs. v. Indus. Comm'n*, 367 Ill. App. 3d 102, 105 (1st Dist. 2006); *Ill. Inst. of Tech. Research Inst. v. Indus. Comm'n*, 314 Ill. App. 3d 149, 162 (1st Dist. 2000).

In this instance, part of Petitioner's job duties as a maid/housekeeper involved dusting, specifically mini-blinds, which was the activity she was performing immediately before she injured her left shoulder. (T.10). Petitioner testified that on September 21, 2016, "I was dusting the levers of the mini-blinds, and I was holding the bottom of the mini-blind so I could get a good wipe on it; but then it started coming loose, and I reached up too quick, and that's when it had popped." (T.11). Petitioner further testified, and the medical evidence corroborated, that the mechanism of injury involved this act of sudden reaching upward, above shoulder height. (T.11; T.20; PX1; PX2; PX4; PX5; RX1; RX2).

Petitioner relies on *Mytnik v. Ill. Workers' Comp. Comm'n*, 2016 IL App (1st) 152116WC, in support of her position that her injury resulted from an employment-related risk.

In *Mytnik*, the claimant worked on an assembly line where he installed rear suspensions on vehicles using an articulating arm to fasten bolts and brackets. At the time of his injury, the claimant was reaching down to grab a bolt that had fallen on the assembly line when he felt pain down the right side of his back and hip. *Id. at P5, 7.* On review, the Appellate Court found, "[w]hile the act of 'bending' may be an act performed by the general public on a daily basis, the evidence established that bolts would regularly fall out of the articulating arm during the assembly process" and that the "claimant had to 'run down there, bend over, reach and *** pick it up before the [rotating platform] r[an] it over.'" *Id. at P45.* The Appellate Court concluded, therefore, that "picking up fallen bolts was an integral part of claimant's job" and that the risk to which the claimant was exposed was necessary to the performance of his job duties at the time of his injury. *Id.*

In the case at bar, Petitioner's act of raising her arm may be an act performed by the general public on a daily basis. However, that was not the whole of Petitioner's testimony. Petitioner testified that in the process of holding the bottom of the mini-blind, and then attempting to dust it, the mini-blind became loose and she quickly reached upward with her left arm to prevent the mini-blind from falling. It was in error that the Arbitrator determined that nothing by way of Petitioner's employment contributed to the risk of raising her arm.

A risk is distinctly associated with the 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." *Caterpillar Tractor Co. v. Indus. 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 unnecessary to perform a neutral-risk analysis. *Young v. Ill. Workers' Comp. Comm'n*, 2014 IL App (4th) 130392WC, P23.

Here, the act of dusting the mini-blind, was a required part of Petitioner's job duties. There was no testimony or evidence to the contrary. The fact that the mini-blind had loosened, began to fall and Petitioner attempted to prevent the mini-blind from falling further by suddenly lifting her left arm, was a risk incidental to, belonging to, and connected to Petitioner's dusting duties. It would be reasonable to conclude that if something were to fall in the process of Petitioner cleaning, dusting and performing her duties as a maid/housekeeper, that Petitioner would not only pick it up, but raise her arm to prevent said item from falling and causing damage or even injury. Therefore, the Commission finds that Petitioner was injured due to an employment-related risk and reverses the Arbitrator's finding of no accident.

In regard to causal connection, the Arbitrator and Respondent considered this issue moot and offered no further discussion on the matter. A chain of events which demonstrates a previous condition of good health, an accident, and a subsequent injury resulting in disability may be sufficient circumstantial evidence to prove a causal nexus between the accident and the employee's injury. *Int'l Harvester v. Indus. Comm'n*, 93 Ill. 2d 59, 63-64 (1982).

In the case at bar, the consistent and credible evidence demonstrates that prior to September 21, 2016, Petitioner had no complaints or problems with her left shoulder. (T.16). Thereafter, following the September 21, 2016 accident, Petitioner sustained injury to her left shoulder which necessitated time off work and treatment by way of medication, a sling, physical therapy, injections and surgery. Specifically, Petitioner underwent a left shoulder arthroscopy with rotator cuff repair, arthroscopic subacromial decompression, extensive debridement of anterior, superior, and posterior labral tears and excision of the distal clavicle. (T.14; PX4).

Petitioner's complaints and symptoms were further corroborated by the clinical findings made by her treating doctors as well as the September 30, 2016 MRI of the left shoulder. The MRI results indicated a severe partial tear versus a complete tear of the supraspinatus tendon at the insertion. (PX2; PX3). During surgery, Petitioner's surgeon, Dr. Li, explained that his intra-operative findings suggested an actual physical tearing versus degenerative tearing because he saw actual separation between the part of the tendon that was torn and the bone. (PX5, pg. 32). Petitioner's post-operative diagnoses were left shoulder partial thickness rotator cuff tear, subacromial impingement and AC joint dysfunction. (PX5, pg. 10).

Dr. Li opined that that the act of suddenly reaching up as quickly as she could to stop the blinds aggravated Petitioner's shoulder and made any possible underlying degenerative tears in her rotator cuff worse and permanently aggravated that condition. (PX5, pg. 12). Dr. Li described the injury as a traction injury – a pulling-type mechanism. "So she's suddenly distracting her arm, raising it up as fast as she could in the hope of catching this falling blind. And when the rotator cuff is put on traction, it can tear further." (PX5, pgs. 12-13). On cross-examination, Dr. Li clarified that the acceleration of Petitioner's arm as she reached for the falling blinds is what caused the tear. (PX5, pg. 27).

Respondent relies on its Section 12 examiner, Dr. Weiss, to dispute causal connection. However, Dr. Weiss not only agreed with the MRI findings, he believed Petitioner's condition was a manifestation of severe rotator cuff tendinopathy. (RX2). Dr. Weiss examined Petitioner on November 15, 2016, prior to her surgery with Dr. Li on January 10, 2017. Dr. Weiss opined that Petitioner's condition was degenerative and pre-existing, and not work related. He further believed that Petitioner's injury was not work related because the force of reaching overhead was insufficient to have caused the partial tear noted on the MRI. (RX2). However, on cross-examination, Dr. Weiss acknowledged that if Petitioner had a degenerative tear of that magnitude, then a non-forceful activity could have easily become symptomatic. (RX4, pg. 33). Dr. Weiss' opinion is not persuasive given the lack of prior left shoulder complaints, symptoms, or treatment as well as the chain of events in this claim.

The Commission therefore finds that Petitioner's left shoulder partial thickness rotator cuff tear, subacromial impingement and AC joint dysfunction are causally related to the September 21, 2016 accident.

Accordingly, the Commission awards all reasonable and necessary medical expenses as evidenced by the billing records contained in Petitioner's Exhibit 6. The Commission further awards TTD benefits to Petitioner from November 22, 2016 through February 22, 2017, or 13 2/7 weeks. Respondent stated on the record that it did not dispute the reasonableness or necessity of the medical charges nor the TTD period, but simply disputed liability based on the absence of accident and causation. (T.4).

As to the nature and extent of Petitioner's injury, the Arbitrator did not consider the five factors under Section 8.1(b) of the Act as he considered the issue of nature and extent moot. Moreover, Respondent did not address this issue in its Brief. Having found accident and causal connection in this claim, and taking into consideration the following five factors listed under Section 8.1(b) of the Act, the Commission awards Petitioner 12.5% loss of use of the person as a whole:

(i) Impairment Rating: The Commission gives no weight to this factor as neither party offered any evidence or opinion relative to impairment.

(ii) Occupation of Injured Employee: The Commission gives this factor no weight. Petitioner was released full duty on March 22, 2017 and she returned to work for Respondent. (T.15). Petitioner worked for Respondent until May 5, 2017. As of the date of arbitration, Petitioner was working for Big Money Bingo Hall and Charity Hall as a cook at the concession stand. (T.16). The parties offered no evidence to indicate that the injury had impacted Petitioner's occupation.

(iii) Petitioner's Age: Petitioner was 44 years old on the accident date. The Commission gives no weight to this factor as there is no evidence in the record that Petitioner's age had any effect on the level of permanent partial disability.

(iv) Petitioner's Future Earning Capacity: There is no evidence in the record as to reduced earning capacity. Therefore, the Commission gives no weight to this factor.

(v) Evidence of Disability: The Commission gives this factor significant weight as evidence of disability was corroborated by the medical records. Petitioner underwent a left shoulder arthroscopy with rotator cuff repair, arthroscopic subacromial decompression, extensive debridement of anterior, superior, and posterior labral tears and excision of the distal clavicle. Petitioner's post-operative diagnoses were left shoulder partial thickness rotator cuff tear, subacromial impingement and AC joint dysfunction.

As of the date of arbitration, Petitioner still noted stiffness and pain in her left shoulder. She also described not having the full range for reaching, especially overhead. (T.16-17). Petitioner continued to take ibuprofen once a day as well as a pain medication and an anti-inflammatory. (T.18). She also used ice and performed her home exercises. (T.19).

In light of the foregoing factors, with no single enumerated factor being the sole determinant of disability, the Commission awards Petitioner 12.5% loss of use of the person as a whole for Petitioner's left shoulder condition.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, filed on May 29, 2018, is hereby reversed for the reasons stated above.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $253.33 per week for a period of 13 2/7 weeks, from November 22, 2016 through February 22, 2017, that being the period of temporary total incapacity for work under Section 8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner all reasonable and necessary medical expenses as detailed in Petitioner's Exhibits 6, pursuant to Sections 8(a) & 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $253.00 per week for a period of 62.5 weeks, as provided in Section 8(d)2 of the Act, for the reason that the injuries sustained caused twelve-and-a-half percent (12.5%) loss of use of the person as a whole.

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $19,300.00. 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: APR 18 2019

Maria E. Portela

Thomas J. Tyrrell

MEP/pm
O: 4-9-19
049

DISSENT

I respectfully dissent from the Decision of the majority. The Commission reversed the Decision of the Arbitrator, found a compensable accident, and awarded benefits. I would have affirmed and adopted the Decision of the Arbitrator through which benefits were denied.

The facts of this claim are undisputed. In his decision, the Arbitrator wrote: "in this case it is undisputed that at the time of her injury, Petitioner was in the process of cleaning a miniblind when she raised her left arm above her head quickly because she was afraid the blind may come loose and fall." She testified that she had nothing in her left hand and neither her arm nor hand came into contact with the blind.

The Arbitrator found that the simple act of raising one's arm is a neutral risk rather than one associated with her employment. He also noted that there was nothing in the record to suggest that Petitioner had to raise her arm in her employment more than members of the general public. I agree with the analysis of the Arbitrator and his conclusion that the risk associated with raising one's arm is neutral in nature and therefore the Petitioner did not sustain her burden of proving that her injury arose out of her employment.

In addition, Respondent's Section 12 medical examiner, Dr. Weiss, opined that the mechanism of injury, as reported by Petitioner, was not sufficient to cause the partial supraspinatus tear she sustained to her left shoulder. He also noted that degenerative tears were relatively common for people in Petitioner's age group. Therefore, he concluded that her condition was degenerative in nature and not the result of any work activity.

For the reasons stated above, I would have affirmed and adopted the Decision of the Arbitrator finding Petitioner did not sustain her burden of proving a compensable accident or causation to a current condition of ill-being and denied benefits. Therefore, I respectfully dissent.

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BUCKLEY, MARY
Employee/Petitioner

Case# **16WC032369**

MOLLY MAIDS
Employer/Respondent

19IWCC0196

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:

0564 WILLIAMS & SWEE LTD
DIRK A MAY
2011 FOX CREEK RD
BLOOMINGTON, IL 61701

0481 MACIOROWSKI SACKMANN & ULRICH
ROBERT MACIOROWSKI
105 W ADAMS ST SUITE 2200
CHICAGO, IL 60603

19IWCC0196

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

Mary Buckley
Employee/Petitioner

v.

Molly Maids
Employer/Respondent

Case # **16** WC **32369**

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 **Bloomington**, on **5/25/17**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

19IWCC0196

FINDINGS

On **9/21/16**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$19,760.00**; the average weekly wage was **$380.00**.

On the date of accident, Petitioner was **44** years of age, ***married*** with **no** dependent children.

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

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

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

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

ORDER

Because Petitioner failed to meet her burden of establishing that she sustained an accident which arose out of and in the course of her employment with Respondent, benefits are denied.

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

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

Michael K. Nowak, Arbitrator

3/20/18
Date

ICArbDec p. 2

MAY 29 2018

FINDINGS OF FACT

On September 21, 2016, Petitioner was employed by the Respondent, Molly Maids of Bloomington, as a Maid. Petitioner testified that she worked for the Respondent in that capacity for over years. She testified that her job involved mopping, vacuuming, sanitizing kitchens and bathrooms, dusting mini blinds, ceiling fans, cobwebs, baseboards, door frames, unloading the car, reloading the car with her supplies. Petitioner testified that this was a full-time position.

Petitioner testified that on September 21, 2016, she was cleaning a mini blind. While doing so she raised her left arm quickly causing it to pop. She testified that she raised her left arm because the mini blind starting coming loose. She testified that is when she felt a pop. On cross examination, it was established that Petitioner did not have anything in her left arm or hand and that the pop occurred while she was in the activity of reaching up, but before she touched the mini blind. She testified that her arm was above shoulder height. Petitioner further testified she had no prior problems with the left shoulder.

Petitioner reported the accident immediately and went to Occupational Health at OSF on the same day. She testified that they put her arm in a sling and she was provided an anti-inflammatory medication and told to take Aleve, over the counter.

The medical records from OSF Occupational Health were admitted into evidence as Petitioner's Exhibit No. 2. The history was of while reaching to hold mini blind, while dusting with the right hand, she felt pain and burning in the left shoulder. Petitioner was diagnosed with a sprain of the left shoulder and tendinitis. She was given a return to work with restrictions, may use sling for support, no use, left arm.

Medical records from Advocate Bromen Medical Center were offered into evidence as Petitioner's Exhibit No. 1. The records show that Petitioner was seen on September 21, 2016 for left shoulder pain. The history was of cleaning mini blinds and reaching to catch with the left arm when experienced burning pain in the shoulder. Petitioner complained of pain but denied any numbness, tingling or weakness. X-rays failed to reveal any fracture. She was encouraged to use the sling she was provided by Occupational Health.

Petitioner testified that she continued to work while in the sling. She testified that she worked with that sling for 2-1/2 months.

Petitioner underwent an MRI of the left shoulder without contrast on September 30, 2016 and it revealed severe partial tear versus a complete tear of the supraspinatus tendon at the insertion. The MRI report was offered into evidence as Petitioner's Exhibit No. 3.

Petitioner testified that OSF was supposed to send her to an orthopedic, Dr. Newcomer, but they never followed through. She testified that she went to Dr. Lawrence Li on her own.

Prior to seeing Dr. Li, Petitioner submitted to an evaluation with Dr. Steven Weiss at the request of the Respondent on November 15, 2016 pursuant to section 12 of the Act. The history was "reaching overhead, but of not yet grabbed anything" when she felt a sudden, sharp, pain in her left shoulder. Dr. Weiss, in addition to the history, reviewed the medical records which were available to include the MRI that was performed September 30, 2016. Dr. Weiss performed an independent medical evaluation and diagnosed Petitioner with manifestation of severe rotator cuff tendinopathy. He was of the opinion that Petitioner's condition was

degenerative and pre-existing and that simply reaching overhead when she developed pain in the left shoulder was not of a significant magnitude of force to sufficiently cause the partial supraspinatus tear noted on the MRI. The doctor indicated that degenerative tears are relatively common for someone in Petitioner's age group. He did not believe the activity of reaching up caused or aggravated her underlining condition. He felt that Petitioner's current restrictions were appropriate but not related to the occurrence of raising her left arm. He did agree with further treatment to include injection, intensive rehabilitation and possible arthroscopic surgery, but that none of these treatments are related to the alleged occurrence.

Petitioner was initially seen by Dr. Lawrence Li on November 22, 2016. The history was "saw blinds were going to fall" and she reached up to keep them from falling, and developed pain. The doctor took a history of her prior medical care and reviewed the medical records and diagnostic studies. He diagnosed Petitioner with left shoulder full thickness rotator cuff tear and left cubital tunnel syndrome from being in a sling for 2-1/2 months. The medical records from Dr. Li were introduced into evidence as Petitioner's Exhibit No. 4.

Petitioner continued to treat with Dr. Li who on January 10, 2017 performed a left shoulder arthroscopy with rotator cuff repair, arthroscopic subacromial decompression, extensive debridement of anterior, superior and posterior labral tears and excision distal clavicle. After the surgery, Petitioner participated in physical therapy. Petitioner underwent an injection and continued to follow with physical therapy. Petitioner was released to return to restricted work on February 15, 2017.

Petitioner testified that she was off from work from November 22, 2016 until February 22, 2017. Petitioner testified that she worked one-handed until March 22, 2017 when she was released to return to work, full duty, no restrictions. Petitioner further testified that she continued to work at Molly Maids of Bloomington until May 5, 2017.

Petitioner testified that she is currently working at Big Money Bingo Hall and Charity Hall since May 5, 2017. She testified that she was right-hand dominant.

Petitioner denied any prior problems with her left shoulder. She testified that currently she notices stiffness and a nagging pain in the shoulder. She testified that she notices it in the morning and if she sits too long. She testified that her range of motion is not the same as it was prior to the injury, although it is better than it was before the surgery. She testified she did not have full range of motion reaching up. She testified that she had full extension to the side and in the front. She testified that she had no swelling in her left shoulder. She testified that she takes over-the-counter Ibuprofen, and that she has a prescription for pain medication and was supplied by Dr. Li. She uses ice on the shoulder and uses the pulley exercise and the bands that Dr. Li suggested and she learned in physical therapy.

On cross examination, she reaffirmed that she had nothing in her left hand at the time of the injury and that the shoulder popped before she touched the mini blinds. She admitted to reaching up with her left arm prior to the occurrence in question in her daily-living activities.

Petitioner last saw Dr. Li on March 22, 2017 and advised him how she was feeling. She testified that he examined her on that date and advised her to come back if she had any additional problems, but she has not returned.

The evidence deposition of Dr. Lawrence Li taken on March 6, 2017 was offered into evidence as Petitioner's Exhibit No. 5. Dr. Li testified that he initially saw Petitioner on November 22, 2016 for left shoulder pain. The history was "reached up to keep blinds from falling" and when she did this, she developed severe pain in her left arm. The doctor outlined Petitioner's care and treatment, his physical findings and diagnosis. The doctor testified to reviewing the MRI. He testified the MRI revealed that the tendon was torn but not retracted. He testified that on January 10, 2017, he performed surgery to repair the rotator cuff tear. Post-operative diagnosis was left shoulder rotator cuff tear, subacromial impingement, AC joint dysfunction. He testified that Petitioner may have had some degeneration of the rotator cuff. He testified that she certainly could have had some degenerative tearing. He opined that it was his opinion that the activity of reaching up was a causative factor. He testified that if there was effusion found on the MRI of September 30, 2016, he would have noted it. He admitted that there was no way to determine whether or not the tear found on the MRI of September 30, 2016 was acute. He testified that on direct he was focusing on aggravation because Dr. Weiss felt that the condition was pre-existing. He testified that he assumed Dr. Weiss was correct. He admitted that the condition could have been degenerative in nature. He admitted there were many times out of the workplace where one would have to raise one's arm upward.

The evidence deposition of Dr. Stephen Weiss taken on March 29, 2017 was offered into evidence as Respondent's Exhibit No. 4. Dr. Weiss testified to evaluating Petitioner at the request of the Respondent on November 15, 2016. The history was of "reaching up to the blind" when she felt pain in her shoulder. He testified to his examination, review of records and diagnostic studies. He diagnosed Petitioner with a severe rotator cuff tendinopathy. He felt that her pathology was degenerative and pre-existing in nature. He testified that the activity of simply reaching up overhead did not involve sufficient force to cause or aggravate a rotator cuff tear. He testified that the pathology found was pre-existing and degenerative in nature and not unusual for someone in her age group. At the time of his deposition, he did review the surgical report from Dr. Li and again ruled out any causal connection indicating that she was basically reaching overhead, without any force a normal activity that you perform a thousand times a day. He was unaware of any literature or research that would suggest causal connection between the activity of reaching quickly and tearing the rotator cuff. He was unaware of any literature that would support the theory in terms of any aggravation. He testified that what Petitioner experienced when she reached her arm up was a manifestation of the pre-existing condition. He gave an example if "you have a broken leg and then the broken leg is operated on and you are told and encouraged to walk on it and bear weight on it, not only does that not produce pathology, but it stimulates the healing process, nonetheless, it produces symptoms; it's going to hurt. He testified that the fact that something produces pain does not mean it causes the pathology. He testified that she had a pre-existing condition, she was engaged in a benign activity and that it was painful. He testified that he saw no evidence on the MRI of an acute condition; it was degenerative.

CONCLUSIONS

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

The claimant in a workers' compensation case has the burden of proving, by a preponderance of the evidence, all of the elements of his claim, including proof that he suffered an accident which arose out of and in the course of his employment. 820 ILCS 305/2 (West 2008); *Metropolitan Water Reclamation District of*

Greater Chicago v. Illinois Workers' Compensation Comm'n, 407 Ill. App. 3d 1010, 1013, 944 N.E.2d 800, 348 Ill. Dec. 559 (2011). Both elements must be present at the time of the claimant's injury in order to justify compensation. *Illinois Bell Telephone Co. v. Industrial Comm'n*, 131 Ill. 2d 478, 483, 546 N.E.2d 603, 137 Ill. Dec. 658 (1989).

Injuries sustained at a place where a claimant might reasonably have been while performing his work duties are deemed to have been received in the course of his employment. *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill. 2d 52, 57, 541 N.E.2d 665, 133 Ill. Dec. 454 (1989). In this case, it is undisputed that the Petitioner's injuries were sustained in the course of her employment. The only issue for analysis in this case is whether the claimant's injuries arose out of her employment.

For an injury to "arise out of" the employment, its origin must be in some risk connected with, or incidental to, the employment so as to create a causal connection. *Caterpillar Tractor Co.*, 129 Ill. 2d at 58. There are three general types of risks to which an employee may be exposed: (1) risks that are distinctly associated with the employment: (2) risks that are personal to the employee; and (3) neutral risks that do not have any particular employment or personal characteristics. *Potenzo v. Illinois Workers' Compensation Comm'n*, 378 Ill. App. 3d 113, 116, 881 N.E.2d 523, 317 Ill. Dec. 355 (2007) (citing *Illinois Institute of Technology Research Institute,* 314 Ill. App. 3d 149, 162, 731 N.E.2d 795, 247 Ill. Dec. 22 (2000)).

In this case it is undisputed that at the time of her injury, Petitioner was in the process of cleaning a mini blind when she raised her left arm above her head quickly because she was afraid the blind may come loose and fall. All of the medical records establish, and Petitioner testified that, she had nothing in her left upper extremity when she reached up and that she did not yet come in contact with the mini blinds when she experienced her pain. Petitioner testified that she raised her arm in a quick fashion.

There is no evidence in the record tending to show that Petitioner suffered from some physical condition which caused her to raise her arm quickly, nor is the risk associated with raising one's arm distinctly associated with employment as a maid. Accordingly, the risk associated with raising an arm while cleaning a mini blind is neutral in nature. See *Metropolitan Water Reclamation District of Greater Chicago*, 407 Ill. App. 3d at 1014.

Injuries resulting from a neutral risk, such as the injury here, do not arise out of the employment and are not compensable under the Act unless the employee was exposed to the risk to a greater degree than the general public. *Illinois Institute of Technology Research Institute*, 314 Ill. App. 3d at 163. The increased risk may be either qualitative, that is when some aspect of the employment contributes to the risk; or quantitative, such as when the employee is exposed to the risk more frequently than the general public. *Metropolitan Water Reclamation District of Greater Chicago*, 407 Ill. App. 3d at 1014.

Nothing in the record suggests that some aspect of the Petitioner's employment contributed to the risk of raising her arm, so as to be said to constitute a qualitative increase in the risk faced by the general public. The question then is whether Petitioner was exposed to the risk of tripping on a step more frequently than the general public.

The risk of raising one's arm is a risk to which the general public is exposed daily. There is no evidence in the record to suggest that Petitioner was required to raise her arms more frequently than the general public. In

fact, there is no evidence as to how frequently Petitioner was required to clean mini blinds or lift her arm above her head.

The Arbitrator finds that Petitioner was performing an activity of daily life, merely reaching up when she experienced pain in her left shoulder. Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner failed to establish that she sustained injuries which arouse out of and in the course of her employment. Benefits are therefore denied. All other issues are moot.

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 down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MICHAEL GOYETTE,
Petitioner,

vs.

NO: 14 WC 19036

A & R LOGISTICS,
Respondent.

ORDER

This matter comes before Commissioner Maria E. Portela pursuant to the Circuit Court's Order of Judge Michael F. Otto, filed February 8, 2019, in Case Number 2018 L 050414. Subsequently, the parties appeared before Commissioner Portela on April 17, 2019 requesting the case be remanded pursuant to the Circuit Court's Order.

Pursuant to the Circuit Court's Order, this matter is hereby remanded to Arbitrator Ory for the limited purpose of conducting a hearing to determine the admissibility of the hearsay document (Exhibit R#9), which may not be altered by Respondent.

IT IS THEREFORE ORDERED BY THE COMMISSION that this matter is remanded back to Arbitrator Ory for further proceedings consistent with the aforementioned Order of February 8, 2019.

APR 23 2019

DATED:
MEP/dmm
041719
049

Maria Elena Portela

Maria E. Portela
Commissioner

STATE OF ILLINOIS)
) SS.
COUNTY OF WILLIAMSON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

David Eldracher,

Petitioner,

vs.

NO: 13 WC 18297

Bowen Engineering,

19IWCC0197

Respondent.

DECISION AND OPINION ON REMAND

This matter comes before the Commission following the remand order of Judge Charles C. Cavaness of the Circuit Court of the First Judicial Circuit instructing the Commission to reverse its denial of accident and causation. Judge Cavaness also instructed the Commission to address the remaining contested issues. The Commission, after considering the remaining issues of temporary total disability (TTD), maintenance benefits, and vocational rehabilitation, reverses the Decision of the Arbitrator and reverses its January 29, 2016, Decision and Opinion on Review (16 IWCC 77) for the reasons stated below. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Comm'n*, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

Findings of Fact

I. Procedural History

The Arbitrator filed an Arbitration Decision on May 18, 2015. The Arbitrator determined that Petitioner did not sustain an occupational disease due to an exposure arising out of or in the course of his employment. While the Arbitrator found that Petitioner proved he sustained a work-related exposure to hydrofluoride on his left arm on the date of accident, she concluded Petitioner's claim did not involve any complaints related to this limited physical exposure. The Arbitrator concluded that Petitioner failed to prove he sustained an occupational disease as a result of that exposure. She also concluded that Petitioner failed to prove his current condition of ill-being is causally related to the limited physical exposure. Consequently, the Arbitrator denied all benefits.

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Petitioner filed for review of the Arbitrator's Decision. Petitioner argued that the Commission should reverse the Arbitration Decision in its entirety and award proper benefits. In its January 29, 2016, Decision and Opinion on Review, the Commission affirmed and adopted the Arbitration Decision (16 IWCC 77).

Petitioner then filed for administrative review of the Commission Decision in the Circuit Court of the First Judicial Circuit, Union County. After providing a review of the medical evidence, Judge Cavaness issued an order on February 7, 2017, in which he found the Commission Decision to be against the manifest weight of the evidence. He thus reversed the January 29, 2016, Commission Decision and remanded the case to the Commission for further findings consistent with his order.

II. Facts

The Commission notes that the facts of the case were thoroughly addressed in the May 15, 2018, Arbitration Decision. In the interest of efficiency, the Commission primarily adopts the facts previously stated in Arbitration Decision. The Commission makes the following findings relating specifically to the issues of TTD, maintenance, and vocational rehabilitation.

Petitioner, an ironworker, alleged he sustained pulmonary issues due to his exposure to hydrofluoride on February 6, 2013. Petitioner testified that debris from a beam fell into his left sleeve and dusted the back of his neck. A short time later, Petitioner noticed an irritation on his left arm and visited the on-site medical facility. Petitioner eventually began experiencing shortness of breath and other respiratory complaints as well as headaches and eye irritation. These symptoms progressively worsened throughout 2013. Petitioner began treatment with Dr. Tuteur, who diagnosed irritant induced bronchial reactivity predominantly in the smaller airways due to Petitioner's exposure while at work. He concluded that Petitioner could not return to work as an ironworker. Petitioner currently has restrictions on exercise and activity due to his shortness of breath.

The submitted evidence reveals that Petitioner continued to work full duty from the date of accident through March 24, 2013. Petitioner testified that he worked a few other jobs through the union until June 30, 2013. Petitioner testified that after June 30, 2013, he had to stop working due to his worsening condition. There are no medical records addressing any work restrictions beginning July 1, 2013. On August 9, 2013, Petitioner visited the ER with complaints of shortness of breath. The ER doctor prescribed lifting restrictions for four weeks and restricted Petitioner from traversing more than two flights of stairs for two weeks. On September 27, 2013, Dr. Tuteur determined that Petitioner could no longer continue working as an ironworker due to Petitioner's work-related respiratory condition. He also prescribed restrictions on Petitioner's exercise and activity. Dr. Tuteur last examined Petitioner on July 25, 2014. On that date, the doctor continued restrictions on Petitioner's activity due to his ongoing shortness of breath.

Petitioner has not worked in any capacity since June 30, 2015. Petitioner testified that he conducted a job search and has not been able to find employment within his restrictions. He submitted notes from six companies stating that Petitioner is unable to work at the companies due to his permanent restrictions regarding his exposure to dust and chemicals. (PX14). One note is

undated, and the remaining notes are dated December 19, 2013. The notes state the following:

> "[Petitioner] is not qualified to work in this establishment. He is not qualified or licensed to work in this business." Touch of Class
>
> "[Petitioner] is not able to apply and work for McDonalds. We use chemicals to clean and we have hot grills and fryer vats." McDonalds
>
> "[Petitioner] has applied for employment 12-19-13 at this time no job available…"
>
> "[Petitioner] is not able to work for Auto Tire & Parts we have chemicals in building. Also we are located in a flood plain."
>
> "[Petitioner] is not able to work in our store. Our building is old and floods so we have mold and our items are old and dirty." Bargain Depot
>
> "[Petitioner] is not eligible for hire as he is not able to handle cleaners, sprays, and glue sold at my store, as it is explained to me." Bill Peters Hardware

Petitioner attended a vocational assessment with Liala Slaise, a vocational rehabilitation consultant on September 16, 2014. (PX12). Ms. Slaise issued a detailed Initial Vocational Report on September 19, 2014. After reviewing the medical records and meeting with Petitioner, Ms. Slaise opined, "It is this consultant's opinion, with a certain degree of vocational certainty that jobs that have a controlled environment such as a biotech or medical lab that are sensitive to perfumes, odors and contaminants, a clean room in a warehouse or manufacturing environment, or a work from home position would be employment options for [Petitioner]." As Petitioner would need a job with limited or superficial contact with the public, coworkers, or work environments with odors that would aggravate his respiratory condition, Ms. Slaise recommended a Labor Market Survey to determine potential employment options for Petitioner.

Conclusions of Law

Pursuant to the explicit mandate of the Circuit Court, the Commission must reverse its January 29, 2016, Decision and find that Petitioner sustained an occupational disease arising out of and in the course of his employment on February 6, 2013. The Commission also must find that Petitioner's current condition of ill-being is causally related to the occupational exposure. Due to this reversal, the Commission now must address the remaining issues of TTD benefits, maintenance benefits, and vocational rehabilitation.

After carefully reviewing the totality of the evidence, the Commission finds Petitioner proved he is entitled to TTD benefits. Petitioner alleges an entitlement to TTD from July 1, 2013 through September 3, 2014, representing 61-27 weeks. However, based on the evidence, Petitioner only met his burden of proving an entitlement to TTD from September 27, 2013 through July 25,

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2014, representing 43-1/7 weeks. Petitioner has not worked since June 30, 2013. However, there is no credible evidence that any doctor restricted Petitioner from work in any capacity prior to Petitioner's September 27, 2013, office visit with Dr. Tuteur. Petitioner testified that he had to stop working due to his worsening condition; however, no doctor took him off work during this period. Petitioner visited the ER on August 9, 2013, and the doctor prescribed lifting restrictions for four weeks and restrictions regarding his ability to traverse more than two flights of stairs for two weeks. There is no evidence that Petitioner could not perform his job as an ironworker with these restrictions. Dr. Tuteur examined Petitioner on September 27, 2013, and restricted Petitioner from returning to work as an ironworker. Thus, Petitioner's entitlement to TTD begins on September 27, 2013. While no doctor formally placed Petitioner at MMI, Petitioner last sought treatment with Dr. Tuteur on July 25, 2014. On that date, the doctor again restricted Petitioner's activity due to his ongoing respiratory complaints. After carefully considering the evidence, the Commission finds Petitioner reached MMI on July 25, 2014, as this was his last day he actively sought treatment from his treating physician for his respiratory condition. For the foregoing reasons, the Commission finds Petitioner met his burden of proving an entitlement to TTD from September 27, 2013, through July 25, 2014, or 43-1/7 weeks. The parties stipulated that Respondent has paid $56,615.14 in TTD benefits and shall receive a credit for that amount.

Petitioner also claims an entitlement to vocational rehabilitation as well as maintenance benefits from September 4, 2014, through March 13, 2015, the date of hearing. After reviewing all the evidence, the Commission finds Petitioner is entitled to vocational rehabilitation in the form of the recommended Labor Market Survey and a very limited period of maintenance benefits. Pursuant to the Act, an employer shall pay for "treatment, instruction and training necessary for the physical, mental and vocational rehabilitation of the employee, including all maintenance costs and expenses incidental thereto." 820 ILCS 305/8(a). A claimant is only entitled to maintenance while the claimant is engaged in vocational rehabilitation. *W.B. Olson Inc. v. Illinois Workers' Compensation Comm'n*, 2012 IL App (1st) 113129WC, ¶ 39. Generally, a claimant is 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." *Euclid Beverage v. Illinois Workers' Compensation Comm'n*, 219 IL App (2d) 180090WC, ¶ 29 (quoting *Greaney v. Industrial Comm'n*, 358 Ill. App. 3d 1002, 1029 (2005)).

Here, Respondent hired Triune Health Group to complete a vocational assessment. (PX12). The company first contacted counsel for Petitioner on September 3, 2014. The assigned vocational consultant, Liala Slaise, reviewed medical records and met with Petitioner in person to review his educational and employment history on September 16, 2014. Her vocational report is dated September 19, 2014. After considering Petitioner's functional guidelines, including his background, education, work history, and restrictions prescribed by Dr. Tuteur, Ms. Slaise opined that jobs with a controlled environment such as a biotech or medical laboratory would be appropriate employment options. Ms. Slaise recommended a Labor Market Survey to identify employers in Petitioner's local area that have appropriate positions available before proceeding with any potential job placement services. The Commission finds Respondent must proceed with vocational rehabilitation services as recommended by Ms. Slaise in her September 16, 2014, report. To determine whether a formal vocational rehabilitation program is appropriate, Respondent shall authorize Ms. Slaise, or another qualified vocational counselor, to complete a Labor Market Survey.

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While the Commission finds Petitioner is entitled to the recommended Labor Market Survey, it also finds Petitioner failed to meet his burden of proving an entitlement to maintenance benefits from September 3, 2014, through March 13, 2015. It is abundantly clear from the evidence that apart from the period during which the vocational assessment was being planned and completed, Petitioner failed to engage in any meaningful vocational rehabilitation. Respondent's failure to authorize the recommended Labor Market Survey does not negate Petitioner's obligation to at the very least engage in a diligent self-directed job search. The Commission finds the six notes Petitioner submitted do not come close to meeting the requirements of a diligent self-directed job search. For example, there is no evidence that Petitioner contacted the employers regarding an available position; instead, it appears that Petitioner randomly visited employers whose work locations most likely would involve chemicals and other irritants and requested a note confirming the locations could not accommodate his restrictions. As further evidence that Petitioner did not attempt to conduct a legitimate job search, Petitioner visited all six employers on the same day. Petitioner did not even spend a full week conducting his alleged job search. For the foregoing reasons, the Commission finds Petitioner is only entitled to maintenance from September 3, 2014, through September 19, 2014, or 2-3/7 weeks. This represents the period during which the vocational assessment was arranged and completed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 18, 2015, reversed. The Decision of the Commission filed January 29, 2016, is also reversed.

IT IS FURTHER ORDERED that Petitioner sustained an occupational disease arising out of and in the course of his employment on February 6, 2013.

IT IS FURTHER ORDERED that Petitioner's current condition of ill-being relating to his irritant induced bronchial reactivity is causally related to the February 6, 2013, occupational exposure to hydrofluoride.

IT IS FURTHER ORDERED that Respondent shall approve and pay for a Labor Market Survey as recommended by the vocational consultant, Liala Slaise.

IT IS FURTHER ORDERED that Respondent shall pay Petitioner temporary total disability benefits of $**$1,129.64**/week for **43-1/7** weeks, commencing **September 27, 2013** through **July 25, 2014**, as provided in Section 8(b) of the Act. Respondent shall receive a credit in the amount of $56,615.14 for temporary total disability benefits previously paid to Petitioner.

IT IS FURTHER ORDERED that Respondent shall pay Petitioner maintenance benefits of **$1,129.64**/week for **2-3/7** weeks, commencing **September 3, 2014** through **September 19, 2014**, as provided in Section 8(a) of the Act.

IT IS FURTHER ORDERED that Respondent maintains a credit after its $56,615.14 credit is applied to the TTD and maintenance benefits awarded herein. Any remaining balance of Respondent's credit for prior compensation shall be applied to future maintenance benefits, if any, or a future award of permanency, if any.

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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 receive a credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $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: APR 2 3 2019

d: 1/14/19
TJT/jds
51

Thomas J. Tyrrell

Michael J. Brennan

STATE OF ILLINOIS)
) SS.
COUNTY OF PEORIA)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DAVID ANDERSON,

Petitioner,

vs.

NO: 16 WC 19543

CATERPILLAR, INC.,

Respondent.

19IWCC0198

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

Findings of Fact and Conclusions of Law

The Commission affirms and adopts the Arbitrator's Findings of Fact. The Commission also affirms and adopts the Arbitrator's Conclusions of Law except with respect to the last paragraph under issue (L) pertaining to the nature and extent of Petitioner's injuries. The Arbitrator found that the injury Petitioner sustained caused zero percent loss of use of the left arm. The Commission concludes otherwise. Based upon the fact that the parties stipulated to accident and the Arbitrator's findings regarding causal connection, the Commission finds that Petitioner sustained injuries that resulted in permanent partial disability as a result of his employment with Respondent.

The determination of permanent partial disability is not simply a calculation, but an evaluation of all five factors as stated in the Act. In making this evaluation of permanent partial disability, consideration is not given to any single enumerated factor as the sole determinant.

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Although the Commission agrees with the Arbitrator's evaluation of the five factors under Section 8.1b(b), the Commission assigns greater weight than the Arbitrator to Subsection (iii) of Section 8.1b(b). The Commission notes Petitioner testified that he limited his activities due to a fear of injuring his left elbow. The Commission concludes that since Petitioner is only at the midpoint of his career, he will work with the effects of his left arm condition for a substantial amount of time before the end of his work life. Therefore, after reviewing the entire record, and applying §8.1b(b) of the Act, the Commission concludes Petitioner suffered a 7.5% loss of use of a left arm under Section 8(e) as the result of the March 24, 2016 work-related accident.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on July 2, 2018, is hereby modified for the reasons stated herein, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $443.07 per week for a period of 14-6/7 weeks, from June 15, 2016 through September 26, 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 pay to Petitioner the sum of $398.76 per week for a period of 18.975 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the loss of use of 7.5% of the left arm.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner failed to prove, by a preponderance of the evidence, entitlement to payment for medical, surgical, hospital, or prescription expenses, beyond those already paid by Respondent, pursuant to §8(a) and §8.2 of the Act.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $14,400.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: APR 24 2019
TJT/bsd
O:03/05/19
42

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ANDERSON, DAVID
Employee/Petitioner

Case# **16WC019543**

CATERPILLAR INC
Employer/Respondent

19IWCC0198

On 7/2/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 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:

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

2994 CATERPILLAR INC
MARK FLANNERY
100 N E ADAMS ST
PEORIA, IL 61629-7140

19IWCC0198

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

David Anderson
Employee/Petitioner

v.

Caterpillar, Inc.
Employer/Respondent

Case # 16 WC 19543

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

DISPUTED ISSUES

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

FINDINGS

On **March 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.

Per the stipulation of the parties, in the year preceding the injury Petitioner earned **$34,548.40**; the average weekly wage was **$664.60**.

On the date of accident, Petitioner was **44** years of age, ***single*** with **0** dependent children.

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, **$0** in non-occupational indemnity disability benefits and **$0** for other benefits, for a total credit of **$0.**

Respondent is entitled to a credit for 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

Petitioner failed to prove an entitlement to payment for medical, surgical, hospital, or prescription expenses, beyond those already paid by Respondent, pursuant to Sections 8(a) and 8.2 of the Act, by a preponderance of the evidence.

Respondent shall pay Petitioner temporary total disability benefits of **$443.07**/week for **14 6/7** weeks, **for the timeframe of June 15, 2016 through September 26, 2016,** as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the sum of **$398.76 week** for a period of **0 weeks**, as provided in **Section 8(e)** of the Act, because the injuries sustained caused **0% loss of use of the left arm.**

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.

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

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

6/28/18
Date

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

David Anderson
Employee/Petitioner

Case # 16 WC 19543

v.

Consolidated cases: N/A

Caterpillar, Inc.
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that on March 24, 2016, he was employed by Respondent at its Morton facility as a material handler. Petitioner described his work duties as looking on the computer screen and seeing his orders, then packing parts. He testified that he would fill orders for screws, washers, big bolts and starters. He testified that he would pack parts into boxes, filling approximately 200 orders per day. He testified that the heaviest part he would lift was about 40-45 pounds. He testified that he was still a material handler up until the time that he voluntarily resigned on April 1, 2016.

Petitioner testified that he would work 8-hour days, but that during the busy season he would be forced to work 10-hour days and some Saturdays. He testified that he is right hand dominant, but that every aspect of the job required him to use both of his hands and arms. He testified that if there were not enough boxes, he would have to build boxes using staple guns to do so.

Petitioner testified that he was feeling sharp, throbbing pain in his left elbow in the summer of 2015. He testified that the problem worsened in March of 2016, and that he reported it and sought medical attention for the first time. He testified that he waited from summer 2015 to March 2016 because he thought the problem would go away.

Petitioner testified that on March 25, 2016, he went to Respondent's medical department and saw a nurse. He testified that he filled out an incident report. He testified that he did not follow-up with Respondent's medical department because he voluntarily left his job on April 1, 2016. He testified that he left his job for better opportunities; because it was stressful work; and that he was trying to find something that would be less physical work. He testified that he relocated to the Chicago area, and that he believed the town to which he relocated was that of Great Lakes. Petitioner testified that he was not under any work restrictions from any doctor from the time he left work at Caterpillar up until the time he started treating with Dr. Rhode. He testified that when he left Caterpillar, he looked for work. He testified that he felt the pain in his elbow, so he could not rightfully go to work and was trying to wait and see if the pain in his elbow would go away. The Arbitrator notes that no job search-related documentation was entered into evidence at the time of arbitration.

Petitioner testified that at some point, he returned back to Peoria. He testified that he did not have a primary care physician in June of 2016, so he asked his attorney for names of doctors and went to Dr. Rhode. He testified that he was not employed from the time he left Caterpillar until the time he came under the care of Dr. Rhode. He testified that Dr. Rhode provided him with an elbow injection and that the

injection lasted a couple of days and then faded. He testified that Dr. Rhode gave him a sheet with some exercises he should do, which did not help with his arm. He testified that he was also provided with some medication from Dr. Rhode's office, which did not help. He further testified that he went to physical therapy at Dr. Rhode's office, which did not help resolve his symptoms. Petitioner could not recall how long he was in physical therapy with Dr. Rhode's office.

Petitioner testified that he had surgery on September 27, 2016, and thereafter was released to full duty by Dr. Rhode's office on December 22, 2016. He testified that he was not employed at any time up until the full duty release. He testified that he was discharged from care by Dr. Rhode's office on January 19, 2017, and has not been seen since.

Petitioner testified that he is currently employed at Houston Methodist Hospital in Houston, Texas. He testified that he started working there on June 5, 2017. He testified that he was unemployed from the time he left Caterpillar until the time he started working at Methodist. He testified that he has not gone back to any medical providers for problems related to the left arm since he was released by Dr. Rhode on January 19, 2017. Petitioner indicated that he currently has no symptoms in the left arm. Petitioner denied any problems with his left arm that he did not have prior to his injury. Petitioner indicated that he does not do as many physical activities as he was performing before because "I'm afraid I might hurt my arm again."

Petitioner testified that at Methodist Hospital, he is a floor tech and that he uses a dust mop, then a floor scrubber, and then he buffs the floor. He testified that the floor scrubber and the floor buffer have two handles and are motorized, although he denied that they vibrate. He testified that he performs these three tasks 8 hours per shift. He testified that he has not had any problems with his left elbow doing that work. He testified that once Dr. Rhode released him from care, he went to Houston in late February of March of 2017 and looked for work, but was not employed until he obtained the hospital job in June of 2017. He testified that he earns a base of $13.60 per hour, plus a night shift premium that leaves him at "$14 something" per hour.

The Amended Application for Adjustment of Claim was entered into evidence at the time of arbitration as Petitioner's Exhibit 1.

The Incident Report dated March 4, 2016 was entered into evidence at the time of arbitration as Petitioner's Exhibit 2. The report reflects that Petitioner noted that on March 24, 2016, he was "picking" parts and felt a pain in his left elbow. (PX2).

Petitioner's Job Description Form was entered into evidence at the time of arbitration as Petitioner's Exhibit 3.

The Interpretive Report for the MRI of the Left Elbow dated June 23, 2016 was entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The report reflects that the films were interpreted as revealing mild tendinosis of the common extensor tendon insertion consistent with lateral epicondylitis; no tear. (PX4).

The medical records of Orland Park Orthopedics were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. The records reflect that Petitioner was seen on June 15, 2016, at which time it was noted that he presented as a self-choice for evaluation of a work-related left elbow injury that developed approximately six months ago. It was noted that Petitioner complained of lateral elbow pain which was made worse by performing his job duties, that he worked as a material handler for Caterpillar, that he was required to pack parts that varied and weighed as much as 45 pounds, and that he would be required to fill 200 orders per shift. It was noted that Petitioner stated that he performed these work activities for five years, that his last date worked was in March of 2016 when he moved to Chicago and that

he stated that he went to the employer nurse in March and filled out a report. It was noted that Petitioner had not worked since March but continued to be symptomatic, and that his past medical history was significant for a right lateral epicondylar release performed for a work-related injury while working at Caterpillar. It was noted that Petitioner demonstrated evidence of left elbow lateral epicondylitis, that he related that he developed his lateral epicondylitis symptomatology approximately six months ago, that he stated that he reported his symptomatology in March of 2016 and filled out a report, that he subsequently terminated his employment at Caterpillar in the interest of moving to Chicago and that he had since returned to the Peoria area and continued to experience symptomatology. It was noted that Dr. Rhode opined that Petitioner's job duties appeared to be sufficiently forceful and repetitious, that his exposure dose was over the course of five years and that it was somewhat concerning that Petitioner was presenting for evaluation three months after his last date of employment. Dr. Rhode noted that if Petitioner did indeed fill out a work-related incident form with the plant nurse in March that he believed that it supported a causal connection to his job as a material handler and that if there was no documentation, Dr. Rhode was somewhat concerned about the gap in treatment with presentation three months after his last date worked. Petitioner was recommended to undergo an MRI. It was noted that Petitioner was off duty. A Work Status form dated June 15, 2016 noted that Petitioner was off duty. (PX5).

The records of Orland Park Orthopedics reflect that Petitioner was seen on June 29, 2016, at which time it was noted that he continued to experience lateral epicondyle pain. It was noted that the left lateral epicondyle was injected on that date and that there were no complications. It was noted that Petitioner was also taught a home stretching program. It was noted that Petitioner was off duty and was to follow-up in four weeks. A Work Status form dated June 29, 2016 noted that Petitioner was off duty. At the time of the July 27, 2016 visit, it was noted that Petitioner continued to experience lateral epicondyle pain and that he stated that the injection provided approximately two weeks of relief. It was noted that Petitioner continued to be subjectively and objectively positive for lateral epicondylitis, that treatment options had been discussed and that he had attempted relative rest, home stretching, oral medications and injections. It was noted that Petitioner was unwilling to live with his current symptoms and that he wished to proceed with a lateral epicondyle release. A Work Status form dated July 27, 2016 noted that Petitioner was off duty. (PX5).

The records of Orland Park Orthopedics reflect that on August 18, 2016, Dr. Rhode was in receipt of a utilization review as performed by Dr. Brecker. It was noted that authorization had been requested and that Dr. Rhode did not feel that this represented a chronic, avascular condition and that he felt that 12 months of conservative care was a significant burden on the worker's compensation system. It was noted that they would continue with a conservative course and institute a physical therapy program, lateral epicondyle injections, activity modifications and oral medications. It was also noted that an appeal would be requested. At the time of the August 29, 2016 visit, it was noted that Petitioner continued to experience lateral epicondyle pain, that he had tried over-the-counter NSAIDs, rest and an injection that provided approximately two weeks of relief, and that he was waiting for surgery authorization. It was noted that Petitioner stated that it was worsening and that he wanted to try an oral medication. It was noted that Petitioner continued to be subjectively and objectively positive for lateral epicondylitis and that he had not trialed a course of physical therapy. It was noted that physical therapy would be started while Petitioner awaited surgery approval and that he was also to start on Meloxicam and Dendracin cream. A Work Status form dated August 29, 2016 noted that Petitioner was off duty. (PX5).

The records of Orland Park Orthopedics reflect that Petitioner underwent a physical therapy assessment on August 29, 2016 and that he underwent physical therapy on September 8, 2016. The September 14, 2016 addendum noted that Petitioner called and stated that he was scheduled for left elbow surgery with Dr. Rhode on or around September 27, 2016 and that he was unsure if he needed to continue physical therapy until surgery. It was noted that physician's assistant Welke approved for Petitioner to be placed on hold from physical therapy until after he had left elbow surgery "pending MD desires." At the

time of the October 10, 2016 visit, it was noted that Petitioner was seen in follow-up of left elbow lateral extensor tendon repair surgery. It was noted that Petitioner was having little pain but just some soreness and stiffness and that he had been icing it. It was noted that stretching exercises were demonstrated and that he was to avoid any weightbearing over one pound on the left side. Petitioner was to continue to ice and take Meloxicam. A Work Status form dated October 10, 2016 noted that Petitioner was off duty. (PX5).

The records of Orland Park Orthopedics reflect that Petitioner was seen on November 2, 2016, at which time it was noted that he continued to perform a home exercise program. It was noted that Petitioner was to continue with a home stretching program, was off duty and was to follow-up in four weeks. A Work Status form dated November 2, 2016 noted that Petitioner was off duty. At the time of the December 22, 2016 visit, it was noted that Petitioner continued to perform a home exercise program, was having little pain and had been off duty but felt ready to return. It was noted that Petitioner was to continue with a home stretching program and was to undergo a trial of full duty. A Work Status form dated December 22, 2016, 2016 noted that Petitioner was released to full duty for the left upper extremity. At the time of the January 19, 2017 visit, it was noted that Petitioner continued to perform a home exercise program, that he was released to full duty but was laid off so had not yet returned and that he was symptom-free. It was noted that Petitioner was to continue with a home stretching program and was also to continue at full duty if he could return to work without symptoms. It was also noted that Petitioner was to return in one month to consider maximum medical improvement. (PX5).

The Operative Report dated September 27, 2016 was entered into evidence at the time of arbitration as Petitioner's Exhibit 6. The report reflects that Petitioner underwent left open lateral epicondyle release on September 27, 2016 for a pre- and post-operative diagnosis of left lateral epicondylitis. (PX6).

The Caterpillar Plant Medical Records were entered into evidence at the time of arbitration as Petitioner's Exhibit 7. The records reflect that the Initial Licensed Health Care Professional Incident/Injury Form dated March 25, 2016 noted that Petitioner was seen with complaints of left elbow pain, that he noted his pain was a 3 (ache), that he stated that he was working picking parts and felt a pain in his left elbow and that it happened on March 24, 2016 at approximately 0230 a.m. It was noted that Petitioner had no limited range of motion, no swelling, no bruising, no radiating pain and that it ached at the elbow. Per the Progress Note dated March 31, 2016, the incident was deemed occupational. (PX7).

The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 8.

The Caterpillar Corporate Medical Records were entered into evidence at the time of arbitration as Respondent's Exhibit 1. The records were effectively duplicative of those as contained in Petitioner's Exhibit 7. (RX1; PX7).

The IDHFS Lien was entered into evidence at the time of arbitration as Respondent's Exhibit 2.

The report of Dr. Brecher was entered into evidence at the time of arbitration as Respondent's Exhibit 3. The report noted that the left lateral epicondyle release was not certified as medically necessary and noted that the ODG required 12 months of conservative treatment which had not yet failed. (RX3).

The Wage Records were entered into evidence at the time of arbitration as Respondent's Exhibit 4.

The transcript of the deposition of Dr. Allan Brecher was entered into evidence at the time of arbitration as Respondent's Exhibit 5. Dr. Brecher testified that he is a board-certified orthopedic surgeon and that he performed a peer review regarding a proposed surgery for Petitioner. He testified that he used the Official Disability Guidelines ("ODG"), which is recognized as a commonly used guide for the

necessity and performance of treatment. He testified that the standard was generally consistent with his own experience and practice. (RX5).

Dr. Brecher testified that based upon the materials that he had reviewed and the standard, he opined that the surgery for the lateral epicondylitis was premature at that point in time. He testified that most cases of lateral epicondylitis resolved with conservative care that could take six months to a year, and that Petitioner had not had that treatment. He testified that the conservative measures that he would expect to see based not only on the guideline but also his own experience and practice were those of therapy, bracing, ice, anti-inflammatories and perhaps one injection as well as rest. When asked if conservative measures were not employed to the standard as of the date of the deposition[1] and whether he would have the same opinion, Dr. Brecher responded affirmatively. (RX5).

On cross examination, Dr. Brecher testified that he is self-employed at Orthopedics Midwest and that the hospital at which he worked the most was that of MacNeal Hospital. He testified that he believed that "NMR" was registered with the Illinois Department of Insurance to perform utilization reviews, but that he could not say that with any certainty. He testified that he performed utilization reviews on a regular basis in his practice and that it constituted approximately 10-15% of his practice at a maximum, as compared to treating patients. (RX5).

On cross examination, Dr. Brecher testified that he has used the ODG guidelines for almost 10 years and was fairly familiar with them. He testified that he was aware that the ODG guidelines had been removed from a federal database of approved clinical practice guidelines in the summer of 2016. (RX5).

On cross examination, Dr. Brecher testified that he reviewed the medical records, attempted to contact the treating physician and then reviewed the ODG guidelines. He testified that the treating physician could give him information that was not clearly in the report and that it might alter his decision-making. He testified that he left a message for Dr. Rhode to call him back, but that he apparently never did. (RX5).

On cross examination, Dr. Brecher agreed that he only performed a utilization review in this case and that he did not perform an IME or offer any opinions with regard to causation. When asked if there was a difference between chronic lateral epicondylitis versus left lateral epicondylitis noted in the ODG guidelines, Dr. Brecher responded that acute was less than three months and that chronic was over three months and that this was a general definition in medicine. He testified that Dr. Rhode referred to Petitioner's condition as lateral epicondylitis and that he did not refer to it as either chronic or acute. (RX5).

On cross examination when asked of the significance of the response to the injection in his determination, Dr. Brecher responded that sometimes one injection was all that was needed and that multiple injections probably would not help. As to the amount of conservative treatment, Dr. Brecher testified that there were some textbooks that indicated six months of treatment and that the ODG guidelines used to say six months and that they had changed to 12 months, but that in this case Petitioner had not even had six months of conservative care. (RX5).

The List of Approved Companies from Illinois Department of Insurance was entered into evidence at the time of arbitration as Respondent's Exhibit 6. The Payment History was entered into evidence at the time of arbitration as Respondent's Exhibit 7. The Allied Bill Review was entered into evidence at the time of arbitration as Respondent's Exhibit 8.

[1] The Arbitrator notes that the deposition took place on January 24, 2017.

The Letter of Resignation was entered into evidence at the time of arbitration as Respondent's Exhibit 9. The letter was dated April 1, 2016 and noted that Petitioner was leaving to pursue employment opportunities outside of Respondent. (RX9).

CONCLUSIONS OF LAW

With respect to 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 March 24, 2016.

The evidence reveals that Dr. Rhode opined that Petitioner's job duties appeared to be sufficiently forceful and repetitious, that his exposure dose was over the course of five years and that it was somewhat concerning that Petitioner was presenting for evaluation three months after his last date of employment. (PX5). Dr. Rhode noted that if Petitioner did indeed fill out a work-related incident form with the plant nurse in March that he believed that it supported a causal connection to his job as a material handler. (*Id.*). Per the Caterpillar Plant Medical Records Progress Note dated March 31, 2016, the incident was deemed occupational. (PX7; RX1). 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 March 24, 2016.

With respect to disputed issue (J) pertaining to reasonable and necessary medical services, the Arbitrator finds that Respondent has paid for all reasonable and necessary medical services for which it is responsible to pay pursuant to Sections 8(a) and 8.7 of the Act, and any award for any further medical care or treatment as claimed by Petitioner is denied.

A claimant maintains the burden of proving all the elements of his or her claim by a preponderance of credible evidence under the Illinois Workers' Compensation Act. *Johnson Outboards v. Indus. Comm'n*, 77 Ill.2d 67, 69, 394 N.E.2d 1176 (1979). The employer is required to pay, pursuant to the Act, medical expenses reasonably required to cure or relieve from the effects of an accidental injury. 820 ILCS 305/8(a). When a payment for medical services has been denied or not authorized by an employer or when authorization for medical services is denied pursuant to utilization review, the employee has the burden of proof to show by a preponderance of the evidence that a variance from the standard of care used by the person or entity performing the utilization review pursuant to Subsection (a) is reasonably required to cure or relieve the effects of his or her injury. 820 ILCS 305/8.7(i)(4).

In the case at hand, the evidence reveals that Respondent obtained a utilization review indicating a lack of medical necessity for the surgery performed by Dr. Rhode based upon a failure to use a sufficient effort at conservative treatment. (RX3). Dr. Brecher, Respondent's peer reviewer, indicated that depending on authority, conservative care should be employed for six months to one year before surgery would be considered based upon a failure, although he used the ODG to determine a 12-month period. (RX3; RX5). The opinion that surgery was not necessary and premature was based not only on the guidelines from ODG, but also Dr. Brecher's own experience in practice. (RX5). In this context, it is notable that Petitioner's MRI showed tendinosis but no tearing of the common extensor tendon. (PX4). Dr. Rhode performed surgery on September 27, 2016, but did not, in fact, note any specific pathology in the elbow at the time of his surgery. (PX6). Dr. Rhode provided one injection on June 29, 2016. (PX5). Dr. Rhode also gave Petitioner a home exercise program. (*Id.*). After Petitioner reported that he had received only two weeks of relief from the injection, Dr. Rhode recommended surgery on July 27, 2016. (*Id.*).

After Dr. Brecher's report was received, Dr. Rhode noted that an appeal would be requested in the entry dated August 18, 2016, but no appeal-related decision was included in the medical evidence submitted

by either party at the time of arbitration which, the Arbitrator notes, occurred nearly two years after such entry was made in the medical records. (PX5). After Dr. Brecher's report was received, Dr. Rhode's physician assistant also documented that a course of physical therapy would be tried "while he waits for surgery approval." (*Id.*). The medical evidence reveals that there were, in fact, only two physical therapy visits that took place on August 29, 2016 and September 8, 2016. (*Id.*). Dr. Rhode then scheduled the surgery and further physical therapy or other conservative modalities were cancelled. (*Id.*). The records of Dr. Rhode further reflect that anti-inflammatory medications were not, in fact, prescribed until August 29, 2016, which was after Dr. Rhode's receipt of the utilization review report. (*Id.*).

Dr. Rhode's response to the peer review of Dr. Brecher was to suggest that going through 12 months of conservative care would be a significant burden on the workers' compensation system. (PX5). The Arbitrator notes that Dr. Rhode in his medical records did not point to any reason why, given the MRI findings, the clinical presentation, or any other fact, Petitioner's condition of left lateral epicondylitis merited a variance from the standard of care established by nationally recognized peer reviewed guidelines pursuant to Section 8.7. Further, the Arbitrator infers from the notation that physical therapy would be tried "while he waits for surgery approval," that Dr. Rhode had already determined that surgery would ultimately be performed, and the Arbitrator further infers that the minimal efforts at conservative care after July 28, 2016, were arguably immeritorious. In sum, the medical evidence in this case reveals that Dr. Rhode made minimal efforts to deploy conservative therapy in an effort to avoid surgery, and did not provide any basis pursuant to Section 8.7 of the Act for a variance from the standard of care established by the utilization review. As a result thereof, the Arbitrator finds that Petitioner has failed to establish the medical necessity for the surgery by a preponderance of the evidence.

The Arbitrator notes that Petitioner placed various medical bills into evidence at arbitration. (PX8). The Arbitrator further notes that Respondent presented evidence of what it had paid for Petitioner's condition of ill-being. (RX7). It appears that Respondent paid the billings of Orland Park Orthopedics up through the date of service September 8, 2016, which was the last date of service prior to Petitioner's surgery. (*Id.*). As the remainder of the billings of Dr. Rhode of Orland Park Orthopedics were for the surgery and post-surgical care, these charges are hereby denied pursuant to Section 8(a) and Section 8.7 of the Act. Similarly, the billings for Bob Rady, Inc. and South Chicago Surgical Solutions are related to the surgery and likewise are hereby denied on the same basis. Regarding the charge of OSF St. Francis, the Arbitrator notes that this is for the date of service June 23, 2016, which was the date of Petitioner's MRI of the left elbow and is therefore compensable. The evidence reveals, however, that the billing for this date of service was already paid by Respondent pursuant to network contract or fee schedule. (RX7). That being the case, the Arbitrator finds that Respondent has paid for all reasonable and necessary medical services for which it is responsible to pay pursuant to Sections 8(a) and 8.7 of the Act, and any award for any further medical care or treatment as claimed by Petitioner is denied.

With respect to disputed issue (K) pertaining to temporary total disability, the Arbitrator notes that Petitioner seeks temporary total disability benefits for the timeframe of June 15, 2016 through December 22, 2016. (AX1).

The Act provides for temporary total disability to be paid for as long as the temporary total incapacity lasts. 820 ILCS 305/8(b). The purpose of the Act is to compensate an employee for lost earnings resulting from work related injuries. *Freeman United Coal Mining Co. v. Indus. Comm'n*, 99 Ill.2d 487, 496, 459 N.E.2d 1368 (1984). The Illinois Supreme Court has held that an employee is temporarily and totally disabled from the time that an injury incapacitates him from working until such time as he is as far recovered or restored as the permanent character of his injury will permit. *Archer Daniels Midland Co. v. Indus. Comm'n*, 138 Ill.2d 107, 118, 561 N.E.2d 623 (1990). The dispositive inquiry generally speaking as to when the period of temporary total disability would cease is whether or not the claimant has reached

maximum medical improvement. *Interstate Scaffolding, Inc. v. Illinois Workers' Comp. Comm'n*, 236 Ill.2d 132, 142, 923 N.E.2d 266 (2010). TTD benefits may be suspended or terminated before an employee reaches maximum medical improvement if he refuses to submit to medical, surgical, or hospital treatment essential to his recovery; refuses to cooperate in good faith with rehabilitation efforts; or refuses work falling within the physical restrictions prescribed by his doctor. *Interstate Scaffolding, Inc.*, 236 Ill.2d at 146. To establish entitlement to TTD benefits, an injured employee must prove not only that he did not work, but also that he was unable to work. *Pietrzak v. Indus. Comm'n*, 329 Ill.App.3d 828, 832, 769 N.E.2d 66 (2002).

In the case at hand, the evidence reveals that Petitioner underwent surgery by Dr. Rhode on September 27, 2016. (PX6). As noted in disputed issue (J) above, the Arbitrator finds that surgery was not proven to be medically necessary. The issue of whether Petitioner is entitled to temporary total disability benefits for incapacity for work related to an unnecessary surgery was not explicitly decided by the Illinois Supreme Court in *Interstate Scaffolding*. It should be noted, however, that there is support for the position that when medical treatment continues which is unnecessary, lost time related to that medical treatment is not compensable as temporary total disability compensation. *Albert v. Roadway Express*, 08 IWCC 0216. In the case at hand, the surgery performed by Dr. Rhode was not medically necessary and, accordingly, Petitioner's lost time from September 27, 2016 through December 21, 2016, is hereby denied, as the Arbitrator finds that the lost time after September 27, 2016 was not causally related to the effects of the injury since it was engendered by treatment unnecessary to cure or relieve the effects of that injury.

As to the pre-surgery timeframe for which temporary total disability benefits are sought, the Arbitrator notes that prior to September 27, 2016, Petitioner was employed by Respondent until April 1, 2016 when he voluntarily resigned. (RX9). It is undisputed that Petitioner was not under any work-related restrictions up to the date of his voluntary separation. Thereafter, although he did not provide any job search documentation or identify any employers from whom he sought work, Petitioner testified that when he moved to the Chicago area, he sought work. The medical evidence reveals that Petitioner did not begin treating for his condition until he returned to the Peoria area in June of 2016 and was directed by his attorney to Dr. Rhode, to whom Petitioner indicated that he had not worked since March and continued to be symptomatic. (PX5).

The medical evidence reveals that Dr. Rhode took Petitioner off work entirely on June 15, 2016. (PX5). While the *Interstate Scaffolding* decision indicated that temporary total disability benefits may be suspended or terminated before an employee reaches maximum medical improvement if he refuses to submit to medical, surgical, or hospital treatment essential to his recovery; refuses to cooperate in good faith with rehabilitation efforts; or refuses work falling within the physical restrictions prescribed by his doctor, the Arbitrator finds that none of these situations exists in the case at hand. *Interstate Scaffolding, Inc.*, 236 Ill.2d at 146. Accordingly, the Arbitrator finds that Petitioner is entitled to temporary total disability benefits for the timeframe of June 15, 2016 through September 26, 2016, as there were corresponding off work slips from Dr. Rhode covering this particular timeframe and there was no contrary evidence suggesting that Petitioner was deemed to have been placed at maximum medical improvement at any point during this timeframe.

With respect to 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 no AMA rating was offered by either party in this matter. 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 at the time of the accident he was working for Respondent as a material handler/specialist and that he currently works as a floor tech, scrubbing and buffing floors for Methodist Hospital in Houston. The Arbitrator places lesser weight on this factor when making the permanency determination.

With respect to Subsection (iii) of Section 8.1b(b), Petitioner was 44 years old on the date of the accident at issue. In light of Petitioner's ability to continue to work without restrictions, the Arbitrator places greater weight on this factor when making the permanency determination.

With respect to Subsection (iv) of Section 8.1b(b), the Arbitrator notes that there was no evidence proffered at arbitration to demonstrate that Petitioner's work accident has impaired or otherwise affected his future earnings capacity, as Petitioner voluntarily resigned from his employment with Respondent and was under no work restrictions at the time of such resignation. The Arbitrator places lesser weight on this factor when making the permanency determination.

With respect to Subsection (v) of Section 8.1b(b), the Arbitrator notes that Petitioner testified that he has no pain, no symptoms, or problems related to the condition of his left arm, even though he is working in employment that requires the use of his arms. While Petitioner testified that he limited his activities due to a fear of injuring his left elbow, he did not testify that there were any activities of any kind that he engaged in that caused him any pain, problems or symptoms. At the time of the January 19, 2017 visit with Dr. Rhode's physician assistant, it was noted that Petitioner had a 0 QuickDASH score, that he had no tenderness to palpation of the elbow, and that he displayed 5/5 strength. It was also noted that Petitioner continued to perform a home exercise program, that he was released to full duty but was laid off so had not yet returned and that he was symptom-free. (PX5). 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 **0% loss of use of the left arm** as provided in 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	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DUSTIN STONE,

Petitioner,

vs.

NO: 08 WC 51795

19IWCC0199

CENTRAL ILLINOIS TRUSS,

Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission affirms and adopts the Arbitrator's Decision in its entirety noting that the Commission has no authority to commute the cost of future medical benefits, to which Petitioner is entitled, to an amount payable in a lump sum.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 29, 2018 is hereby modified for the reasons stated herein, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $206.67 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 the loss of use of 25% of the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay reasonable and necessary medical services in the amount of $12,435.69 as set forth in Petitioner's

19IWCC0199

exhibit 12, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall also authorize and pay for prospective medical care including but not limited to treatment as it relates to the left lower extremity amputation, other related complications such as back pain, and replacement/maintenance of the prosthesis, as provided in Sections 8(a) and 8.2 of the Act.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $38,400.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: APR 24 2019
TJT/bsd
O:3/5/19
42

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

STONE, DUSTIN
Employee/Petitioner

Case# **08WC051795**

CENTRAL ILLINOIS TRUSS
Employer/Respondent

19IWCC0199

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:

0724 JANSSEN LAW CENTER
JAY H JANSSEN
333 MAIN ST
PEORIA, IL 61602

5647 ACCIDENT FUND HOLDINGS
PERRY GENTILE
PO BOX 40785
LANSING, MI 48901

19IWCC0199

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

Dustin Stone
Employee/Petitioner

v.

Central Illinois Truss
Employer/Respondent

Case # 08 WC 51795

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 **Bloomington**, on **8/31/17**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

19IWCC0199

FINDINGS

On 11/10/08, 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 $; the average weekly wage was $327.33.

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 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 $12,435.69, as set forth in Petitioner's exhibit 12, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall authorize and pay for prospective medical care including but not limited to treatment as it relates to the left lower extremity amputation, other related complications such as back pain, and replacement/maintenance of the prosthesis, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $206.67/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.

Michael K. Nowak, Arbitrator

5/10/18
Date

ICArbDec p. 2

BACKGROUND

As a result of the accident described below a civil action was filed on behalf of Petitioner against Mitek Industries, the manufacturer of the roof truss machine, allegeding an unreasonably dangerous condition of the machine due to the defective safety bar. Mitek filed a Third-Party Complaint against Respondent (CIT) alleging that CIT knew of the defective condition and made repairs using duct tape.

The Tazewell County case, No. 08 L 155, was treid to a jury verdict on August 26, 2011, with the jury verdict being entered in the amount of $13,315,535.15 against Mitek Industries. (Pet. Ex. 4) CIT waived their workers' compensation lien and the Court deducted from the jury's damages award the amount of workers' compensation benefits CIT had paid up to that point ($228,637.56). The judgment was appealed to the Appellate Court Third District of the State of Illinois and an opinion was rendered in 2014 (2014 Ill App (3d) 120122-U), affirming the trial court judgment in its entirety. (Pet. Ex. 5) The judgment of approximately $17,000,000 including interest was paid in full by Mitek.

The final trial court judgment provides, in pertinent part:

> 6. Without a ruling from the IWCC (which we know is not forthcoming) or a stipulation amoung the parties as to the present value of future work comp benefits to Dustin Stone, the only apparent option left available to this court, as confined by existing case law, is to require Dustin Stone and CIT/Accident Fund to reimburse Mitek or its designee the amount of future work comp benefits that Dustin Stone is entitled to in the pending work comp proceeding as detailed in paragraph B below....
>
> B. As to Defendant's Third Party Complaint, and taking into account CIT's waiver of future workers' comp lien, CIT/Accident Fund and its successors are ORDERED to remit directly and payable to MITEK INDUSTRIES, INC., or its designees all future amounts of workers' compensation benefits (but no more than $3,927,810.09, inclusive of the amount referred to in paragraph 1 above) that Dustin Stone is eligible for, applies for, and is approved for in the ordinary course of his pending work comp proceeding before the IWCC. Dustin Stone is ordered to apply for eligible future benefits of any type in his pending case before the IWCC and enter into a stipulation with CIT/Accident Fund in the IWCC that any monetary benefits that would have otherwise been payable to or on behalf of Dustin Stone by CIT/Accident Fund in the ordinary course of the work comp proceeding will be remitted to MITEK as described herein. Dustin Stone is further ORDERED responsible for and shall pay directly himself any provider of such comp related services. That is, all eligible work comp bills should be submitted by Dustin Stone to CIT/Accident Fund who in turn will then pay the eligible work comp benefits directly to MITEK. Any non-medical benefits available to Dustin Stone in the ordinary course of such proceeding, after IWCC determination, would then be payable directly by Dustin Stone to MITEK. Any disputes as to eligible benefits can be resolved by the IWCC. (Pet Ex. 4)

The parties dispute is not as to the outstanding medical expenses or to Respondent's obligataion to pay future medical benefits, but rather the dispute pertains to the method of that payment.

FINDINGS OF FACT

Petitioner was employed with Central Illinois Truss (CIT) to work with a roof glider machine building roof trusses. On November 10, 2008, the safety bar that was operated by Petitioner did not operate because the screws vibrated loose and Respondent had attempted to correct the defective condition of the safety bar by placing duct tape around the C collar on the top cord side of the push bar, all unknown to Petitioner.

Petitioner's left leg was caught in the machine and he sustained an amputation above the left knee. (Pet. Ex. 2 and 3)

The disputed issues in this matter are medical expenses, primarily future expenses, and nature and extent.

Petitioner testified that he currently uses a passive C-leg prosthesis. It was noted that on the date of trial, the Petitioner ambulated without any other assistive device. Petitioner testified that he sometimes has difficulty fitting the prosthesis. He testified that he has back pain as a result of his altered gait. Petitioner testified that he has to go up stairs one at a time. He testified that in the future he would like to obtain a power knee prosthesis that might assist him with walking and stairs.

Petitioner testified that in 2011 he obtained employment at Gil's Restaurant as a fry cook. This position lasted a few months but the Petitioner resigned due to safety issues from grease on the kitchen floor. In 2013, the Petitioner obtained employment at Hardees but again the Petitioner left this position because of his perceived safety concerns as well as it being very hot.

Petitioner testified that he prevailed in the personal injury lawsuit and received a multi-million-dollar verdict. He testified that a trust was set up in his name from which he receives a monthly stipend. In addition to the trust, the Petitioner utilized the settlement funds to purchase a home in Princeville, IL.

Most notably with regards to income and employment, Petitioner testified that he purchased seven other homes in the central Illinois area. The Petitioner and his wife, established a management company for the seven properties owned by the Petitioner. The Petitioner testified that he rents these homes and receives rental income from each.

Other than owning the aforementioned homes and management company, Petitioner testified that in the last two years he submitted approximately 12 applications for employment. It is noted that Petitioner submitted no evidence of the alleged job search at trial. Petitioner testified that his job search was not going well and therefore he and his wife recently enrolled at a local community college, Illinois Central College (ICC), where he hopes to obtain a business degree.

At trial, Monkia Dabrowiecka, a Vocational Rehabilitation Consultant with Triune Health Group, testified on behalf of the Respondent. Ms. Dabrowiecka authored a vocational assessment and labor market survey reports. (Resp. Ex. 2 and 5) Ms. Dabrowiecka met with the Petitioner on February 22, 2017 for an interview. At the time of this meeting, the Petitioner reported experiencing phantom pain that increased with prolonged standing, stair climbing, or putting too much pressure on his leg. Nonetheless, Petitioner stated that he could tolerate walking for 20-30 minutes and sitting for 30 minutes before having to change positions.

Petitioner stated his mobility was improved but it takes him longer to walk. Petitioner stated that his balance and driving were fine. He struggled, however, with lifting heavy items.

Ms. Dabrowiecka relied on the opinions of Dr. Virkus for the purposes of her assessment in this case. According to the report from Dr. Virkus dated February 17, 2010, Dr. Virkus reviewed a work conditioning discharge report dated September 4, 2009 that found the Petitioner to be capable of lifting/carrying up to 50lbs frequently and 75lbs rarely. (Resp. Ex. 1) Petitioner was also cleared for stairs and ladders as well as walking and standing. Dr. Virkus opined, "I would limit his lifting and carrying to 75lbs, which he states he can do. Also, although he was cleared to go on ladders, based on his prosthesis I think this would be somewhat dangerous and although short step ladders would be fine I think he should avoid working on ladders at heights about 10 to 15 feet. I think these are going to be permanent restrictions for him." (Id.)

Ms. Dabrowiecka performed a labor market survey utilizing the restrictions found in the work conditioning discharge report and reiterated by Dr. Virkus. Ms. Dabrowiecka contacted 30 employers and received 16 responses. She opined that of the 16 responses, 14 positions were found to be within the Petitioner's work restrictions. Ms. Dabrowiecka opined that based on the information gathered, the Petitioner would be able to obtain a full-time position within his physical restrictions, skills, educational level, and work history with an anticipated salary between $10.00 and $15.00/hr.

At trial, Petitioner offered no evidence or opinion from a vocational rehabilitation expert to suggest that Petitioner is not employable.

Moreover, the Petitioner offered no evidence whatsoever from a medical expert to suggest that the Petitioner is permanently and totally disabled.

Petitioner submitted the Circuit Court trial testimony transcripts of two of the Petitioner's physicians, Dr. Savitha Reddy and Dr. Samir Gupta. There is no dispute regarding the necessity of the treatment rendered.

Dr. Reddy opined that Petitioner may require pain medications to help him with phantom leg pain and possible back pain. Dr. Reddy further testified that Petitioner will require adjustments to his prosthetic device for the remainder of his life. (Pet. Ex. 7)

Dr. Gupta is the physician who performed the amputation. He opined that the Petitioner might experience phantom pain after the injury. (Pet. Ex. 8)

Petitioner submitted the Circuit Court trial testimony of two prosthetists, Todd McCallister and John Michael (Pet. Ex. 9 and 10). These persons offered testimony regarding the type of prosthesis the Petitioner was utilizing, maintenance, and future needs including potential for a "power" knee.

Petitioner submitted the Circuit Court trial testimony of Dr. Charles Linke who testified that Petitioner will have future medical costs of $3,387,131.00.

CONCLUSIONS

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

The Respondent paid 100% loss use of the left lower extremity (215 weeks plus an additional 25 weeks as the amputation was above the knee) ($110,201.54 based on the minimum PPD rate for amputations $456.28). (Resp. Ex. 3)

The Petitioner provided no evidence from a medical professional that he is permanently and totally disabled. In fact, the only medical evidence offered of Petitioner's work status is the report from Dr. Virkus dated February 17, 2010. Of note, Dr. Virkus relied heavily on the work conditioning discharge report in formulating the permanent restrictions.

Respondent offered the testimony of a qualified Vocational Rehabilitation Consultant who opined that based on the information gathered, the Petitioner would be able to obtain a full-time position within his physical restrictions, skills, educational level, and work history with an anticipated salary between $10.00 and $15.00/hr.

In addition, Petitioner has not performed a diligent job search. Petitioner testified that in the last two years he contacted only 12 employers about work.

Significantly, the Arbitrator notes that the Petitioner has resumed employment as a landlord or property manager/investor. Petitioner testified that he purchased seven homes in central Illinois. He testified that he and his wife manage the homes and that he receives rental income from each.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner is not permanently and totally disabled.

Further the Arbitrator finds there is insufficient evidence in the record to support an award under section 8(d)1 of the Act. The parties stipulated that at the time of the accident Petitioner's average weekly wage was $327.33. There was no evidence of the number of hours worked or the duration of the pre-accident employment.

However, based of permantne restrictions as well as the residual symptoms from which Petitioner suffers and the loss of trade sustained, the Arbitrator awards an additional 25% loss use of the person based on a minimum PPD rate of $206.67. This award is in addition to the 100% loss use of the leg plus 25 weeks already paid by the Respondent.

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

Issue (O): Is Petitioner entitled to any prospective medical care?

Petitioner submitted the medical bills $12,435.69. These bills were for services rendered prior to or near the Final Trial Court Judgment of October 21, 2011. There is no dispute regarding reasonableness or necessity of the treatment rendered.

Respondent shall pay reasonable and necessary medical services of $12,435.69, as set forth in Petitioner's exhibit 12, as provided in Sections 8(a) and 8.2 of the Act.

With regard to prospective medical expenses there is no dispute that Petitioner will require future medical treatment as it relates to the left lower extremity amputation, other related complications such as back pain, and replacement/maintenance of the prosthesis.

It is understood that Petitioner's future medical rights under Section 8(a) remain open for life. The issue in this case is how those medical expenses should be awarded and paid.

It is Petitioner's position that Respondent owes subrogation on future medical expenses in the amount of $3,387,181.00. These future medical expenses have already been paid by Mitek Inc. and, pursuant to the Workers' Compensation Act 820 ILCS 305/5(b), Respondent is now obligated to pay, through Dustin Stone, the sum of $3,387,181 that Petitioner must turn over to Mitek pursuant to the Court Order of October 21, 2011. Petitioner further asserts that Respondent's obligation is in subrogation to Mitek, who paid in full projected future medical expenses. They claim Respondent is not to pay future medical costs to providers, but must reimburse Mitek through Dustin Stone, as Mitek paid all of Dustin's future medical costs in full.

Respondent points out, and correctly so, that the projected medical expenses of $3,387,181.00 have not yet been incurred or paid for. Although the jury verdict form indicates that the jury found the anticipated future medical expenses to be $3,387,181.00, the actual future medical expenses cannot be determined until the services are incurred. Respondent further asserts that all future medical expenses must be paid by Dustin Stone. Mr. Stone must provide a yearly accounting of said expenses to CIT/Accident Fund. CIT/Accident Fund must then issue reimbursement to Mitek or its designees.

The Arbitrator is unaware of any provision in the Act which requires, or even allows for an award of a specific dollar amount for medical expenses which are projected to be incurred in the future and the Arbitrator declines to do so.

The Arbitrator does find Petitioner is entitled to prospective medical care including but not limited to treatment as it relates to the left lower extremity amputation, other related complications such as back pain, and replacement/maintenance of the prosthesis. The Arbitrator further finds that Respondent shall pay said expenses as they are incurred and submitted, as provided in Sections 8(a) and 8.2 of the Act. In this case said payments should be made directly to Mitek pursuant to the Circuit Court order.

The Arbitrator is not unmindful of the Quandary resulting in the Circuit Court order as it relates to the fee schedule and who derives the benefit from its application. However, the Petitioner has been awarded the full amount of his projected medical expenses in the civil matter. The fact that Respondent applies the fee schedule to the amount it is required to pay Mitek pursuant to the civil action simply places Respondent in the same position it would have been if there were no civil award and assures a true measure of its liability under the Act pursuant to Kotecki.

12 WC 31334

STATE OF ILLINOIS)
) SS.
COUNTY OF PEORIA)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DENISE WAKEFIELD,

Petitioner,

vs. NO: 12 WC 31334

PEORIA PUBLIC SCHOOL DISTRICT 150,

19IWCC0200

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 causation, 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 September 7, 2017 is hereby affirmed and adopted.

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

12 WC 31334

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: APR 24 2019

D. Douglas McCarthy

Stephen J. Mathis

L. Elizabeth Coppoletti

DDM/dmm
O: 40919
52

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

WAKEFIELD, DENISE
Employee/Petitioner

Case# **12WC031334**

12WC031338

PEORIA PUBLIC SCHOOL DISTRICT 150
Employer/Respondent

19IWCC0200

On 9/7/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.11% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

5354 STEPHEN P KELLY
2710 N KNOXVILLE AVE
PEORIA, IL 61604

19IWCC0200

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)

Denise Wakefield
Employee/Petitioner

v.

Peoria Public School District 150
Employer/Respondent

Case # 12 WC 31334

Consolidated cases: 12 WC 31338

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Peoria, on July 24, 2017. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, August 15, 2012, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $11,225.18; the average weekly wage was $268.76.

On the date of accident, Petitioner was 53 years of age, single with 0 dependent child(ren).

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

Respondent shall be given a credit of $203.50 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $203.50.

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

ORDER

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibit 18 for medical services provided to Petitioner from August 15, 2012, through January 30, 2013, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

Petitioner's petition for prospective medical treatment is denied.

Respondent shall pay Petitioner temporary total disability benefits of $220.00 per week for three weeks commencing August 29, 2012, through September 19, 2012, as provided in Section 8(b) of the Act.

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

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

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

William R. Gallagher, Arbitrator
ICArbDec19(b)

August 29, 2017
Date

SEP - 7 2017

Petitioner filed two Applications for Adjustment of Claim which alleged she sustained accidental injuries arising out of and in the course of her employment for Respondent. In case number 12 WC 31338, the Application alleged that on March 21, 2012, Petitioner "Lifted heavy pots and pans" and sustained an injury to her left arm (Petitioner's Exhibit 2). In case number 12 WC 31334, the Application alleged that on August 15, 2012, Petitioner "Slipped and fell on stainless steel oil" and sustained injuries to the right arm, right hand, hip, low back and whole person (Petitioner's Exhibit 1).

The cases were previously consolidated and were heard in a 19(b) proceeding. In case number 12 WC 31338, Petitioner sought an order for payment of medical bills and prospective medical treatment. Respondent disputed liability on the basis of accident, notice and causal relationship (Arbitrator's Exhibit 1). In case number 12 WC 31334, Petitioner sought an order for payment of medical bills and temporary total disability benefits as well as prospective medical treatment. Respondent stipulated that Petitioner sustained a work-related accident on August 15, 2012; however, Respondent disputed liability on the basis of causal relationship (Arbitrator's Exhibit 2).

In regard to the accident of March 21, 2012, Petitioner testified that she was in the process of moving pans that had food in them and felt a "pop" in her left shoulder. Petitioner stated that she informed Maggie Jackson, the cafeteria manager, of the accident a few days after it occurred. Petitioner also stated that the accident happened just shortly before the two week spring break.

Respondent tendered into evidence a copy of the "Employer's First Report of Injury" which was prepared on July 11, 2012. According to that report, Petitioner sustained an injury on April 1, 2012, while lifting a heavy object and the accident was reported to Maggie Jackson on April 2, 2012 (Respondent's Exhibit 12).

Petitioner was cross-examined about the date of accident and stated that the report was not prepared until sometime after the spring break. She had no other explanation as to why the report indicated the date of accident was April 1, 2012, and not March 21, 2012. On redirect examination, Petitioner stated she was not completely certain of the exact date of the accident. Petitioner's counsel made an oral motion to amend the Application to allege the date of accident to be "on or about" March 21, 2012. Respondent's counsel objected to the motion and the Arbitrator reserved ruling on same. Because of the Arbitrator's decision regarding accident, it was not necessary for the Arbitrator to rule on Petitioner's counsel's motion to amend the Application.

Petitioner initially sought medical treatment at Proctor First Care on April 10, 2012, were she was seen by Dr. Lashunda Williams. According to the record of that date, Petitioner complained of severe pain in the neck and left shoulder as well as right lower back pain. There was no reference to Petitioner having sustained any type of work-related injury (Petitioner's Exhibit 5).

Petitioner was later seen at Proctor First Care on May 9, and June 8, 2012, for low back and right knee pain, respectively. The low back pain had been present for approximately one month and the right knee was injured after Petitioner fell down some stairs. While neither of these conditions was alleged as being work-related, the record did not note that Petitioner had any left shoulder symptoms and there was no reference to Petitioner having sustained a work-related accident (Petitioner's Exhibit 5).

Dr. Williams referred Petitioner to Dr. Daniel Mulconrey, an orthopedic surgeon, who evaluated Petitioner on May 9, 2012. At that time, Petitioner complained of left shoulder pain that had been present for the past two years. There was no reference to Petitioner having sustained a work-related accident. Dr. Mulconrey diagnosed Petitioner with cervical spondylosis and axial neck pain. He recommended Petitioner have physical therapy (Petitioner's Exhibit 7).

On June 26, 2012, an MRI of Petitioner's left shoulder was performed. According the radiologist, the MRI revealed tears of the infraspinatus and supraspinatus tendons, atrophy of the musculature of the supraspinatus tendon, tendinosis of the biceps tendon and some subluxation of the head of the humerous (Petitioner's Exhibits 5 and 6).

On July 11, 2012 (the same day that the Employer's First Report of Injury was prepared), Petitioner was seen at Illinois Work Injury Resource Center (IWIRC) at the direction of Respondent. According to the record of that date, Petitioner sustained the injury in April, 2012, (no specific date indicated) when she was lifting boxes and putting away supplies when she felt a pop in her left shoulder. In the same record, it was noted that Petitioner had left shoulder pain since March, 2012, had no specific injury and had previously received treatment for bilateral shoulder pain. The MRI was reviewed in its findings were noted; however, the assessment was left shoulder pain that was not work-related. Petitioner was advised that she should see Dr. Williams because she had previously treated her for her shoulder symptoms (Petitioner's Exhibit 4).

Dr. Williams referred Petitioner to Dr. Brent Johnson, an orthopedic surgeon, who evaluated Petitioner on August 8, 2012. His record of that date noted Petitioner had left shoulder pain, numbness and weakness since she injured it. It was noted that Petitioner did a lot of lifting at work and worked in a cafeteria; however, there was no specific description of how or when Petitioner sustained the injury to her left shoulder. Dr. Johnson examined Petitioner and reviewed the MRI. He opined Petitioner had a left shoulder rotator cuff tear. Dr. Johnson administered an injection and recommended that Petitioner receive physical therapy (Petitioner's Exhibit 7).

At trial, Petitioner testified she had some prior left shoulder symptoms. Petitioner did not describe in any detail the extent of the prior left shoulder symptoms; however, medical records regarding left shoulder treatment Petitioner received prior to March/April, 2012, were received into evidence.

Petitioner was previously seen at St. Francis Medical Center for left shoulder symptoms on March 12, 2003, and September 29, 2011. On March 12, 2003, Petitioner stated she had left shoulder pain which had been present for a couple of years and the pain was radiating to her face. On June 29, 2011, Petitioner complained of neck pain radiating into her left shoulder, but it was not due to any trauma (Respondent's Exhibit 5).

On September 17, 2011, Petitioner was seen at Proctor First Care for left shoulder pain that had been present for three months, but without a history of trauma. X-rays of the left shoulder were taken which revealed some degenerative changes, but were otherwise normal (Respondent's Exhibit 4).

In the physical therapy record of August 14, 2012, it was noted that Petitioner had left shoulder pain for the last four to five years and increased pain about four months ago. There was no reference to Petitioner having sustained a work-related injury (Petitioner's Exhibit 7).

In regard to the accident of August 15, 2012, Petitioner testified she slipped and fell on a wet floor and landed on her right shoulder and right hip. While Petitioner was falling, she attempted to grasp steam table and, when she did so, she injured her right elbow and wrist.

Petitioner was evaluated at IWIRC on August 15, 2012. At that time, Petitioner stated she slipped and fell on a wet floor falling sideways hitting her right elbow/wrist on some tables and then hitting her right shoulder and right hip on the floor. Petitioner was diagnosed with multiple contusions, given some medications and authorized to return to work (Petitioner's Exhibit 4).

On August 17, 2012, Petitioner was seen at St. Francis Medical Center. At that time, Petitioner advised, that two days prior, she slipped and fell on a wet floor and injured her right shoulder and right hip. Petitioner was diagnosed with contusions to the right shoulder and right hip and discharged (Petitioner's Exhibit 3).

Petitioner was again seen at IWIRC on August 22, 2012. It was noted that the contusions to the right shoulder, hip, elbow and wrist had resolved. However, Petitioner was diagnosed with a right wrist sprain. A wrist splint was prescribed and Petitioner was authorized to return to work on light duty (Petitioner's Exhibit 4).

Petitioner was again seen at Proctor First Care on August 27, 2012. Petitioner was seen by Dr. Williams, given some medications and discharged. Dr. Williams subsequently released Petitioner to return to work without restrictions on September 4, 2012 (Petitioner's Exhibit 5).

Petitioner sought treatment from Dr. Blair Rhode, an orthopedic surgeon, who initially saw Petitioner on August 29, 2012. According to his record of that date, Petitioner injured her left shoulder in March, 2012, (no specific date indicated) when she lifted a crate of milk and felt a pop in her left shoulder. It was also noted Petitioner injured her right shoulder and right hip on August 15, 2012, when she slipped and fell on a wet floor. Dr. Rhode authorized Petitioner to be off work and ordered an MRI scan of the right shoulder (Petitioner's Exhibit 12).

Dr. Rhode subsequently saw Petitioner on September 19, 2012. He was awaiting authority for the MRI scan. He authorized Petitioner to return to work on light duty with restrictions regarding lifting and overhead use of the right shoulder (Petitioner's Exhibit 12).

The MRI of Petitioner's right shoulder was performed on November 14, 2012. According to the radiologist, the MRI revealed rotator cuff tendinosis, a tear of the supraspinatus tendon as well as atrophy of the supraspinatus musculature (Petitioner's Exhibit 8).

Dr. Rhode saw Petitioner on November 28, 2012, and he reviewed the MRI scan. He administered an injection to the right shoulder and ordered physical therapy. He continued Petitioner's light duty restrictions, but he subsequently released Petitioner to return to work without restrictions and opined Petitioner was at MMI as of January 30, 2013 (Petitioner's Exhibits 12 and 13).

At trial, Petitioner testified that she had no prior injuries or symptoms referable to her right shoulder or right wrist/elbow. In regard to her right hip, Petitioner stated she sustained a gunshot wound to the right abdominal area close to the right hip in 1997.

In regard to the right hip, Petitioner was previously seen at Proctor First Care on June 30, 2010. The condition was described as chronic right hip pain and that Petitioner had sustained a gunshot wound to the right hip in 1997. X-rays of the pelvis and right hip were obtained which were negative (Respondent's Exhibit 4).

In regard to her right shoulder, Petitioner was previously seen at St. Francis Medical Center on March 15, 2012. According to the record of that date, Petitioner rolled over in her sleep and felt a "pop" in her right shoulder. Petitioner stated it felt like it was dislocated. Petitioner was diagnosed with a right shoulder pain, given some medications and discharged (Respondent's Exhibit 5).

At the direction of Respondent, Petitioner was examined by Dr. Richard Lehman, an orthopedic surgeon, on August 29, 2013. Dr. Lehman examined Petitioner in regard to both accidents. In connection with his examination of Petitioner, Dr. Lehman reviewed medical records and the MRI scans which were provided to him by Respondent. In regard to the earlier accident (the case with the higher case number), Petitioner informed Dr. Lehman that she injured her left shoulder on April 1, 2012, when she was lifting boxes and putting away supplies. In regard to the accident of August 15, 2012, Petitioner informed Dr. Lehman that she slipped and fell on a wet floor and landed on her right elbow, right shoulder, right wrist and right hip. Petitioner also informed Dr. Lehman she had sustained a gunshot wound to the right hip in 1997 (Respondent's Exhibit 8).

In his report, Dr. Lehman commented about his review of the medical records in considerable detail which included medical records he reviewed for treatment Petitioner had received prior to both accidents. Dr. Lehman opined Petitioner had degenerative breakdowns of the right and left rotator cuffs, degenerative joint disease of the right wrist and right hip as well as degenerative joint disease of the lumbar spine. In regard to causality, Dr. Lehman opined that Petitioner's bilateral upper extremity problems were not caused, aggravated or exacerbated by her work injuries. He based this opinion, in part, on his review of the MRIs which indicated that Petitioner

had long term chronic problems that occurred over a prolonged period of time. Dr. Lehman also opined that Petitioner's right hip problems were not related to the accident of August 15, 2012. He specifically noted Petitioner had sustained a gunshot wound to the right hip and had hip symptoms that predated the accident (Respondent's Exhibit 8).

Petitioner was again seen by Dr. Rhode on December 18, 2013, primarily for her right shoulder symptoms. At that time, Dr. Rhode opined that a repeat MRI be performed, but he continued to authorize Petitioner to work without restrictions (Petitioner's Exhibit 12).

When Dr. Rhode saw Petitioner on March 15, 2014, she had complaints of right shoulder and right hip pain. Dr. Rhode restated his recommendation that Petitioner have a repeat MRI performed on the right shoulder as well as an MRI of the right hip (Petitioner's Exhibit 12).

MRIs of the left shoulder (the radiologist report indicated the study was performed on the left shoulder) [even though the records indicated Dr. Rhode recommended an MRI of the right shoulder] and right hip were performed on April 2, 2014. The MRI of the shoulder revealed severe degenerative changes of the AC joint, a tear of the supraspinatus and rotator cuff tendinosis. The MRI of the right hip revealed minimal fraying of the anterior acetabulum consistent with a tear and mild trochanteric bursitis (Petitioner's Exhibits 9 and 10).

Dr. Rhode saw Petitioner on April 9, 2014, and reviewed the MRI scans. One portion of his record of that date indicated that the MRI was performed on the right shoulder, but, on the same page, it also indicated it was performed on the left shoulder. In any case, Dr. Rhode noted that his examination of the left shoulder was positive for impingement. At that time, Dr. Rhode did not address Petitioner's right hip condition (Petitioner's Exhibit 12).

When Dr. Rhode saw Petitioner on May 7, 2014, he noted that the MRI of the right hip revealed a labral tear. Petitioner complained of locking and catching in the right hip. Dr. Rhode recommended Petitioner undergo right hip arthroscopy. He also examined Petitioner's right shoulder and opined it was positive for impingement (Petitioner's Exhibit 12).

Dr. Rhode continued to see Petitioner. When he evaluated Petitioner on August 27, 2014, he noted he was awaiting authorization to proceed with right shoulder surgery (even though the records did not indicate a prior recommendation for right shoulder surgery). When Dr. Rhode saw Petitioner on September 10, 2014, he noted he was awaiting authority for the right hip surgery (Petitioner's Exhibit 12).

Dr. Rhode subsequently saw Petitioner on October 14, 2014, for bilateral shoulder and right hip pain. At that time, Dr. Rhode indicated he was awaiting authorization for arthroscopic left shoulder surgery (Petitioner's Exhibit 12).

Dr. Rhode continued to periodically see Petitioner from March 9, through November 7, 2015. He continued to recommend Petitioner undergo arthroscopic surgeries on both the right and left shoulders as well as the right hip (Petitioner's Exhibit 12).

Dr. Rhode was deposed on February 24, 2016, and his deposition testimony was received into evidence at trial. In regard to his testimony regarding Petitioner's left shoulder condition, Dr. Rhode said that he initially saw Petitioner on August 29, 2012, and she informed him that she had lifted a crate of milk and felt a "pop" in her left shoulder. He stated that the MRI of June 26, 2012, revealed a rotator cuff tear. Dr. Rhode recommended Petitioner undergo a rotator cuff repair on the left shoulder. In regard to the MRI of April 2, 2014, Dr. Rhode testified that the report which indicated that it was of the left shoulder was probably a typo (Petitioner's Exhibit 14; pp 5-6, 9-10, 17).

Dr. Rhode was questioned about the causality of the left shoulder rotator cuff tear. He stated that it was caused or aggravated by the accident when Petitioner lifted a milk crate and felt a "pop" in her left shoulder (Petitioner's Exhibit 14; pp 24-25).

In regard to Petitioner's right shoulder and right hip conditions, Dr. Rhode testified that Petitioner informed him of the accident of August 15, 2012. Dr. Rhode's testimony regarding his diagnosis and surgical recommendations in regard to Petitioner's right shoulder condition was consistent with his medical records. In regard to causality of the right shoulder condition, Dr. Rhode testified that Petitioner's falling and attempting to break the fall with her outstretched hand could have caused the right shoulder rotator cuff tear (Petitioner's Exhibit 14; pp 22-23).

In regard to Petitioner's right hip condition, Dr. Rhode testified that, as a result of the accident of August 15, 2012, Petitioner sustained a right hip contusion with trochanteric bursitis which had resolved. In regard to the labral tear he diagnosed, Dr. Rhode had no hope opinion as to whether it was related to the accident of August 15, 2012 (Petitioner's Exhibit 14; p 24).

On cross-examination, Dr. Rhode agreed he had no knowledge of whether Petitioner had any prior left shoulder, right shoulder or right hip problems. He agreed that if there was evidence of prior problems in those anatomical areas, it could affect his opinion as to causality. Specifically, Dr. Rhode knew nothing about Petitioner having sustained the gunshot wound in 1997 and that she also received medical treatment for her right hip in June, 2010 (Petitioner's Exhibit 14; pp 32-34).

Respondent provided Dr. Lehman with additional medical records and the transcript of Dr. Rhode's deposition testimony. Dr. Lehman reviewed same and prepared a supplemental report dated June 21, 2016. Dr. Lehman did an extensive and comprehensive review of the information provided to him. In regard to the left shoulder, Dr. Lehman opined Petitioner had a chronic massive rotator cuff tear and noted that Petitioner also had atrophic changes of the musculature of the supraspinatus tendon which was consistent with long term chronic changes. In regard to the right shoulder, Dr. Lehman opined Petitioner had impingement syndrome, atrophy of the supraspinatus muscle and degenerative changes. In regard to causality, Dr. Lehman opined that Petitioner's current problems in her shoulders were not caused, exacerbated or altered by either the work-related incident of April 1, 2012, or August 15, 2012 (Respondent's Exhibit 9; Deposition Exhibit 1).

Dr. Lehman was deposed on March 3, 2014, and again on August 23, 2016, and his deposition testimony was received into evidence at trial. In regard to his testimony of March 3, 2014, Dr. Lehman's testimony was consistent with his medical report of August 29, 2013, and he reaffirmed the opinions contained therein. The various medical records Dr. Lehman reviewed were received as deposition exhibits when he was deposed and Dr. Lehman testified in detail regarding his review of same. Specifically, Dr. Lehman noted Petitioner had complaints and medical treatment that predated both of the accidents (Respondent's Exhibit 7; pp 15-26).

In regard to Petitioner's left shoulder condition, Dr. Lehman noted that the MRI of June 26, 2012, did not reveal an acute tear, but it did reveal findings consistent with long term degenerative changes which would have been a multi-year process. Based upon the preceding and the fact that Petitioner had prior medical treatment for her left shoulder symptoms, Dr. Lehman testified that Petitioner's left shoulder condition was not aggravated or accelerated by the accident of April 1, 2012 (Respondent's Exhibit 7; pp 16-19, 30-31).

In regard to Petitioner's right shoulder condition, Dr. Lehman noted that the MRI of November 14, 2012, revealed severe degenerative changes that were chronic and pre-existed the accident of August 15, 2012. He also noted that there was atrophy of the supraspinatus musculature which was indicative of a long term chronic condition. He testified that Petitioner's right shoulder condition was not aggravated or accelerated by the accident of August 15, 2012 (Respondent's Exhibit 7; pp 27-31).

In regard to Petitioner's right hip condition, Dr. Lehman noted Petitioner had prior right hip symptoms, including the gunshot wound of 1997. He testified that her current right hip problems were not related to the accident of August 15, 2012 (Respondent's Exhibit 7; pp 32-33).

When Dr. Lehman was deposed on August 23, 2016, his testimony was consistent with his report of June 21, 2016, and he reaffirmed the opinions contained therein. Dr. Lehman's opinions in regard to causality of Petitioner's left shoulder, right shoulder and right hip conditions remained the same (Respondent's Exhibit 9; pp 10-15).

At trial, Petitioner testified that Dr. Rhode recommended she have surgery on both the left and right shoulders as well as the right hip. Petitioner still has pain in both shoulders and stated that they feel like they are going to come out of their sockets. She also continues to have right hip pain. Petitioner does want to proceed with the surgeries as recommended by Dr. Rhode. Petitioner also testified that she had no prior right shoulder problems. In regard to her right hip, Petitioner stated that the gunshot wound of 1997 was in the right abdominal area and was close to the hip, but not in the same area where she is presently having symptoms.

Conclusions of Law

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

The Arbitrator concludes that Petitioner's current condition of ill-being in regard to her right shoulder and right hip is not related to the accident of August 15, 2012.

In support of this conclusion the Arbitrator notes the following:

At trial, Petitioner testified that she had no right shoulder symptoms prior to the accident of August 15, 2012. As noted herein, Petitioner did seek treatment for her right shoulder on March 15, 2012, just five months prior to the date of accident.

Respondent's Section 12 examiner, Dr. Lehman, performed an extensive review of Petitioner's medical records and the MRI scan of Petitioner's right shoulder of November 14, 2012. Dr. Lehman noted that the scan revealed severe degenerative changes as well as atrophy of the supraspinatus musculature. He opined that this was a long standing chronic condition which was not aggravated or accelerated by the accident of August 15, 2012.

Petitioner's treating physician, Dr. Rhode, opined that there was a causal relationship between Petitioner's right shoulder condition and the accident of August 15, 2012; however, he had no knowledge of whether Petitioner had any prior right shoulder problems. Further, he did not comment about the significance of the degenerative changes and muscular atrophy that was noted in the MRI scan.

Based upon the preceding, the Arbitrator finds the opinion of Dr. Lehman to be more persuasive than that of Dr. Rhode.

In regard to Petitioner's right hip condition, Dr. Rhode did not opine as to whether the labral tear he diagnosed was related to the accident of August 15, 2012.

Dr. Lehman opined that Petitioner's right hip problem was not related to the accident of August 15, 2012.

Accordingly, there was no medical opinion that related Petitioner's right hip problem to the accident of August 15, 2012.

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

The Arbitrator concludes that the medical treatment provided to Petitioner from August 15, 2012, through January 30, 2013, was reasonable and necessary and that Respondent is liable for payment of the medical bills incurred therewith.

Respondent shall pay reasonable and necessary medical expenses as identified in Petitioner's Exhibit 18 for medical services provided to Petitioner from August 15, 2012, through January 30, 2013, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

In support of this conclusion the Arbitrator notes the following:

There was no dispute Petitioner sustained a work-related injury on August 15, 2012, and received medical treatment thereafter. The Arbitrator finds the medical treatment provided to Petitioner through January 30, 2013 (the date Dr. Rhode opined Petitioner was at MMI) to be related to the accident of August 15, 2012.

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

Based upon the Arbitrator's conclusion of law in disputed issue (F) the Arbitrator concludes Petitioner is not entitled to prospective medical treatment.

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

The Arbitrator concludes Petitioner is entitled to payment of temporary total disability benefits of three weeks commencing August 29, 2012, through September 19, 2012.

In support of this conclusion the Arbitrator notes the following:

Petitioner was receiving medical treatment and was authorized to be off work during the aforestated period of time.

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF PEORIA)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DENISE WAKEFIELD,

Petitioner,

vs.

NO: 12 WC 31338

19IWCC0201

PEORIA PUBLIC SCHOOL DISTRICT 150,

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, notice, causation, 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, but makes a clarification as outlined below.

Conclusions of Law

A. Accident

On the threshold issue of accident, the Commission affirms the Arbitrator's finding Petitioner failed to prove she sustained an accidental injury arising out of her employment on March 21, 2012. As Petitioner did not meet her burden of proof regarding accident, the Commission finds the issue of notice is moot.

Petitioner testified that this accident occurred over spring break and/or shortly before spring break, and that she reported the injury to her supervisor within a few days or maybe after spring break. (T. 22, 49, 83, 86) Petitioner first sought treatment on April 10, 2012 with her

primary care doctor wherein there were no reports of a work-related accident, and she described the problem with her left shoulder as chronic. (Px5, 4/10/12) On May 9, 2012, Petitioner received treatment for lower back pain she related to lifting, but made no complaints regarding her shoulder. (Px5, 5/9/12) She was seen by Dr. Mulconrey on May 9, 2012, wherein she complained of upper extremity pain for a duration of two years, and again made no complaints of a work-related injury. (Rx7 DepEx4, 5/9/12) Petitioner reported a fall down her stairs to her primary care physician during a visit of June 8, 2012, with again no mention of a work injury. (Px5, 6/8/12) It was not until July 11, 2012 when an incident report was completed, and Petitioner was seen at IWIRC, wherein Petitioner referenced an accident dating back to April. (Rx12 and Px4)

The Commission notes that Petitioner reported multiple dates of injury as well as various mechanisms of injury – carrying a milk crate (Px14, p. 6; Rx9, p. 11), carrying heavy pots and pans (T. 19, Application), lifting boxes and putting away supplies (Px4, 7/11/12 visit).

The Commission finds the histories provided by Petitioner to Dr. Williams, Dr. Mulconrey, IWIRC, and Dr. Rhode have varying versions of both the onset date and the mechanism of injury to her left shoulder, are inconsistent with Petitioner's testimony at trial. Further, the Commission finds Petitioner's testimony is not consistent with the contemporaneous medical records and is, therefore, not credible.

B. Causal Relationship

Even assuming *arguendo* an accident occurred, the Commission finds Petitioner failed to prove a causal relationship exists between such incident and Petitioner's condition of ill-being. Petitioner testified that prior to March 21, 2012, she had some problems with her left shoulder, though minimized the extent to which she had sought medical treatment. (T. 42)

On cross-examination, Petitioner testified that prior to the March 21, 2012 accident that she didn't remember going to Proctor Hospital on September 6, 2011 for left arm pain or going to Midwest Orthopedic on May 9, 2012 and telling them that she had had left arm and shoulder pain for two years. (T. 59) She did not recall telling anyone at Midwest Orthopedic that she had pain to her left shoulder for five years pre-dating her accident in August of 2012. (T. 63)

On cross-examination, Petitioner testified that she sought treatment with Dr. Rhode on her own. She further testified that she injured her left shoulder in October of 2016 when she fell off a CityLink bus bench. (T. 68)

On both direct examination and cross-examination, Petitioner did not recall the date of the accident, testified it was from lifting heavy pots and pans, and insisted she filled out the First Report of Injury within a couple of days of the accident. (T. 86-88) The medical records reflect an emergency room visit for her left shoulder as far back as 2003, as well as complaints of left shoulder popping as far back as June of 2011. (Rx5) Petitioner sought left shoulder treatment

though the remainder of 2011, as well as through 2012. (Rx4, Rx5, Rx7) Petitioner did not report any traumatic injury or specific incident to her left shoulder until her visit with IWIRC on July 11, 2012. (Px4)

Petitioner's treating physician, Dr. Rhode, testified that Petitioner reported a history of traumatic injury in March of 2012 while lifting a crate of milk, at which time she felt a pop in her left shoulder. (Px14, p. 6) Dr. Rhode testified that based on Petitioner's description of the injury that she was lifting a milk crate and felt a pop in the shoulder, it was his opinion that Petitioner's left shoulder or left shoulder rotator cuff tear was caused or aggravated by that event. (Px14, p. 25) However, Dr. Rhode qualified his causation opinion on cross-examination by stated that his opinion as it relates to the left shoulder are based on the assumption that Petitioner had no pre-existing left shoulder problems pre-dating March 21, 2012. (Px14, p. 30) Dr. Rhode's opinion was predicated on an inaccurate history obtained from Petitioner and, was therefore flawed.

When Petitioner attended an independent medical with Dr. Lehman, she reported a work injury on April 1, 2012 when she felt a pop in her left shoulder while lifting boxes and putting away supplies. (Rx7, p. 8) Dr. Lehman opined that Petitioner's condition was due to long-term degenerative changes of both her shoulders with chronic changes in both rotator cuffs, rather than due to a March 2012, work injury. (Rx7, p. 30)

The Commission weighs the competing medical evidence and finds Dr. Lehman's opinions more persuasive than those of Dr. Rhode. Dr. Lehman reviewed Petitioner's treatment records prior to March 21, 2012, while Dr. Rhode did not. (Rx7, p. 10; Px14, p. 33). Based upon his lack of understanding of Petitioner's prior medical treatment, Dr. Rhode opined the left shoulder rotator cuff tear, found on the June 26, 2012 MRI, is causally related to the March 21, 2012 incident at work. (Px14) 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 contrast, Dr. Lehman possessed a complete understanding of Petitioner's prior medical treatment. Dr. Lehman opined Petitioner suffered from a chronic degenerative condition for which she received treatment. As the Court noted in *County of Cook v. Industrial Commission*:

> Every employee whose disease or preexisting condition disables him while at work is not automatically entitled to recovery under the Workmen's Compensation Act...'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. 68 Ill.2d 24, 31-32 (1977).

Petitioner's condition was degenerated to such an extent any activity would have caused the rotator cuff tear and, it likely occurred well before the alleged March 21, 2012 accident based on the prior medical records. (Rx7, p. 30) Therefore, based on the opinions of Dr. Lehman, the Commission finds Petitioner failed to prove a causal relationship.

19IWCC0201

All else is affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 7, 2017 is hereby affirmed for the reasons stated herein.

IT IS FURTHER ORDERED BY THE COMMISSION that since Petitioner failed to prove she sustained accidental injuries arising out of her employment on March 21, 2012, and failed to prove a causal relationship, her claim for temporary total disability compensation, medical expenses, and prospective medical treatment 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: APR 24 2019

D. Douglas McCarthy

Stephen J. Mathis

L. Elizabeth Coppoletti

DDM/dmm
O: 040919
52

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

WAKEFIELD, DENISE
Employee/Petitioner

Case# **12WC031338**

12WC031334

PEORIA PUBLIC SCHOOL DISTRICT 150
Employer/Respondent

19IWCC0201

On 9/7/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.11% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

5354 STEPHEN P KELLY
2710 N KNOXVILLE AVE
PEORIA, IL 61604

19IWCC0201

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)

Denise Wakefield
Employee/Petitioner

Case # 12 WC 31338

v.

Consolidated cases: 12 WC 31334

Peoria Public School District 150
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Peoria, on July 24, 2017. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [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. [ ] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [ ] TTD
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other ____

FINDINGS

On the date of accident, March 21, 2012, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was not given to Respondent.

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

In the year preceding the injury, Petitioner earned $11,225.18; the average weekly wage was $268.76.

On the date of accident, Petitioner was 53 years of age, single with 0 dependent child(ren).

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

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

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

ORDER

Based upon the Arbitrator's Conclusions of Law attached hereto, 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.

William R. Gallagher

William R. Gallagher, Arbitrator
ICArbDec19(b)

August 29, 2017
Date

SEP - 7 2017

Findings of Fact

Petitioner filed two Applications for Adjustment of Claim which alleged she sustained accidental injuries arising out of and in the course of her employment for Respondent. In case number 12 WC 31338, the Application alleged that on March 21, 2012, Petitioner "Lifted heavy pots and pans" and sustained an injury to her left arm (Petitioner's Exhibit 2). In case number 12 WC 31334, the Application alleged that on August 15, 2012, Petitioner "Slipped and fell on stainless steel oil" and sustained injuries to the right arm, right hand, hip, low back and whole person (Petitioner's Exhibit 1).

The cases were previously consolidated and were heard in a 19(b) proceeding. In case number 12 WC 31338, Petitioner sought an order for payment of medical bills and prospective medical treatment. Respondent disputed liability on the basis of accident, notice and causal relationship (Arbitrator's Exhibit 1). In case number 12 WC 31334, Petitioner sought an order for payment of medical bills and temporary total disability benefits as well as prospective medical treatment. Respondent stipulated that Petitioner sustained a work-related accident on August 15, 2012; however, Respondent disputed liability on the basis of causal relationship (Arbitrator's Exhibit 2).

In regard to the accident of March 21, 2012, Petitioner testified that she was in the process of moving pans that had food in them and felt a "pop" in her left shoulder. Petitioner stated that she informed Maggie Jackson, the cafeteria manager, of the accident a few days after it occurred. Petitioner also stated that the accident happened just shortly before the two week spring break.

Respondent tendered into evidence a copy of the "Employer's First Report of Injury" which was prepared on July 11, 2012. According to that report, Petitioner sustained an injury on April 1, 2012, while lifting a heavy object and the accident was reported to Maggie Jackson on April 2, 2012 (Respondent's Exhibit 12).

Petitioner was cross-examined about the date of accident and stated that the report was not prepared until sometime after the spring break. She had no other explanation as to why the report indicated the date of accident was April 1, 2012, and not March 21, 2012. On redirect examination, Petitioner stated she was not completely certain of the exact date of the accident. Petitioner's counsel made an oral motion to amend the Application to allege the date of accident to be "on or about" March 21, 2012. Respondent's counsel objected to the motion and the Arbitrator reserved ruling on same. Because of the Arbitrator's decision regarding accident, it was not necessary for the Arbitrator to rule on Petitioner's counsel's motion to amend the Application.

Petitioner initially sought medical treatment at Proctor First Care on April 10, 2012, were she was seen by Dr. Lashunda Williams. According to the record of that date, Petitioner complained of severe pain in the neck and left shoulder as well as right lower back pain. There was no reference to Petitioner having sustained any type of work-related injury (Petitioner's Exhibit 5).

Petitioner was later seen at Proctor First Care on May 9, and June 8, 2012, for low back and right knee pain, respectively. The low back pain had been present for approximately one month and the right knee was injured after Petitioner fell down some stairs. While neither of these conditions was alleged as being work-related, the record did not note that Petitioner had any left shoulder symptoms and there was no reference to Petitioner having sustained a work-related accident (Petitioner's Exhibit 5).

Dr. Williams referred Petitioner to Dr. Daniel Mulconrey, an orthopedic surgeon, who evaluated Petitioner on May 9, 2012. At that time, Petitioner complained of left shoulder pain that had been present for the past two years. There was no reference to Petitioner having sustained a work-related accident. Dr. Mulconrey diagnosed Petitioner with cervical spondylosis and axial neck pain. He recommended Petitioner have physical therapy (Petitioner's Exhibit 7).

On June 26, 2012, an MRI of Petitioner's left shoulder was performed. According the radiologist, the MRI revealed tears of the infraspinatus and supraspinatus tendons, atrophy of the musculature of the supraspinatus tendon, tendinosis of the biceps tendon and some subluxation of the head of the humerous (Petitioner's Exhibits 5 and 6).

On July 11, 2012 (the same day that the Employer's First Report of Injury was prepared), Petitioner was seen at Illinois Work Injury Resource Center (IWIRC) at the direction of Respondent. According to the record of that date, Petitioner sustained the injury in April, 2012, (no specific date indicated) when she was lifting boxes and putting away supplies when she felt a pop in her left shoulder. In the same record, it was noted that Petitioner had left shoulder pain since March, 2012, had no specific injury and had previously received treatment for bilateral shoulder pain. The MRI was reviewed in its findings were noted; however, the assessment was left shoulder pain that was not work-related. Petitioner was advised that she should see Dr. Williams because she had previously treated her for her shoulder symptoms (Petitioner's Exhibit 4).

Dr. Williams referred Petitioner to Dr. Brent Johnson, an orthopedic surgeon, who evaluated Petitioner on August 8, 2012. His record of that date noted Petitioner had left shoulder pain, numbness and weakness since she injured it. It was noted that Petitioner did a lot of lifting at work and worked in a cafeteria; however, there was no specific description of how or when Petitioner sustained the injury to her left shoulder. Dr. Johnson examined Petitioner and reviewed the MRI. He opined Petitioner had a left shoulder rotator cuff tear. Dr. Johnson administered an injection and recommended that Petitioner receive physical therapy (Petitioner's Exhibit 7).

At trial, Petitioner testified she had some prior left shoulder symptoms. Petitioner did not describe in any detail the extent of the prior left shoulder symptoms; however, medical records regarding left shoulder treatment Petitioner received prior to March/April, 2012, were received into evidence.

Petitioner was previously seen at St. Francis Medical Center for left shoulder symptoms on March 12, 2003, and September 29, 2011. On March 12, 2003, Petitioner stated she had left shoulder pain which had been present for a couple of years and the pain was radiating to her face. On June 29, 2011, Petitioner complained of neck pain radiating into her left shoulder, but it was not due to any trauma (Respondent's Exhibit 5).

On September 17, 2011, Petitioner was seen at Proctor First Care for left shoulder pain that had been present for three months, but without a history of trauma. X-rays of the left shoulder were taken which revealed some degenerative changes, but were otherwise normal (Respondent's Exhibit 4).

In the physical therapy record of August 14, 2012, it was noted that Petitioner had left shoulder pain for the last four to five years and increased pain about four months ago. There was no reference to Petitioner having sustained a work-related injury (Petitioner's Exhibit 7).

In regard to the accident of August 15, 2012, Petitioner testified she slipped and fell on a wet floor and landed on her right shoulder and right hip. While Petitioner was falling, she attempted to grasp steam table and, when she did so, she injured her right elbow and wrist.

Petitioner was evaluated at IWIRC on August 15, 2012. At that time, Petitioner stated she slipped and fell on a wet floor falling sideways hitting her right elbow/wrist on some tables and then hitting her right shoulder and right hip on the floor. Petitioner was diagnosed with multiple contusions, given some medications and authorized to return to work (Petitioner's Exhibit 4).

On August 17, 2012, Petitioner was seen at St. Francis Medical Center. At that time, Petitioner advised, that two days prior, she slipped and fell on a wet floor and injured her right shoulder and right hip. Petitioner was diagnosed with contusions to the right shoulder and right hip and discharged (Petitioner's Exhibit 3).

Petitioner was again seen at IWIRC on August 22, 2012. It was noted that the contusions to the right shoulder, hip, elbow and wrist had resolved. However, Petitioner was diagnosed with a right wrist sprain. A wrist splint was prescribed and Petitioner was authorized to return to work on light duty (Petitioner's Exhibit 4).

Petitioner was again seen at Proctor First Care on August 27, 2012. Petitioner was seen by Dr. Williams, given some medications and discharged. Dr. Williams subsequently released Petitioner to return to work without restrictions on September 4, 2012 (Petitioner's Exhibit 5).

Petitioner sought treatment from Dr. Blair Rhode, an orthopedic surgeon, who initially saw Petitioner on August 29, 2012. According to his record of that date, Petitioner injured her left shoulder in March, 2012, (no specific date indicated) when she lifted a crate of milk and felt a pop in her left shoulder. It was also noted Petitioner injured her right shoulder and right hip on August 15, 2012, when she slipped and fell on a wet floor. Dr. Rhode authorized Petitioner to be off work and ordered an MRI scan of the right shoulder (Petitioner's Exhibit 12).

Dr. Rhode subsequently saw Petitioner on September 19, 2012. He was awaiting authority for the MRI scan. He authorized Petitioner to return to work on light duty with restrictions regarding lifting and overhead use of the right shoulder (Petitioner's Exhibit 12).

The MRI of Petitioner's right shoulder was performed on November 14, 2012. According to the radiologist, the MRI revealed rotator cuff tendinosis, a tear of the supraspinatus tendon as well as atrophy of the supraspinatus musculature (Petitioner's Exhibit 8).

Dr. Rhode saw Petitioner on November 28, 2012, and he reviewed the MRI scan. He administered an injection to the right shoulder and ordered physical therapy. He continued Petitioner's light duty restrictions, but he subsequently released Petitioner to return to work without restrictions and opined Petitioner was at MMI as of January 30, 2013 (Petitioner's Exhibits 12 and 13).

At trial, Petitioner testified that she had no prior injuries or symptoms referable to her right shoulder or right wrist/elbow. In regard to her right hip, Petitioner stated she sustained a gunshot wound to the right abdominal area close to the right hip in 1997.

In regard to the right hip, Petitioner was previously seen at Proctor First Care on June 30, 2010. The condition was described as chronic right hip pain and that Petitioner had sustained a gunshot wound to the right hip in 1997. X-rays of the pelvis and right hip were obtained which were negative (Respondent's Exhibit 4).

In regard to her right shoulder, Petitioner was previously seen at St. Francis Medical Center on March 15, 2012. According to the record of that date, Petitioner rolled over in her sleep and felt a "pop" in her right shoulder. Petitioner stated it felt like it was dislocated. Petitioner was diagnosed with a right shoulder pain, given some medications and discharged (Respondent's Exhibit 5).

At the direction of Respondent, Petitioner was examined by Dr. Richard Lehman, an orthopedic surgeon, on August 29, 2013. Dr. Lehman examined Petitioner in regard to both accidents. In connection with his examination of Petitioner, Dr. Lehman reviewed medical records and the MRI scans which were provided to him by Respondent. In regard to the earlier accident (the case with the higher case number), Petitioner informed Dr. Lehman that she injured her left shoulder on April 1, 2012, when she was lifting boxes and putting away supplies. In regard to the accident of August 15, 2012, Petitioner informed Dr. Lehman that she slipped and fell on a wet floor and landed on her right elbow, right shoulder, right wrist and right hip. Petitioner also informed Dr. Lehman she had sustained a gunshot wound to the right hip in 1997 (Respondent's Exhibit 8).

In his report, Dr. Lehman commented about his review of the medical records in considerable detail which included medical records he reviewed for treatment Petitioner had received prior to both accidents. Dr. Lehman opined Petitioner had degenerative breakdowns of the right and left rotator cuffs, degenerative joint disease of the right wrist and right hip as well as degenerative joint disease of the lumbar spine. In regard to causality, Dr. Lehman opined that Petitioner's bilateral upper extremity problems were not caused, aggravated or exacerbated by her work injuries. He based this opinion, in part, on his review of the MRIs which indicated that Petitioner

had long term chronic problems that occurred over a prolonged period of time. Dr. Lehman also opined that Petitioner's right hip problems were not related to the accident of August 15, 2012. He specifically noted Petitioner had sustained a gunshot wound to the right hip and had hip symptoms that predated the accident (Respondent's Exhibit 8).

Petitioner was again seen by Dr. Rhode on December 18, 2013, primarily for her right shoulder symptoms. At that time, Dr. Rhode opined that a repeat MRI be performed, but he continued to authorize Petitioner to work without restrictions (Petitioner's Exhibit 12).

When Dr. Rhode saw Petitioner on March 15, 2014, she had complaints of right shoulder and right hip pain. Dr. Rhode restated his recommendation that Petitioner have a repeat MRI performed on the right shoulder as well as an MRI of the right hip (Petitioner's Exhibit 12).

MRIs of the left shoulder (the radiologist report indicated the study was performed on the left shoulder) [even though the records indicated Dr. Rhode recommended an MRI of the right shoulder] and right hip were performed on April 2, 2014. The MRI of the shoulder revealed severe degenerative changes of the AC joint, a tear of the supraspinatus and rotator cuff tendinosis. The MRI of the right hip revealed minimal fraying of the anterior acetabulum consistent with a tear and mild trochanteric bursitis (Petitioner's Exhibits 9 and 10).

Dr. Rhode saw Petitioner on April 9, 2014, and reviewed the MRI scans. One portion of his record of that date indicated that the MRI was performed on the right shoulder, but, on the same page, it also indicated it was performed on the left shoulder. In any case, Dr. Rhode noted that his examination of the left shoulder was positive for impingement. At that time, Dr. Rhode did not address Petitioner's right hip condition (Petitioner's Exhibit 12).

When Dr. Rhode saw Petitioner on May 7, 2014, he noted that the MRI of the right hip revealed a labral tear. Petitioner complained of locking and catching in the right hip. Dr. Rhode recommended Petitioner undergo right hip arthroscopy. He also examined Petitioner's right shoulder and opined it was positive for impingement (Petitioner's Exhibit 12).

Dr. Rhode continued to see Petitioner. When he evaluated Petitioner on August 27, 2014, he noted he was awaiting authorization to proceed with right shoulder surgery (even though the records did not indicate a prior recommendation for right shoulder surgery). When Dr. Rhode saw Petitioner on September 10, 2014, he noted he was awaiting authority for the right hip surgery (Petitioner's Exhibit 12).

Dr. Rhode subsequently saw Petitioner on October 14, 2014, for bilateral shoulder and right hip pain. At that time, Dr. Rhode indicated he was awaiting authorization for arthroscopic left shoulder surgery (Petitioner's Exhibit 12).

Dr. Rhode continued to periodically see Petitioner from March 9, through November 7, 2015. He continued to recommend Petitioner undergo arthroscopic surgeries on both the right and left shoulders as well as the right hip (Petitioner's Exhibit 12).

Dr. Rhode was deposed on February 24, 2016, and his deposition testimony was received into evidence at trial. In regard to his testimony regarding Petitioner's left shoulder condition, Dr. Rhode said that he initially saw Petitioner on August 29, 2012, and she informed him that she had lifted a crate of milk and felt a "pop" in her left shoulder. He stated that the MRI of June 26, 2012, revealed a rotator cuff tear. Dr. Rhode recommended Petitioner undergo a rotator cuff repair on the left shoulder. In regard to the MRI of April 2, 2014, Dr. Rhode testified that the report which indicated that it was of the left shoulder was probably a typo (Petitioner's Exhibit 14; pp 5-6, 9-10, 17).

Dr. Rhode was questioned about the causality of the left shoulder rotator cuff tear. He stated that it was caused or aggravated by the accident when Petitioner lifted a milk crate and felt a "pop" in her left shoulder (Petitioner's Exhibit 14; pp 24-25).

In regard to Petitioner's right shoulder and right hip conditions, Dr. Rhode testified that Petitioner informed him of the accident of August 15, 2012. Dr. Rhode's testimony regarding his diagnosis and surgical recommendations in regard to Petitioner's right shoulder condition was consistent with his medical records. In regard to causality of the right shoulder condition, Dr. Rhode testified that Petitioner's falling and attempting to break the fall with her outstretched hand could have caused the right shoulder rotator cuff tear (Petitioner's Exhibit 14; pp 22-23).

In regard to Petitioner's right hip condition, Dr. Rhode testified that, as a result of the accident of August 15, 2012, Petitioner sustained a right hip contusion with trochanteric bursitis which had resolved. In regard to the labral tear he diagnosed, Dr. Rhode had no hope opinion as to whether it was related to the accident of August 15, 2012 (Petitioner's Exhibit 14; p 24).

On cross-examination, Dr. Rhode agreed he had no knowledge of whether Petitioner had any prior left shoulder, right shoulder or right hip problems. He agreed that if there was evidence of prior problems in those anatomical areas, it could affect his opinion as to causality. Specifically, Dr. Rhode knew nothing about Petitioner having sustained the gunshot wound in 1997 and that she also received medical treatment for her right hip in June, 2010 (Petitioner's Exhibit 14; pp 32-34).

Respondent provided Dr. Lehman with additional medical records and the transcript of Dr. Rhode's deposition testimony. Dr. Lehman reviewed same and prepared a supplemental report dated June 21, 2016. Dr. Lehman did an extensive and comprehensive review of the information provided to him. In regard to the left shoulder, Dr. Lehman opined Petitioner had a chronic massive rotator cuff tear and noted that Petitioner also had atrophic changes of the musculature of the supraspinatus tendon which was consistent with long term chronic changes. In regard to the right shoulder, Dr. Lehman opined Petitioner had impingement syndrome, atrophy of the supraspinatus muscle and degenerative changes. In regard to causality, Dr. Lehman opined that Petitioner's current problems in her shoulders were not caused, exacerbated or altered by either the work-related incident of April 1, 2012, or August 15, 2012 (Respondent's Exhibit 9; Deposition Exhibit 1).

Dr. Lehman was deposed on March 3, 2014, and again on August 23, 2016, and his deposition testimony was received into evidence at trial. In regard to his testimony of March 3, 2014, Dr. Lehman's testimony was consistent with his medical report of August 29, 2013, and he reaffirmed the opinions contained therein. The various medical records Dr. Lehman reviewed were received as deposition exhibits when he was deposed and Dr. Lehman testified in detail regarding his review of same. Specifically, Dr. Lehman noted Petitioner had complaints and medical treatment that predated both of the accidents (Respondent's Exhibit 7; pp 15-26).

In regard to Petitioner's left shoulder condition, Dr. Lehman noted that the MRI of June 26, 2012, did not reveal an acute tear, but it did reveal findings consistent with long term degenerative changes which would have been a multi-year process. Based upon the preceding and the fact that Petitioner had prior medical treatment for her left shoulder symptoms, Dr. Lehman testified that Petitioner's left shoulder condition was not aggravated or accelerated by the accident of April 1, 2012 (Respondent's Exhibit 7; pp 16-19, 30-31).

In regard to Petitioner's right shoulder condition, Dr. Lehman noted that the MRI of November 14, 2012, revealed severe degenerative changes that were chronic and pre-existed the accident of August 15, 2012. He also noted that there was atrophy of the supraspinatus musculature which was indicative of a long term chronic condition. He testified that Petitioner's right shoulder condition was not aggravated or accelerated by the accident of August 15, 2012 (Respondent's Exhibit 7; pp 27-31).

In regard to Petitioner's right hip condition, Dr. Lehman noted Petitioner had prior right hip symptoms, including the gunshot wound of 1997. He testified that her current right hip problems were not related to the accident of August 15, 2012 (Respondent's Exhibit 7; pp 32-33).

When Dr. Lehman was deposed on August 23, 2016, his testimony was consistent with his report of June 21, 2016, and he reaffirmed the opinions contained therein. Dr. Lehman's opinions in regard to causality of Petitioner's left shoulder, right shoulder and right hip conditions remained the same (Respondent's Exhibit 9; pp 10-15).

At trial, Petitioner testified that Dr. Rhode recommended she have surgery on both the left and right shoulders as well as the right hip. Petitioner still has pain in both shoulders and stated that they feel like they are going to come out of their sockets. She also continues to have right hip pain. Petitioner does want to proceed with the surgeries as recommended by Dr. Rhode. Petitioner also testified that she had no prior right shoulder problems. In regard to her right hip, Petitioner stated that the gunshot wound of 1997 was in the right abdominal area and was close to the hip, but not in the same area where she is presently having symptoms.

Conclusions of Law

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

The Arbitrator concludes that Petitioner did not sustain an accidental injury arising out of and in the course of her employment for Respondent on March 21, 2012, or April 1, 2012.

In support of this conclusion the Arbitrator notes the following:

Petitioner was uncertain of the date of the accident. The Application alleged a date of accident of March 21, 2012. However, the "Employer's First Report of Injury" indicated that the date of accident was April 1, 2012.

As noted herein, because of Petitioner's uncertainty as to the date of the accident, at trial, Petitioner's counsel made a motion to amend the date of accident on the Application to "on or about" March 21, 2012. Respondent's counsel objected to the motion and the Arbitrator reserved ruling on same. Because of the Arbitrator's decision regarding accident, it is not necessary for the Arbitrator to rule on Petitioner's counsel's motion to amend the Application.

When Petitioner first sought medical treatment on April 10, 2012, at Proctor First Care, the record made no reference at all to Petitioner having sustained a work-related accident. As noted herein, subsequent medical records from that same provider likewise did not have any reference to Petitioner having sustained a work-related accident.

Various other medical records received into evidence for treatment Petitioner received were unclear as the date of accident as well, some of them indicating either March, 2012, or April, 2012.

When Petitioner was evaluated by Dr. Lehman on August 29, 2013, she advised the date of accident was April 1, 2012.

There were numerous versions as to exactly how the accident occurred. The Application alleged that Petitioner injured her left arm while lifting heavy pots and pans. Petitioner's testimony at trial was consistent with what was alleged in the Application. However, the history given by Petitioner at IWIRC on July 11, 2012, was that she injured her left shoulder while lifting boxes. When Petitioner was initially seen by Dr. Rhode on August 29, 2012, she stated she injured her left shoulder when she lifted a crate of milk. When Petitioner was examined by Dr. Lehman on August 29, 2013, she advised she hurt her left shoulder while lifting boxes and putting away supplies.

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

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF MCCLEAN)

☒ 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

Jeremy Swiech,
Petitioner,
vs.

NO: 16WC 29250

Petersen Motors, Inc., d/b/a
Petersen Chevrolet Buick,
Respondent.

19IWCC0202

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, notice, causal connection, medical, prospective medical, temporary total disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 11, 2018, is hereby affirmed and adopted.

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

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

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

DATED: APR 24 2019

L. Elizabeth Coppoletti

Douglas McCarthy

Stephen Mathis

o040819
LEC/jrc
043

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

SWIECH, JEREMY
Employee/Petitioner

Case# **16WC029250**

PETERSEN MOTORS INC D/B/A PETERSEN CHEVROLET BUICK
Employer/Respondent

19IWCC0202

On 6/11/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.07% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0564 WILLIAMS & SWEE LTD
STEVEN R WILLIAMS
2011 FOX CREEK RD
BLOOMINGTON, IL 61701

0264 HEYL ROYSTER VOELKER & ALLEN
DANA HUGHES
PO BOX 6199
PEORIA, IL 61601-6199

19IWCC0202

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)

JEREMY SWIECH,
Employee/Petitioner

v.

PETERSEN MOTORS INC., d/b/a PETERSEN CHEVROLET BUICK,
Employer/Respondent

Case # **16** WC **29250**

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 **Gerald Granada**, Arbitrator of the Commission, in the city of **Bloomington**, on **5/21/18**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

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

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

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

E. [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

19IWCC0202

On the date of accident, **5/3/16**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident ***was 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 $**28,277.08**; the average weekly wage was **$543.79**.

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

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

ORDER

Petitioner failed to prove the issue of accident. Therefore 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

6/8/18
Date

Jeremy Swiech v. Petersen Motors, 16 WC 29250 - ICArbDec19(b)

JUN 11 2018

FINDINGS OF FACT

This case involves a Petitioner alleging injuries sustained while working for the Respondent on May 3, 2016. Respondent disputes Petitioner's claims and the issue in dispute are: 1) accident; 2) notice; 3) causation; 4) medical expenses; and 5) TTD.

Petitioner worked for Respondent as a mechanic/lube tech and began working for Respondent in August, 2015. Petitioner testified that on May 3, 2016 he was retrieving a rear-end differential for a Dodge Durango at Lincoln Truck and Auto in Bloomington, Illinois. An employee of Lincoln Truck and Auto retrieved the part on a fork truck. As Petitioner was standing in the bed of the pick-up truck to guide the delivery of the part, he picked up the part and, as the fork lift was pushing it into the bed of the truck, he twisted and fell backwards into the bed. He fell onto his buttocks and was embarrassed. The employee asked him if he was alright. He felt that he was and jumped out of the back end of the pick-up truck, and completed the paperwork portion of the parts pick-up inside.

Petitioner testified that when he went back to work that day he felt a tightening in his low back. He reported the injury to Mike Petersen who did not prepare any accident paperwork. Petitioner finished his work day and then sought an office visit on May 4, 2016 with his primary care physician, Dr. Stevens, filling in for his regular doctor Schweizer. (PX 2) He had previously seen his primary care doctor for low back pain on January 22, 2016. When he saw her on May 4, 2016, he again had complaints of low back pain with bilateral sciatica after lifting a rear end (car part) and hitting his back against the back of a pick-up truck. Petitioner continued to work for two more weeks until he sought treatment at OSF Occupational Health Clinic on May 17, 2016 through his employer. (PX 1) X-rays showed degenerative disc disease at L5-S1. An MRI obtained on May 23, 2016 showed small herniations and possible small annular tears at the L4-5 and L5-S1 levels. The radiologist's impression was degenerative changes with mild protrusions and small annular tears at those levels with no significant stenosis. Petitioner obtained an orthopedic referral at that time.

On June 9, 2016, Petitioner saw orthopedic surgeon Ann Stroink, M.D. Dr. Stroink's impression was that Petitioner had degenerative disc disease at L4-5 and L5-S1 levels. She noted no damage to his neural elements. She opined that Petitioner's condition was not surgical and described it as a back strain related to traumatic injury. (PX 3) Dr. Stroink referred the Petitioner to Won Jhee, M.D. to manage his return to work issues.

On July 5, 2016, Petitioner saw Won Jhee, M.D. on referral from Dr. Stroink. (PX 4) Dr. Jhee recommended Petitioner undergo physical therapy and to see him for re-evaluation in six weeks. He wrote the Petitioner a twenty pound work restriction at that time. On July 7, 2016, Petitioner underwent his initial evaluation for physical therapy pursuant to Dr. Jhee's recommendation. He reported his pain was 10 out of 10. A treatment plan was initiated, with his first visit to begin on July 8, 2016.

On July 8, 2016, Respondent obtained surveillance of Petitioner. The surveillance showed Petitioner engaged in many activities, including bending, lifting, diving into a pool and throwing children in the pool. After doing so, he got in and out of the pool and his car without obvious signs of discomfort on his face or in the manner in which he moved. (RX 4) Petitioner's Exhibit No. 10 shows Petitioner's daughter, the smaller of the two children in the video, weighed 34 pounds at that time. Petitioner

testified that while in the water, he was attempting to do physical therapy. That same day at physical therapy, Petitioner noted his low back pain was a 10 out of 10. He described an incident at home where his knees buckled and he fell, increasing his pain. Petitioner described that he believed his legs buckled due to the low back pain, which was radiating into his bilateral legs. He continued to complain of pain at 10/10 levels for the next several PT visits.

Petitioner underwent an EMG on August 5, 2016. It showed mild left L5 nerve root irritation with no lumbosacral radiculopathy. Petitioner obtained a referral to Millennium Pain at that time for injection therapy with Dr. Vallejo.

On August 30, 2016, Dr. Timothy VanFleet examined Petitioner at Respondent's request. Based on this examination, Respondent denied the Petitioner's referral to Millennium Pain. (RX 3) Dr. VanFleet testified via evidence deposition on September 13, 2017. He opined that Petitioner has suffered a back strain as a result of the May 3, 2016 incident at Lincoln Truck and Auto, but was at MMI for that condition as of July 8, 2016, the date of the surveillance video. Dr. VanFleet opined that Petitioner had been exaggerating his pain complaints and that they were not consistently reported in the medical records as they were shown on the surveillance. Dr. VanFleet believed Petitioner was malingering, did not have a surgical condition, and did not require further care and treatment as a result of the work injury. He opined the mechanism of injury as described would not permanently aggravate a low back condition. (RX 4)

On October 17, 2016, Petitioner presented to Dr. Vallejo for treatment at Millennium Pain Center. (PX 5) Dr. Vallejo instituted a pain management treatment plan for the Petitioner, which included facet joint injections to rule out facet join pain, and radiofrequency, if facet joints were the problem. When the facet joint injections did not provide relief, Dr. Vallejo performed bilateral sacroiliac joint injections - which provided no relief. Dr. Vallejo then performed a discogram on December 15, 2016, which revealed two ruptured discs at L4-5 and L5-S1 levels. Dr. Vallejo indicated "lumbar fusion is unlikely to provide any relief." In March of 2017, Dr. Vallejo performed biacuplasty, which also provided Petitioner no relief. In June, 2017, Petitioner again requested to see Dr. Stroink. A new MRI was ordered and completed on July 3, 2017, which showed worsening of the conditions at L4-5 and L5-S1.

On November 2, 2017, Petitioner saw Jesse Bulter, M.D. Petitioner testified Dr. Vallejo provided the referral to see Dr. Butler, but that referral is not contained within Dr. Vallejo's notes. Petitioner testified he heard of Dr. Butler through an acquaintance. None of the medical treatment providers appear to have been recommending Dr. Butler as a choice for second opinion regarding surgery. When Dr. Butler saw the Petitioner, he indicated he did not have a comprehensive set of medical records nor the Petitioner's IME with Dr. VanFleet or the surveillance. (PX 6) He nevertheless recommended a surgical fusion at the L5-S1 levels, which he performed on December 22, 2017. As of the last visit before trial, May 3, Petitioner was still restricted but was doing very well and anticipated to return to work in July of 2018. Petitioner agreed he was doing well and felt he would be capable of returning to work in July, 2018.

Mike Struck testified on Respondent's behalf. He is employed at Lincoln Truck and Auto, and was the person who placed the part into Petitioner's pick-up truck on May 3, 2016. Mr. Struck testified he retrieved the rear-end of the Dodge Durango with a fork truck that had a boom and chains on it as safety

precautions. He described his boss at Lincoln Truck and Auto to be very concerned about customers and employee safety at Lincoln Truck and Auto so he required these safety mechanisms. He retrieved the part with the truck and placed the part in the back end of Petitioner's pick-up truck. When he did so, the Petitioner was in the back end of the pick-up truck. Mr. Struck could not recall whether he or the Petitioner unchained the part. At the time they did this, the part was securely placed into the bed of the pick-up truck. Mr. Struck never observed the Petitioner lift or handle the part in any way. He did not observe the Petitioner fall and did not ask the Petitioner if he was okay at any time. He observed the Petitioner sustained no injury whatsoever. Mr. Struck saw the Petitioner the entire time he was in the bed of the pick-up truck until he jumped out after the part was securely placed in the bed of the pick-up truck. Mr. Struck never spoke with the Petitioner after that and observed the Petitioner in no pain. He testified there would have been no reason for the Petitioner to have lifted the part in any way due to the manner in which he retrieved it and secured it in the bed of the pick-up truck. Petitioner claimed on redirect that the fork truck had no boom and no chains.

CONCLUSIONS OF LAW

1. With regard to the issue of accident, the Arbitrator finds that the Petitioner has failed to meet his burden of proof. In support of this finding, the Arbitrator relies on the testimony at trial, in particular the testimony of Mr. Struck, the video surveillance and the medical evidence – all of which cast great doubt on Petitioner's credibility. Mr. Struck's testimony directly contradicts Petitioner's description of his alleged accident. The Arbitrator finds credible Mr. Struck's testimony regarding the use of a boom on a fork truck to lift and transport the heavy car part to avoid any individual having to physically handle the car part – as Petitioner alleges. The Arbitrator further finds credible Mr. Struck's testimony that he observed the Petitioner the entire time he was loading the car part onto Petitioner's truck and did not observe the Petitioner fall or sustain any injury.

Dr. VanFleet's testimony was also very persuasive on this issue. Dr. VanFleet reviewed the Petitioner's medical records and the video surveillance before concluding that Petitioner was malingering. He noted that the Petitioner attended physical therapy on July 8, 2016 and complained of back pain rated at 10/10. He further noted that Petitioner's report of pain on July 8, 2016 was clearly inconsistent with Petitioner's presentation in the video surveillance from that same date. This Arbitrator viewed the 56 minutes and 03 seconds of video and strongly agrees with Dr. VanFleet's assessment. During the 56 minutes and 03 seconds of video, Petitioner is seen walking, bending, standing, diving, lifting and throwing children with not even the slightest indication of difficulty or any sign of pain. Petitioner testified that while he was in the swimming pool, he was attempting to do physical therapy – yet the Arbitrator saw no sign of any such effort.

After reviewing Dr. VanFleet's testimony, the video surveillance and the testimony of Mr. Struck, the Arbitrator concludes that the Petitioner's testimony lacks credibility. Therefore, the Arbitrator concludes that the Petitioner failed to meet his burden of proof with regard to the issue accident.

2. Based on the Arbitrator's findings with regard to the issue of accident, all other issues are rendered moot.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jimmy Fitzwater,

Petitioner,

vs. NO: 14 WC 12265

Mr. Bult's Inc.,

Respondent.

19IWCC0203

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

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

The Commission affirms the decision of the Arbitrator relying on the opinions of Dr. Wilkey, Respondent's Section 12 Examiner, but with different reasoning as noted herein. The Commission acknowledges credibility issues noted by the Arbitrator under the evidence and testimony presented, and that the surveillance video alone could bring into question the credibility of Petitioner's subjective complaints. However, it is the acknowledgement of Petitioner's treating physician, Dr. Gornet, relating to the reliability of Petitioner's subjective reports, that buttress the opinions of Dr. Wilkey rendering them persuasive in this case.

Dr. Gornet has recommended an anterior/posterior fusion surgery at L5-S1 since August 18, 2014 to address Petitioner's low back condition that he opined was causally related to the injury at work. As noted in the Arbitrator's decision (page 10), Dr. Gornet testified at his deposition that he had reviewed IME reports from Dr. Lange which he stated supported his opinion that Petitioner needed surgery. However, Dr. Lange's reports were excluded as hearsay. The Arbitrator noted that Dr. Lange did not testify due to his retirement.

On January 5, 2015, Dr. Gornet reviewed an additional MRI that he ordered to evaluate for further pathology. Respondent also submitted Dr. Gornet's treatment plan for the proposed staged anterior/posterior fusion surgery at L5-S1. On January 12, 2015, Dr. Gornet noted that his surgical treatment plan was referred for utilization review and was denied, with which Dr. Gornet disagreed.

Petitioner later underwent additional evaluation at Respondent's request. On April 14, 2015, Dr. Wilkey performed a records review and agreed that Petitioner's condition was causally related to the work injury requiring surgery, but he did not examine Petitioner at that time nor did he view any of the surveillance video.

While Dr. Gornet's surgery recommendation was made in 2014, Petitioner's credibility remained a core issue. Respondent placed Petitioner under surveillance, which was performed between April 29, 2015 and May 1, 2015.

Petitioner then saw Dr. Wilkey for a Section 12 examination on June 23, 2015. Dr. Wilkey had the opportunity to take a history, examine Petitioner, and view the surveillance video. Given this additional information, Dr. Wilkey opined that Petitioner's condition was not causally related to the injury at work and that he did not require surgery as a result.

Dr. Wilkey gave deposition testimony on April 26, 2016 regarding his opinions. He noted that Petitioner complained of low back pain at a level of 9/10. Petitioner also reported that his symptoms had not significantly changed over the past several months. He further reported that twisting/bending aggravated his symptoms, and he had difficulty sleeping. Dr. Wilkey testified that what he saw on video was contrary to Petitioner's complaints. Specifically, Dr. Wilkey noted that the video showed that Petitioner was able to cut the grass with minimal difficulty, move a pallet and lift a flower pot that required him to bend further than he was willing to bend at the time of his examination. He also noted that the video showed Petitioner helping clean a vehicle and otherwise exhibiting range of motion without pain, difficulty, or the facial grimacing he expressed during the Section 12 examination during less extensive range of motion testing.

The Commission finds that Dr. Wilkey's ultimate opinion that Petitioner's subjective complaints were unsubstantiated, and that there is no causal connection between Petitioner's condition and the accident at work, is supported by the admissions of Petitioner's treating physician, Dr. Gornet. Dr. Gornet's testimony on both direct and cross examination that the "unfortunate" surveillance video created a credibility problem is telling. Although Dr. Gornet maintained his recommendation for surgery and his causal connection opinion despite "... a long discussion [with Petitioner] regarding his symptoms and his credibility[,]", he admitted that Petitioner's credibility was ultimately "... what this comes down to[and] I think that's why we are here today and I'd rather

be honest about that." (PX 1, 43-45). As noted in the Arbitrator's decision, Dr. Gornet acknowledged that Petitioner had 'credibility' issues. However, he refused to acknowledge that Petitioner was magnifying symptoms, or that surgery was unreasonable or unnecessary."(PX 1, 31-32,35). Notwithstanding, Dr. Gornet's concerns about Petitioner's subjective complaints, after viewing the surveillance video, ultimately supports Dr. Wilkey's conclusion that, from a medical perspective, no further causal connection existed between the accident at work and Petitioner's condition. Given the foregoing, the Commission accepts the ultimate opinions of Dr. Wilkey given the evidence and testimony presented at trial and affirms the decision of the Arbitrator as stated herein.

The Commission further finds that Petitioner's current condition of ill-being is not causally related to the accident. Petitioner suffered a compensable low back injury on March 10, 2014, however, he failed to meet his burden of proving that any treatment subsequent to Dr. Wilkey's June 23, 2015 Section 12 examination is reasonable or work related. Respondent has paid the reasonable and necessary medical expenses through that date; all further medical benefits are denied as not causally related.

IT IS THEREFORE 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: APR 25 2019

Barbara N. Flores

DLG/jsf
4/4/19
045

Deborah L. Simpson

Marc Parker

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

FITZWATER, JIMMY
Employee/Petitioner

Case# **14WC012265**

MR BULT'S INC (MBI)
Employer/Respondent

19IWCC0203

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

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

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

5341 BROWN & BROWN
DAVID J JEROME
5440 N ILLINOIS ST SUITE 101
FAIRVIEW HTS, IL 62208

0000 WIEDNER & McAULIFFE LTD
KHRISTOPHER S DUNARD
8000 MARYLAND AVE SUITE 550
ST LOUIS, MO 63105

STATE OF ILLINOIS)
)SS.
COUNTY OF MADISON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Jimmy Fitzwater
Employee/Petitioner

v.

Mr. Bult's, Inc. (MBI)
Employer/Respondent

Case # 14 WC 12265

Consolidated cases:

19IWCC0203

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Collinsville**, on **3/21/18**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

19IWCC0203

FINDINGS

On the date of accident, **3/10/14**, 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 not* causally related to the accident.

In the year preceding the injury, Petitioner earned **$34,192.08**; the average weekly wage was **$657.54.**

On the date of accident, Petitioner was **43** years of age, *married* with **0** dependent children.

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

Respondent shall be given a credit of **$10,390.58** for TTD, **$n/a** for TPD, **$n/a** for maintenance, and **$0.00** for other benefits, for a total credit of **$10,390.58.**

Respondent is entitled to a credit of **$2,206.78** under Section 8(j) of the Act.

ORDER

Petitioner suffered a compensable lower back injury on March 10, 2014. However, Petitioner failed to meet his burden of proving any treatment subsequent to Dr. Wilkey's June 23, 2015 IME is reasonable or work related.

-The Arbitrator denies any additional medical expenses and finds Respondent has paid for all reasonable/necessary medical expenses. The discogram procedure performed by Dr. Gornet is denied as unnecessary based Dr. Wilkey's IME opinion. The staged fusion procedure is denied as unnecessary based Dr. Wilkey's IME opinion.

-All TTD benefits subsequent to June 23, 2015 are denied. Respondent shall receive a credit of $10,390.58 against any future award of benefits.

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

Date 5/12/18

ICArbDec19(b)

MAY 15 2018

JIMMY FITZWATER v. MR. BULT'S INC., 14 WC 12265

RESPONDENT'S PROPOSED FINDINGS

FINDINGS OF FACT:

This case was tried in Collinsville on 3/21/18. The primary issues in dispute are causation subsequent to Dr. Wilkey's June 23, 2015 IME, the reasonableness and necessity of Petitioner's discogram and staged L5-S1 fusion procedure, and TTD benefits from 7/14/15 through 9/28/15. (Arb. Ex. 1).

Petitioner testified that he is a 46-year-old welder who was employed with Mr. Bult's at the time of his March 10, 2014 incident. He noted that his position at Mr. Bult's was as a welder/trailer mechanic. This required him to work on larger equipment and lifting sheeting 100 pounds or more, as well as brake drums up to 80 pounds. He indicated that he also had his welding lead and gun that weighed approximately 50 pounds. He estimated that he was performing some type of lifting or welding activity approximately 50% of the day. Most of his day was spent standing and walking. (T. 6-10).

With respect to his March 10, 2014 incident, he noted that he was in a bay performing a repair on a top rail of a trash hauling body. In order to get up onto the truck, he had to climb up an extension ladder onto a pallet. As he was coming down the ladder, it slipped from underneath him and he landed directly on his lower back. He felt immediate pain in his lower back and left hip and along with a sharp pain in his legs. He noted that his primary symptoms were on the left side. (T. 10-13).

Petitioner subsequently presented to the emergency room for initial treatment. He was then evaluated at the request of the employer by Concentra and his primary care physician. Both providers referred him to Dr. Gornet for further evaluation. He ultimately underwent injections with Dr. Boutwell, which helped some, but did not significantly improve his symptoms. Given the failure to improve, Dr. Gornet recommended a L5-S1 fusion procedure. Petitioner testified that although the surgery was originally authorized, it was subsequently denied after Dr. Wilkey's 2015 IME report. (T. 15-21).

The medical records show that Petitioner presented to Community Memorial Hospital Emergency Department on March 10, 2014 for initial treatment. (PX 3). He reported that he had fallen from a ladder at a height of about five feet and landed on his left side. His primary complaint was pain to his lower back, left hip, and some pain to the left elbow. He noted that he drove himself to the emergency room. Examination revealed tenderness over the lower lumbar spine, posterior aspect of left hip and posterior aspect of left elbow. X-ray and CT scans of the lumbar spine revealed no evidence of acute injury. Mild spondylolisthesis and degenerative changes were present in the apophyseal joints which was thought to be responsible for the slight mal-alignment with L5 anterior and S1 by two to three millimeters. A CT scan of the pelvis was normal.

Petitioner was diagnosed with lower back, left hip, and left elbow contusions, and degenerative disc disease of the lumbar spine. He was given a prescription for Vicodin and instructed to follow up with his primary care physician, Dr. Poos, for further care. (PX 3).

Petitioner presented to Dr. Poos for a follow up evaluation on March 13, 2014, reporting intense pain in his back, radiating up his back and down into his leg. (PX 2). He also described numbness and tingling in both of his legs, which was worse in the left side. Dr. Poos noted petitioner had a past history of cigarette smoking of one pack per day, but quit in 2005. Examination revealed that petitioner was limping, had tenderness in the lumbar spine, and positive straight leg testing. He also reported tenderness in the left elbow. Although Dr. Poos noted that the CT revealed chronic appearing features, he placed petitioner on sedentary-duty restrictions. He also recommended a lumbar spine MRI and referred petitioner for an orthopedic specialist.

Petitioner underwent the recommended MRI on March 19, 2014. (PX 9). It was interpreted to show a transitional lumbosacral appearance, mild degenerative changes in the lumbar spine, mild to moderate facet arthropathy at L5-S1, mild bulging, and at most mild spinal canal and/or foraminal narrowing. However, no focal neural impingement or herniations were noted.

Petitioner returned to Dr. Poos on March 24, 2014. (PX 2). Dr. Poos interpreted the MRI to show a clear injury to petitioner's disc in addition to the degenerative findings. He believed that this was most likely caused by the fall at work, and recommended a referral to an orthopedist.

On April 21, 2014, petitioner presented to Dr. Gornet for an orthopedic evaluation. (PX 5). He gave a consistent history of his injury, and indicated he did not recall any previous lower back problems. Petitioner reported that his symptoms were constant and severe, worse with prolonged sitting, bending, lifting or standing and is better with a change in position.

Examination showed decreased extensor hallucis longus function at 4/5 and severe pain with any type of bending activity. Dr. Gornet also reviewed the March 19, 2014 MRI and interpreted it to show edema in the pedicles at L5-S1 consistent with acute trauma. He also noted there was a suggestion of a fracture line to the right and left pedicles at S1 and subtle changes and protrusion of the disc at L5-S1, with suggestion of an annular tear. He noted that none of these findings, other than the facet arthropathy, were mentioned in the MRI report. Based upon petitioner's history and lack of prior lower back complaints, Dr. Gornet opined that petitioner's work incident was at least an aggravation of his underlying facet condition. He recommended a new MRI, as well as a plane CT scan to determine whether petitioner had findings consistent with a near or possible fracture. He placed petitioner completely off work. (PX 5).

Petitioner also completed a patient questionnaire indicating that his low back pain was constantly a 9 to 10 out of 10. (PX 5). When asked how bad his pain was at the time of the exam, Petitioner indicated "always pain (10)."

Petitioner underwent the recommended MRI on April 21, 2014. (PX 6). It was interpreted by Dr. Matt Ruyle to show Grade I anterolisthesis at L5-S1 with bilateral facet joint diastasis; abnormal edematous signal in the pedicles of both L5 and S1, and a pars interarticularis of L5, raising concern for pars interarticularis fractures on the right. He noted there was certainly a component of degenerative spondylolisthesis and erosive facet arthropathy, but petitioner's edematous marrow pattern was not typically seen with an entirely erosive facet arthropathy. He recommended a CT for further evaluation.

Dr. Gornet reviewed the MRI and CT images on April 21, 2014. (PX 5). He interpreted the studies to show significant bone edema at the L5-S1 pedicles bilaterally with suggestion of a fracture, in addition to disc/facet pathology. He interpreted the CT scan to reveal a fracture through the pars into the pedicle. He diagnosed petitioner with an L5 fracture and potentially impending fractures at L5-S1, along with an aggravation of underlying facet arthritis. He recommended rest and conservative care, and if petitioner did not improve, injections or surgery could be considered.

Petitioner returned to Dr. Gornet on June 2, 2014, reporting slow improvement, but continued pain and symptoms. Dr. Gornet recommended epidural steroid injections at L5-S1 and prescribed physical therapy. He continued to place petitioner off work. (PX 5).

Petitioner underwent a left L5-S1 epidural steroid injection on June 16, 2014. (PX 8).

Petitioner underwent a second L5-S1 epidural steroid injection on June 30, 2014. (PX 8).

On July 17, 2014, petitioner presented to Dr. Gornet for a post-injection follow up. Dr. Gornet noted that petitioner's symptoms had failed to improve with physical therapy and injections. As such, he recommended a CT discogram at L4-5 and L5-S1. (PX 5).

On August 12, 2014, petitioner underwent the recommended discogram and CT scan. The discogram revealed pain at 0-1/10 at L4-5 with a pressure of 15 psi. In regards to the L5-S1 level, Petitioner's pain was assessed at 8/10. The CT scan was interpreted by Dr. David Wu to show a broad-based Grade III-IV annular tear in the right and greater than left lateral portion of L5-S1 disc; 7-8 mm anterolisthesis and broad-based disc bulge with facet hypertrophy resulting in bilateral moderate to severe foraminal encroachment at L5-S1; and mild disc bulge without discreet annular tear in the disc at L4-5. (PX 5).

Dr. Gornet reevaluated petitioner on August 18, 2014. He noted that the discogram revealed a provocative disc at L5-S1, and recommended an AP fusion at L5-S1 with decompression. He continued to place petitioner off work. (PX 5).

A third MRI was performed on 1/05/15 and interpreted to show degenerative grade I anterolisthesis at L5-S1 measuring up to 4mm; no fracture and no L5 pars defects were detected. Severe erosive facet arthropathy, ligamentum flavum hypertrophy and left sided facet synovial cyst protruding into the left lateral recess were present. Mild bilateral foraminal stenosis and mild central canal stenosis was present at L5-S1. (PX 6).

Dr. Lange originally conducted an Independent Medical Examination and prepared several addendum reports. Although Petitioner attempted to introduce the reports into evidence as part of Dr. Gornets's deposition, Respondent raised a hearsay objection. (PX 1, 22). As Dr. Lange retired, Respondent was unable to obtain his deposition. In addition, Dr. Lange did not have the opportunity to review the 4/29/15-5/1/15 surveillance footage. The Arbitrator sustains Respondent's objection to the Dr. Lange's IME reports.

Respondent elected to have Dr. Wilkey perform a records review IME on April 14, 2014 after reviewing petitioner's medical records and diagnostic imaging. Based solely on the records and imaging, Dr. Wilkey diagnosed petitioner with L5-S1 spondylolisthesis, and a possible pars fracture at L5-S1. He believed that based on the studies the L5-S1 AP fusion recommended by Dr. Gornet could be considered an option for petitioner. (RX 2, 108).

Respondent subsequently obtained surveillance footage of Petitioner showing Petitioner engaged in multiple activities between 4/29/15 and 5/1/15. (RX 1 and RX 2). The total footage is 218 minutes. However, the Arbitrator had the chance to review the relevant portion of the surveillance footage at trial.

The footage shows Petitioner pushing and pulling a self-propelled lawnmower for approximately 24 minutes on 4/29/15. Petitioner bends over without difficulty while mowing the lawn. Contrary to Petitioner's testimony of constant pain of from 9-10/10, there is no evidence of significant discomfort seen.

On 4/30/15, Petitioner is seen bending over to pick up a pallet while holding his dog without difficulty. Petitioner also lifts up a plastic pot without difficulty.

On 5/1/15, Petitioner is seen cleaning out a car. He bends over, squats down, and beats dust out of a car mat.

Petitioner attempted to explain the footage. (T. 31). With respect to the footage of him mowing the lawn, he reported that he was advised by Dr. Gornet that it would be helpful to attempt to engage in activities if possible. Dr. Gornet also advised petitioner to strengthen his core. Petitioner indicated that the portions of the video showing him bending resulted in increased pain. However, the Arbitrator notes there is no visible evidence of increased pain on the footage. (T. 32-37).

Petitioner also commented on footage showing him bending over and picking up a pallet for approximately nine seconds seconds. He indicated that the pallet was a landscape pallet that had rotted out and weight approximately four to five pounds. Although Petitioner testified the pallet only weighed 4-5 pounds, he indicated that his pain became so severe after lifting the pallet that he had to go back inside to sit down. The Arbitrator notes there is no visible evidence of pain on the footage. (T. 38-42)

With respect to the plastic pot, Petitioner noted that the pot was very light. Further, he had to lay down between lifting the pallet and the plastic pot. (T43-44). Finally, petitioner

addressed footage of him cleaning a car and bending over. He was engaged in these activities for approximately 25 minutes. He indicated that he was never told by anyone that he could not bend over. He further indicated that he did not lift anything heavier than a floor matt while cleaning the car. (T. 44-48).

Petitioner also testified that he had good and bad days. He attempted to engage in more extensive physical activities on his good days, but sometimes was unable to do so. He stated that his pain had been relatively consistent since the time of his initial incident. (T. 46).

Dr. Wilkey performed an in person IME on June 23, 2015 and also reviewed the surveillance footage. (RX2, 111). Petitioner reported that his pain level was 9/10 most of the time, which Dr. Wilkey indicated would essentially be consistent with sufficient pain to present to the emergency room. Petitioner also reported difficulties with bending and twisting and engaging in other activities of daily living. Petitioner did not indicate his difficulties occurred with repetitive bending or twisting.

On physical examination, Dr. Wilkey noted extreme facial grimacing with range of motion testing and decreased range of motion in all planes. Dr. Wilkey noted that petitioner demonstrated "cog-wheeling" on examination. He explained that cog-wheeling is present where the patient demonstrates weakness in a give way type fashion and was indicative of symptom magnification. (RX2, 111-112).

Dr. Wilkey also commented on the surveillance footage. He believed that the activities Petitioner engaged in were inconsistent with petitioner's presentation at the time of the IME. After reviewing the surveillance footage and conducting his own physical examination, Dr. Wilkey no longer believed that petitioner required the surgery or any further treatment. He further believed that petitioner was capable of returning to work full duty. (RX2, 112-113).

With respect to Dr. Wilkey's IME, petitioner alleged that Dr. Wilkey failed to conduct any physical examination. Rather, Dr. Wilkey kept his back turned to petitioner during the entire exam and told him to leave. (T. 30-31). Despite this testimony, petitioner acknowledged on cross examination that he was unaware of any reason Dr. Wilkey would have to falsify the physical examination portion of the IME. He also indicated that there were no confrontations or other issues during his evaluation with Dr. Wilkey. Further, petitioner acknowledged that the findings noted in Dr. Wilkey's IME report including tenderness to palpation over the left lower back and hip, and decreased range of motion, were both consistent with his complaints. (T. 79-81).

Petitioner acknowledged on cross examination that Dr. Gornet discussed the surveillance footage with him. Dr. Gornet advised that the footage created "credibility issues". Based on the footage, Dr. Gornet agreed with Dr. Wilkey that petitioner could return to work full duty. Given these opinions, petitioner ultimately returned to work on September 29, 2015 in his prior position. (T. 82).

He stated that Mr. Anthony House had been hired prior to his return to assist with some of his job duties. (T. 51). Specifically, petitioner's supervisor, Nathan Winton, limited him to no lifting more than 25 to 30 pounds. Mr. House would help out with lifting heavier equipment

such as brake drums and steel sheets. Despite the additional assistance, petitioner indicated that he would be limping by the end of the day. He would also be sent to the breakroom by Mr. Winton to rest when his pain increased. He also reported experiencing terrible pain after the workday. (T. 51-54).

Petitioner reported that he continued to experience ongoing symptoms since the work incident which were alleviated in part by pain medication including tramadol, Flexeril, and ibuprofen. Specifically, he experienced increased pain when standing for more than a half of a day, walking for an extending period, bending over repetitively, and lifting heavy objects. He indicated that when he was not on medications, his pain became excruciating. (T. 64-66).

With respect to his work restrictions, he indicated that Dr. Gornet had placed him completely off work prior to reviewing the surveillance footage. However, this was not as his request. (T. 45, 48).

Petitioner's position was subsequently changed to the Bridgeton location as a loader operator. Petitioner denied the change was made at his request. He noted that the loader operator position required him to make a two hour drive. Further, the position essentially involved driving to trash with a truck and picking it up. He described the position as like being in a mini-car wreck all day. Subsequent to transitioning to the loader operator position, his back condition worsened and he experienced increased soreness. (T. 55-58).

Petitioner indicated that he was ultimately terminated on October 17, 2016. (T. 58). Since that time, he obtained four different temp jobs that lasted approximately 30 days. He was unable to perform some of the jobs given his back pain. He ultimately obtained a full time position with Clark Industrial Fabrication as a welder. He noted that he had been employed in that position for less than one year. Although there were some lifting requirements, petitioner could obtain assistance from a crane for heavier items. (T. 59-62).

Petitioner also discussed two prior altercations. (T. 64-65). He noted that one altercation involved a conflict with his neighbor where he was sprayed with weed killer. He also described his October 2016 altercation which led to his termination. He indicated that another employee head-butted him. He denied any injury to his lower back as a result of either incident. (T. 64, 90).

The Arbitrator notes that Petitioner provided a signed statement on 10/17/16 contradicting his testimony. (RX10). Petitioner specifically indicated "I left my bay and went into office. John Wolf, Dave Shaw, and Doug seen what happen and asked if I was okay and if I needed something. I said thanks but my back is hurt and I was going to report what happened." (RX 10).

Petitioner testified that he wished to proceed with the surgery recommended by Dr. Gornet. He continued to experience ongoing pain between 5-8/10. He also continued to miss time at his new job due to increased lower back pain. He estimated he missed approximately five to six days. Petitioner further indicated that he was unable to perform his prior hobbies including baseball coaching, hunting, fishing, and cycling. (T. 65-68, 70-71).

On cross examination, petitioner acknowledged that although he indicated he had good and bad days, he completed several patient questionnaires including his April 21, 2014 questionnaire with Dr. Gornet, and June 23, 2015 questionnaire with Dr. Wilkey. He acknowledged that he understood 10 represented the worst pain possible. He reported his pain as being 9-10/10 on both documents. He also indicated that his pain was constant and worsened with sitting, bending, lifting, or standing. (T.75-77). Petitioner acknowledged that despite reporting constant pain of 9-10/10, he was able to mow his lawn for 24 minutes, bend over on multiple occasions to clean his car, and lift a planter pot. (T. 82-83).

Based on Dr. Gornet's recommendations, he returned to work on September 29, 2015. Although petitioner originally testified on direct examination that Mr. Hunter was hired specifically to help him, he clarified that Mr. Hunter was actually hired to take his position while he was off work. Petitioner denied that it was common for other employees to assist with lifting of steel sheeting prior to the incident. (T. 84-86).

Anthony House Testimony

Petitioner called Mr. Anthony House to testify per subpoena. Mr. House stated that he was hired in 2014 to take over petitioner's position. He also assisted petitioner with lifting heavier items after petitioner returned to work. He indicated that he would see petitioner limping after a day of work. Petitioner also appeared to have a hunched over posture. He indicated that petitioner reported experiencing back pain to him on several occasions. (T. 96-100).

Mr. House noted that he observed petitioner on several occasions after he transferred to the loader/operator position. He believed that petitioner's symptoms became more pronounced after the transition. (T. 101-103).

On cross examination, Mr. House indicated that it was not unusual for workers to request assistance from other employees lifting the brake drums and floor sheets. (T. 104-105). He noted that he floor sheets could weigh as much as 150 pounds. Although employees could potentially lift the sheets on their own, this was unusual. (T. 104-105). Mr. House further stated that he only worked directly with the petitioner prior to petitioner's transfer as an operator/loader. As a result, Mr. House only occasionally observed the petitioner after the transfer. (T. 105-106).

Nathan Winton Deposition Testimony

Mr. Winton testified that he was employed as petitioner's supervisor at the time of the March 10, 2014 incident. He indicated that petitioner's immediate supervisor was J.R. Neal. Mr. Winton oversaw the day-to-day operations of the St. Louis location of Mr. Bult's. He indicated that he had been employed as a terminal manager for 13 years at the time of the March 10, 2014 incident. His job involved hiring and dismissing employees, overseeing shop employees, motor operators, and transfers. He stated that he was no longer employed with Mr. Bults, as he was

unable to continue due to his own personal health issues. Mr. Winton indicated that he was not being paid to testify as a witness. (RX9, 5-10).

With respect to petitioner's March 10, 2014 incident, Mr. Winton recalled that petitioner fell off of a ladder injuring his lower back. He believed that petitioner had reported the incident on the same day it occurred, and presented for treatment shortly thereafter. Mr. Winton explained that petitioner was employed as a mechanic at the time of his injury. This involved repairing trailers, and included lifting up to 50 pounds. He noted that job duties could also potentially include lifting sheets of metal weighing between 120 to 180 pounds. However, this would be done with the assistance of another worker, per company policy. (RX9, 8-11).

Mr. Winton indicated that petitioner was originally off work following the March 10, 2014 incident. He could not recall reviewing any medical records other than perhaps an initial occupational therapy note. He was unaware of any formal restrictions being provided by petitioner's physicians. Petitioner returned to work in August of 2015. He instructed petitioner not to lift anything over 25 to 30 pounds without assistance, but petitioner was able to perform his full job duties other than lifting brake drums. Mr. Winton stated that he would regularly interact with petitioner, and estimated that he would see him between four to five times per day. There were also intervals where he spent more than an hour ahead of time with petitioner. He estimated that this would be approximately once per week. (RX9, 12-14).

Mr. Winton testified that after petitioner's return in August of 2015, petitioner did advise of a potential intervening incident. Specifically, petitioner stated that he was involved in a fight with his neighbor, in which he was flipped out of his chair. He was unsure whether petitioner sustained any injuries to his lower back as a result of the incident. (RX9, 15-16).

That being said, Mr. Winton noted that petitioner continued working in essentially a full-duty capacity up until May 26, 2016. At that time, petitioner switched positions to a loader-operator. Mr. Winton indicated that this change in position was made at petitioner's request. He was paid the same amount. Mr. Winton noted that this position involved less manual labor, but did involve riding around on a bumpy vehicle most of the day. (RX9, 16).

Based on Mr. Winton's recollection, petitioner continued working in the loader-operator position until his termination on October 17, 2016. Mr. Winton confirmed that petitioner's termination had nothing to do with his lower back issues. Further, petitioner was able to perform his job duties up until the time of his termination. (RX9, 17-18).

On cross-examination, Mr. Winton confirmed that he advised petitioner to seek assistance lifting over 25 to 30 pounds. (RX9, 23). The Arbitrator notes that there is no documentation of any need for restrictions from a physician. With respect to petitioner's complaints, Mr. Winton indicated that petitioner occasionally reported that his back was sore. However, he did not report any difficulties performing his job duties. Mr. Winton further elaborated on petitioner's job duties, and noted that petitioner's job as a mechanic involved standing and walking the majority of the day on concrete/aluminum flooring. He noted that steel-toed boots were required. (RX9, 23-25).

Mr. Winton also noted that he had spoken to petitioner's immediate supervisor, J.R. Neal, regarding petitioner's difficulties performing his job. He indicated that other than petitioner reporting a little bit of a tough time lifting, or limping occasionally at the end of the work day, no significant issues were present. Mr. Winton indicated that petitioner may have called in sick after returning in August of 2015. However, he was unsure whether any of the sick days were due to petitioner's lower back. (RX9, 27-30).

Mr. Winton indicated that petitioner was involved in an altercation with another employee in October of 2016, just prior to his termination. He indicated that the fight could have led to petitioner's termination. He believed that the other driver involved in the altercation was also terminated. He noted that he assisted with the investigation of the incident, and obtained several witness statements. (RX9, 30-32).

He acknowledged that one of the witness statements from Mr. John Wilkes indicated that the other employee involved in the incident (Rodger G.) pulled into the shop at an unsafe speed, and began yelling and cussing at Jimmy. Mr. Wilkes subsequently saw Rodger in petitioner's face, with petitioner's back against a trailer. Rodger also apparently told Jimmy to meet him outside the fence. (RX9, 32-34).

On re-direct examination, Mr. Winton reiterated that he had helped conduct the subsequent investigation, and any witness statements would be contained in the personnel file. Although he did not have the recollection of each individual statement, he did indicate that his understanding was that there was no clear aggressor in the altercation. Rather, based on the witness statements, it was unclear who initially started the confrontation. (RX9, 39-42).

Dr. Matthew Gornet Deposition Testimony

Dr. Gornet testified that he is a board-certified orthopedic spine surgeon. He first performed an examination of petitioner on April 21, 2014. Petitioner reported that he suffered a work injury on March 10, 2014 after falling off a ladder and landing on his buttocks and side. In conjunction with the examination, Dr. Gornet reviewed medical records and petitioner's diagnostic imaging. He noted that the diagnostic imaging revealed Grade I spondylolisthesis at L5-S1, edema in the pedicles at L5-S1 consistent with acute trauma, and an annular tear. He believed this was consistent with petitioner's examination findings of decreased EHL strength. Ultimately, Dr. Gornet diagnosed petitioner with aggravation of his pre-existing spondylolisthesis, a bone bruise, and a disc injury. He recommended a high quality MRI and a CT scan to better identify whether petitioner had a fracture. He further indicated that petitioner's diagnosis would be considered work-related. (PX2, 5-10).

In regard to petitioner's work restrictions, he placed petitioner off work. In support of his restrictions, he noted that returning to work could potentially aggravate petitioner's symptoms and cause him discouragement. Further, it may lead to narcotic dependence as pain medication would likely be required for petitioner to return to his regular duties. (PX2, 12-14).

Dr. Gornet next followed up with petitioner on June 2, 2014 and reviewed the CT and MRI studies. He indicated that the CT scan failed to reveal a fracture at L5-S1, but the MRI still

showed edema over the petitioner's pedicles. (PX2, 15). Based on the findings and petitioner's continued complaints, he recommended injections and physical therapy. Despite undergoing the recommended treatment, petitioner did not improve. As such, Dr. Gornet recommended a CT discogram at L4-L5 and L5-S1. He believed that the discogram would help isolate petitioner's subjective complaints to the appropriate level. Further, the discogram would help to determine whether adjacent levels were sufficiently stable to perform a fusion. (PX2, 15-20).

Petitioner underwent the discogram on August 12, 2014. It revealed concordant pain at the L5-S1 level, but no pain was elicited at the L4-L5 level. Based on the results of the testing, Dr. Gornet recommended a circumferential staged L5-S1 fusion and decompression surgery. (PX2, 20).

Dr. Gornet also indicated that he reviewed several IME reports from Dr. David Lange addressing the need for surgery. (PX2, 21-22). The Arbitrator excludes any testimony relating to Dr. Lange's IME reports as the reports are hearsay prepared in anticipation of litigation. In addition, Dr. Lange did not have the chance to testify via deposition or review the surveillance footage due to his retirement.

Dr. Gornet recommended an additional MRI to ensure that there was no additional pathology. Despite the fact that petitioner had undergone a significant amount of diagnostic testing already, Dr. Gornet noted that he recommended additional studies every three to four months with an outside limit of six months. This was to determine whether there were any new findings demonstrating further progression which would need to be addressed during surgery. (PX2, 23-24).

On January 5, 2015, Dr. Gornet reviewed the MRI and it revealed no new changes. Based on the findings, he recommended proceeding with a staged procedure with the anterior portion of the operation being performed on one day, and the posterior portion of the operation being performed on another day. He acknowledged that a utilization review report had non-certified the staged procedure, and acknowledged that Dr. Wilkey did not believe that a staged procedure could be considered necessary. (PX2, 24-25).

Dr. Gornet believed a staged procedure was warranted based on his own clinical experience. (PX2, 25-26).

Dr. Gornet also testified that he reviewed surveillance footage showing petitioner engaging in a number of activities. This included him mowing a lawn for approximately 24 minutes, bending over to lift a pallet for about 10 seconds, picking up a planter pot, and bending over from side to side while cleaning his car. (PX2, 30-31).

Dr. Gornet acknowledged that the footage created credibility issues for Petitioner. (PX2, 31-32, 35, 44). As a result, he released petitioner to return to work full duty as of October 1, 2015. Although he had no objection to petitioner working full duty subsequent to the surveillance, he continued to recommend surgery. (PX2, 31-32, 35).

On cross examination, Dr. Gornet agreed that in determining whether surgery is necessary, the subjective complaints are significant. (PX2, 40). He further indicated that it was important for complaints to be reliable prior to recommending surgery. (PX2, 40-41).

In regards to petitioner's specific complaints here, Dr. Gornet acknowledged that petitioner reported his pain was always 10 out of 10 during his initial evaluation on April 21, 2014. Further, petitioner reported to his physical therapist that his pain was at best a 9, and at worst a 12. Petitioner reported that he had difficulty performing even regular activities of daily living. He ambulated with a slow and guarded gait. He reported significant loss of range of motion due to subjective complaints of pain. Finally, he had complaints of severe pain with any bending motions. (PX2, 61-64).

Dr. Gornet acknowledged that petitioner's complaints in these records and indicated the video speaks for itself. Dr. Gornet further acknowledged that petitioner had "credibility" issues. However, he refused to acknowledge that petitioner was magnifying his symptoms, or that surgery was unreasonable or unnecessary. (PX2, 63-65).

Dr. Gornet acknowledged that petitioner told him he was a non-smoker during his initial office evaluation. However, petitioner was seen smoking on the surveillance video. (PX2, 68).

Dr. Keith Wilkey Deposition Testimony

Dr. Wilkey testified that he is a board certified orthopedic spine surgeon. He further indicated that 100% of his practice related to treatment of spinal conditions and he routinely performs spine surgery. (RX3, 16-18).

He first had the opportunity to prepare an IME report on April 14, 2014 after reviewing petitioner's medical records and diagnostic imaging. Based solely on the records and imaging, Dr. Wilkey diagnosed petitioner with L5-S1 spondylolisthesis, and a possible pars fracture at L5-S1. He ultimately believed that based on the studies the L5-S1 AP fusion recommended by Dr. Gornet could be considered an option for petitioner. (RX3, 18-19).

Dr. Wilkey was careful to note that he did not have the opportunity to personally examine petitioner at the time of his April 14, 2014 report. However, he subsequently had the opportunity to examine petitioner on June 23, 2015 and prepare an IME report. Petitioner reported that his pain level was 9/10 most of the time, which Dr. Wilkey indicated would essentially be consistent with sufficient pain to present to the emergency room. Petitioner also reported difficulties with bending and twisting and engaging in other activities of daily living. (RX3, 20-21).

Dr. Wilkey also testified that he performed a physical examination. The Arbitrator notes that this Dr. Wilkey's testimony directly contradicts Petitioner's assertion that no examination was performed. (RX3, 22).

During the examination, Dr. Wilkey found it significant that petitioner exhibited extreme facial grimacing on range of motion testing and also exhibited a decreased range of motion in all

planes. Dr. Wilkey also noted tenderness to palpation over the lower left lumbar area. (RX3, 22-23).

Dr. Wilkey was unable to find any objective findings consistent with the need for surgery other than weakness on testing of the ankle. Although this could potentially be considered an objective finding, he indicated that petitioner demonstrated "cog-wheeling" on examination. He explained that cog-wheeling is present where the patient demonstrates weakness in a give way type fashion and was indicative of symptom magnification. In individuals with findings of true weakness, he would expect to see more of a slow controlled type weakness. As a result, he did not believe that the finding of weakness on petitioner's exam was reliable. (RX3, 49-53).

Most significantly, Dr. Wilkey indicated that he had the opportunity to review approximately 214 minutes of surveillance footage. The footage showed petitioner engaged in several activities such as mowing his lawn, lifting a wooden pallet, and cleaning out his car. He strongly emphasized that all of these activities were inconsistent with petitioner's presentation to him at the time of his IME. It was clear to Dr. Wilkey from the surveillance video that petitioner's examination with him was disconcordant with petitioner's actual capabilities. Specifically, the video showed petitioner engaging in activities and exhibiting full range of motion. Petitioner also failed to exhibit any signs of facial grimacing that would indicate an increase in pain. (RX3, 20-23).

After reviewing the surveillance footage and conducting his own physical examination, Dr. Wilkey no longer believed that petitioner required the surgery or any further treatment. He further believed that petitioner was capable of returning to work full duty. He noted the fact that a surgical recommendation takes into consideration a number of factors including objective findings, the patient's functional abilities, and the reliability of the petitioner's subjective complaints of pain. (RX3, 20-23).

In petitioner's case, the reliability of his subjective complaints was strongly brought into question by the different presentation on exam and the surveillance video. Further, Dr. Wilkey did not believe that petitioner exhibited significant enough functional limitations based on the surveillance video to warrant surgical intervention. Finally, although petitioner's MRI scan initially revealed changes that could possibly be consistent with a pars fracture warranting surgery, later CT imaging appeared to confirm that petitioner did not in fact have a fracture. Thus, the only objective finding on dominant diagnostic imaging was petitioner's L5-S1 spondylolisthesis. He noted that this finding was a degenerative finding present in much of the population and was usually asymptomatic. This made it even more important in petitioner's case to be able to be able to rely on the veracity of his subjective complaints. (RX3, 20-23, 28, 57-58, 65-67).

In regard to the reasonableness and necessity of petitioner's treatment, Dr. Wilkey indicated that the L4-5 and L5-S1 discogram would not have been considered reasonable. He agreed with Dr. Gornet that the purpose of the test would be to determine whether the L4-5 level was stable enough for a fusion. However, he believed that the diagnostic imaging clearly showed that the L4-5 condition was stable and did not have any findings which would cause for

concern. As a result, the discogram would not have provided Dr. Gornet with any further information. (RX3, 27-28).

In regard to the recommended two-day stage procedure, Dr. Wilkey stated that he did not believe the same was necessary. He noted that only about 5% of the physicians in the St. Louis area would even consider performing the operation in a staged manner. Further, the concerns raised by Dr. Gornet during his deposition relating to putting the patient under for one surgery were unwarranted, as the operation would usually only take about an hour. Dr. Wilkey was unaware of any studies indicating that the length of time for such a procedure increased the risk for developing other complications. Further, there were increased risks associated with a staged procedure as the petitioner would be required to go under anesthesia on two separate occasions. (RX3, 24-26).

As a final matter, Dr. Wilkey noted that he prepared an addendum report on April 14, 2016 after reviewing Dr. Gornet's deposition testimony. He indicated that Dr. Gornet's testimony did not change his opinion regarding the necessity for surgery. He further highlighted that Dr. Gornet himself agreed that the surveillance raised issues as to petitioner's credibility. (RX3, 27).

On cross-examination, Dr. Wilkey acknowledged that even though the L5-S1 spondylolisthesis condition was degenerative in nature, it could potentially be aggravated by a work incident. He also believed that the onset of symptoms from such aggravation could necessitate treatment. He further noted that petitioner's facet arthritis could have been aggravated by the incident and acknowledged that petitioner did not seek any treatment that he was aware of prior to the alleged work incident. In regard to a potential acute injury, he noted that the MRI did show edema in the pedicles which was consistent with the location of the pain. However, he reiterated that the CT scan appeared to reveal no evidence of an acute injury. (RX3, 41-44).

Dr. Wilkey also acknowledged that he initially concluded that petitioner's condition was work related and the surgery was a direct result of the incident. However, he noted that this opinion was provided prior to having the chance to conduct a physical exam of petitioner or review the surveillance footage. (RX3, 34-35).

Petitioner's attorney introduced a letter to Dr. Wilkey sent prior to the June 23, 2015 addendum IME. Although Dr. Wilkey acknowledged that he reviewed the letter, he indicated that his opinion would have been the same regardless of the statement. (RX3, 38-39).

In regard to his June 23, 2015 exam, Dr. Wilkey noted that he was unaware of any new incidents. Since his review of records on April 4, 2015, he also did not believe he received any additional records prior to his exam. However, he once again noted that his opinion was based on review of the surveillance footage and his physical exam. (RX3, 41-42).

Dr. Wilkey also admitted that petitioner had weakness in his great toe extensor, which could be consistent with pathology at the L5 level. However, he once again noted that this testing was unreliable based on petitioner's "cog-wheeling." Dr. Wilkey indicated that this test

was capable of being faked, and it would not be unreasonable for petitioner to have learned the test after undergoing several examinations. (RX3, 51-54, 66).

Dr. Wilkey acknowledged that he did not remember many of the specifics about the footage at the time of his deposition as he had reviewed it almost one year prior and it was 217 minutes long. That being said, he believed he listed the most significant parts of the footage in his IME report. He further indicated that these were the activities that were most important as they were the ones that showed petitioner's findings were disconcordant. He acknowledged that petitioner could have been having a "good day" at the time the footage was taken. (RX3, 56-62, 65-66).

CONCLUSIONS OF LAW:

As to F, whether the petitioner's present condition of ill-being is causally related to the injury:

The Arbitrator finds that Petitioner suffered a compensable lower back injury as a result of his March 10, 2014 incident. However, Petitioner failed to meet his burden of proving his condition subsequent to Dr. Wilkey's June 23, 2015 IME is causally related to the March 10, 2014 work incident. In support of this opinion, the Arbitrator relies on 1) the significant issues with respect to Petitioner's credibility as well as the questionable reliability of Petitioner's subjective complaints; and 2) Dr. Wilkey's well reasoned deposition testimony.

In regards to Petitioner's credibility the Arbitrator notes that it is the function of the Commission to judge the credibility of the witnesses and to resolve conflicts in the medical testimony. Caterpillar Tractor Co. v. Industrial Comm'n, 124 Ill. App. 3d 650 (1984). Testimony under oath and subject to cross-examination is the benchmark of credibility." Chicago Messenger Service v. Industrial Comm'n, 356 Ill. App. 3d 843, 850 (1st Dist. 2005). If the claimant did not testify truthfully under oath, then he had no credibility. Id.

In this case, Petitioner testified at trial that he continues to experience ongoing pain between 5-8/10. He also continues to miss time at his new job due to increased lower back pain. Petitioner further indicated that he was unable to perform his prior hobbies including baseball coaching, hunting, fishing, and cycling. (T. 65-68, 70-71).

Petitioner completed several patient questionnaires including his April 21, 2014 questionnaire with Dr. Gornet, and June 23, 2015 questionnaire with Dr. Wilkey. He acknowledged that he reported his pain as being 9-10/10 on both documents. Significantly, Petitioner indicated that his pain was constant and worsened with sitting, bending, lifting, or standing. Petitioner indicated that his complaints of pain have been relatively consistent since the time of injury. (PX5, RX3 101, T. 75-77).

The Arbitrator finds Petitioner's subjective complaints and physical exam findings are inconsistent with the surveillance footage introduced by Respondent. Although Petitioner reported constant pain of 9-10/10, and difficulty simply bending, sitting, and standing, he was

able to mow his lawn for 24 minutes, bend over on multiple occasions while cleaning his car and mowing his lawn, and lift a planter pot. Petitioner testified to experiencing significant pain after engaging in these activities. (RX1). However, there is no visible evidence on the surveillance footage of any pain or difficulty.

Petitioner's credibility is also called into question by Dr. Wilkey's June 23, 2015 IME findings. Specifically, Dr. Wilkey noted the presence of facial grimacing on simple range of motion testing. This is despite the fact that Petitioner did not show any similar grimacing while performing more intensive activities on the surveillance footage. In addition, Dr. Wilkey indicated that petitioner demonstrated "cog-wheeling" on examination that is indicative of symptom magnification. (RX3 20-23).

Although Petitioner alleges that Dr. Wilkey never examined him, Petitioner was unable to explain why Dr. Wilkey would falsify exam findings in the IME report. Petitioner was also unable to explain why Dr. Wilkey would provide false testimony under oath. Petitioner acknowledged that the documented findings of Dr. Wilkey's exam were consistent with his complaints. (T. 79-81). Unlike Petitioner, Dr. Wilkey has nothing to gain from falsifying his testimony regarding the exam. Given these considerations, the Arbitrator relies on Dr. Wilkey's testimony that he performed an exam over Petitioner's self serving testimony.

The Arbitrator also finds it significant that Petitioner's own treating physician, Dr. Gornet, agreed with Dr. Wilkey that the surveillance footage created "credibility issues" for Petitioner. In fact, the video created such significant credibility issues that Dr. Gornet rescinded his prior restrictions keeping Petitioner off work and released Petitioner to return to work full duty. (PX2, 31-32, 35, 44)

Not only does the surveillance footage and Petitioner's testimony regarding his exam with Dr. Wilkey raise credibility issues, but there are several other inconsistencies in Petitioner's testimony.

First, Petitioner testified that his October 2016 altercation did not cause injury to his lower back. (T. 64, 90). However, Petitioner provided a signed statement on 10/17/16 contradicting this testimony. (RX10). Petitioner specifically indicated "I left my bay and went into office. John Wolf, Dave Shaw, and Doug seen what happen and asked if I was okay and if I needed something. I said thanks but my back is hurt and I was going to report what happened." (RX 10).

Second, petitioner originally stated that Mr. House was hired specifically to help him with his job duties. However, when pressed on the issue on cross examination, he acknowledged that Mr. House was actually hired to replace him. (T. 84-86).

Third, petitioner's statements that he did not request to be relocated are inconsistent with Mr. Winton's testimony that petitioner specifically requested the transfer. The Arbitrator notes that Mr. Winton has no reason to falsify these statements as he was no longer employed with the insured at the time of his deposition testimony.

Finally, Dr. Gornet acknowledged that petitioner told him he was a non-smoker during his initial office evaluation. However, petitioner was seen smoking on the surveillance video.

Given the issues with Petitioner's credibility, the Arbitrator does not find Petitioner's subjective complaints of pain to be reliable.

In addition, the Arbitrator finds Dr. Wilkey's opinion to be more credible than that of Dr. Gornet. Dr. Wilkey clearly explained that a surgical recommendation must take into consideration a number of factors including objective findings, the patient's functional abilities, and the reliability of the petitioner's subjective complaints of pain. (RX3, 20-23).

In petitioner's case, the reliability of his subjective complaints is strongly brought into question by his disconcordant presentation on exam compared to the surveillance video. Further, Dr. Wilkey did not believe that petitioner exhibited significant enough functional limitations based on the surveillance video to warrant surgical intervention. Finally, although petitioner's MRI scan initially revealed changes that could possibly be consistent with a pars fracture warranting surgery, later CT imaging confirmed that petitioner did not in fact have a fracture. (RX3, 20-23).

Thus, the only objective finding on diagnostic imaging was petitioner's L5-S1 spondylolisthesis. Dr. Wilkey noted that this finding was a degenerative finding present in much of the population and was usually asymptomatic. This made it even more important in petitioner's case to be able to be able to rely on the veracity of his subjective complaints. (RX3, 20-23, 28, 57-58, 65-67). The Arbitrator finds Dr. Wilkey's testimony to be well reasoned and supported by the surveillance footage.

In contrast, the Arbitrator finds Dr. Gornet's testimony to be unconvincing. The Arbitrator notes that a claimant generally relies on medical testimony establishing a causal connection between the work performed and the claimant's disability. *Nunn v. Industrial Comm'n*, 157 Ill. App. 3d 470, 477 (4th Dist. 1987). Although medical testimony as to causation is not necessarily always 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 a claimant's work injury caused the condition complained of. *Id.* at 478. In such cases there must be a showing that the injury is work-related and not the result of a normal degenerative aging process. *Id.*

In this case, Dr. Gornet agrees at multiple points throughout his deposition that the surveillance footage creates credibility issues for Petitioner. He agrees that Petitioner could return to work full duty that based on the surveillance. (PX2, 31-32, 35, 44)

Dr. Gornet also agrees the surveillance video shows several activities Petitioner reported pain performing. Specifically, petitioner reported his pain was always 10 out of 10 during his initial evaluation on April 21, 2014. Petitioner then reported to his physical therapist that his pain was at best a 9, and at worst a 12. (PX 10). Petitioner reported that he had difficulty performing even regular activities of daily living. He ambulated with a slow and guarded gait.

He reported significant loss of range of motion due to subjective complaints of pain. Finally, he had complaints of severe pain with *any* bending motions. (PX2, 61-64).

When pressed on how the surveillance video corresponded with Petitioner's complaints documented in the medical records, Dr. Gornet stated, "The video speaks for itself. I think that we know what the video shows" (PX2, 63).

Most importantly, Dr. Gornet agreed that subjective complaints are significant in determining whether surgery is necessary. (PX2, 40-41). Thus, he typically would not perform surgery on someone with objective findings but unreliable subjective complaints. (PX2, 40-41).

Despite these admissions, Dr. Gornet continues to recommend that Petitioner undergo surgery based on the MRI findings and his physical exam. Specifically, Dr. Gornet relied on his interpretation of the MRI showing Grade I spondylolisthesis at L5-S1, edema in the pedicles at L5-S1, and an annular tear. He also relied on his finding of EHL weakness on examination. (PX2, 20).

The Arbitrator finds Dr. Gornet's testimony in this regard fails to take into consideration the questionable reliability of Petitioner's subjective complaints. In addition, Dr. Wilkey testified that only objective finding on Petitioner's diagnostic imaging is L5-S1 spondylolisthesis. He noted that this finding was a degenerative finding present in much of the population and was usually asymptomatic. As a result, the finding alone was not enough to support surgical intervention. (RX3, 20-23, 28).

Dr. Wilkey also cast doubt on the reliability of Dr. Gornet's finding of ankle/EHL weakness. Dr. Wilkey was able to reproduce a finding of ankle weakness on exam. However, he explained that Petitioner demonstrated ankle weakness in a give way type fashion that was indicative of symptom magnification and therefore unreliable. In short, the physical findings noted by Dr. Gornet do support surgery in the absence of reliable subjective complaints. (RX3, 51-54, 66).

Given Petitioner's credibility issues, Petitioner's disconcordant appearance on the surveillance compared to his physical exam, and Dr. Wilkey's credible opinion, the Arbitrator denies all benefits subsequent to Dr. Wilkey's June 23, 2015 IME.

As to F, Were the medical services that were provided to Petitioner reasonable and necessary, the Arbitrator concludes as follows:

The Arbitrator finds Respondent has paid for all reasonable/necessary and denies any additional medical expenses. The Arbitrator also denies the August 12, 2014 CT discogram as unreasonable. The Arbitrator relies on Dr. Wilkey's opinion that the L4-5 and L5-S1 discogram would not be considered reasonable as definitive testing had already been performed. Dr. Wilkey agreed with Dr. Gornet that the purpose of the test would be to determine whether the L4-5 level was stable enough for a fusion. However, he believed that the diagnostic imaging clearly showed that the L4-5 condition was stable and did not have any findings which would

cause for concern. As a result, the discogram would not have provided Dr. Gornet with any further information. (RX3, 27-28).

Irrespective of causation, the Arbitrator denies the interest charges listed on Dr. Gornet's (2,950.32), MRI Partners of Chesterfield ($161.00), and CT Partners of Chesterfield ($306.04), as there is no evidence that the requirements of Section 8.2(d) were met in this case and the interest charges are unsupported. The Arbitrator also notes that interest charges from Dr. Gornet, MRI Partners of Chesterfield, and CT Partners of Chesterfield have previously been denied by the Commission in similar circumstances. *See Harold McCoy v. PDF Supply*, 17 IWCC 0474.

The Arbitrator also denies medical bills from Dr. Joshua Poos. Although an outstanding balance of $260.00 is listed on Petitioner's Medical Bill Summary (PX12), no corresponding bills were introduced into evidence. Finally, the Arbitrator notes that PX 12 list outstanding charges of $158.17 from Sullivan Drugs. However, the bill introduced into evidence only shows an outstanding balance of $18.40.

As to K, is Petitioner entitled to any prospective medical care, the Arbitrator concludes as follows:

Based on the aforementioned findings, the Arbitrator denies all medical care subsequent to Dr. Wilkey's June 23, 2015 IME. Regardless of causation, the Arbitrator finds the two stage fusion procedure recommended by Dr. Gornet is unreasonable and unnecessary.

Although Dr. Gornet recommended a staged procedure, Dr. Wilkey did not believe a staged procedure was necessary. Dr. Wilkey noted that only about 5% of the physicians in the St. Louis area would even consider performing the operation in a staged manner. Further, the concerns raised by Dr. Gornet during his deposition relating to putting the patient under for one surgery were unwarranted, as the operation would usually only take about an hour. Dr. Wilkey was unaware of any studies indicating that the length of time for such a procedure increased the risk for developing other complications. Further, there were increased risks associated with a staged procedure as the petitioner would be required to go under anesthesia on two separate occasions. (RX3, 24-26).

As to L, what temporary benefits are in dispute, the Arbitrator concludes as follows:

The Arbitrator denies all TTD benefits subsequent to Dr. Wilkey's June 23, 2015 IME as Petitioner was released to return to work full duty at that time. Even assuming that Petitioner is in need of additional treatment, the Arbitrator denies TTD benefits for the period from 7/14/15-9/28/15 as Dr. Gornet agreed Petitioner was capable of returning to work full duty based on the surveillance footage.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Joseph J. Amendola,
Petitioner,
vs.

NO: 16 WC 30400

Chicago Park District,
Respondent.

19IWCC0204

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 29, 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: APR 25 2019
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BF/mw
045

Barbara Flores

Deborah Simpson

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION

NOTICE OF 19(b) ARBITRATOR DECISION

AMENDOLA, JOSEPH J
Employee/Petitioner

Case# **16WC030400**

CHICAGO PARK DISTRICT
Employer/Respondent

19IWCC0204

On 10/29/2018, 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 2.42% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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1946 CHICAGO PARK DIST LAW DEPT
LEON W PAWLYCOWYCZ
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CHICAGO, IL 60611

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Joseph J. Amendola
Employee/Petitioner

v.

Chicago Park District
Employer/Respondent

Case # **16 WC 30400**

Consolidated cases: **N/A**

19IWCC0204

An *Application for Adjustment 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 **October 2, 2018 (Proofs closed on October 25, 2018)**. After reviewing all of the evidence presented, the arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's 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. ☒ 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

19IWCC0204

FINDINGS

On the date of accident, **9/22/2016**, 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 **$90,064.00**; the average weekly wage was **$1,732.00** .

On the date of accident, Petitioner was **58** years of age, ***married*** with **0** dependent children.

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

Respondent shall be given a credit of **$-0-** for TTD, **$-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 in the amount of **$1,154.67**/week for **3-5/7** weeks, for the period of **9/23/2016 through 10/18/2016**, which is the period of temporary total disability for which compensation is due.

- Respondent shall authorize and provide payment for the medical treatment, including the left shoulder surgery, recommended by Petitioner's treating physician, Dr. Nuber. The authorization shall be in writing and forwarded to Petitioner's attorney.

- See Rider attached hereto and made a part of hereof.

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

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

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

David A. Kane
Signature of Arbitrator

October 29, 2018
Date

OCT 29 2018

ICArbDec19(b)

----------Joseph J. Amendola
Case Number: 16 WC 30400
D/A: 9/22/2016

19IWCC0204

RIDER TO ARBITRATION DECISION

I. Introduction

Evidence in the above-captioned claim was presented to Arbitrator Kane on October 2, 2018 and proofs were closed on October 25, 2018. On October 2, 2018, the Arbitrator heard the testimony of Petitioner. On October 25, 2018, the Arbitrator received into evidence various exhibits, which included: 1) medical records from multiple providers; 2) MRI reports; 3) operative report dated August 13, 2010; 4) narrative report of Dr. Nuber; and 5) transcripts of the evidence depositions of Dr. Nuber and Dr. Cohen. The Arbitrator is considering the disputed issues of medical causation, prospective medical treatment and payment of temporary total disability benefits.

Before making conclusions of law in connection with this case, the Arbitrator makes the following findings of fact:

II. Findings of Fact

Petitioner testified before the Arbitrator on October 2, 2018. The Arbitrator finds that Petitioner's testimony was credible. The Arbitrator also finds that Petitioner's testimony was consistent with the histories, treatment and objective findings documented in the medical records, which were offered into evidence at the time of the hearing.

A. Work History

Petitioner testified that he was employed by Respondent on September 22, 2016. As of September 22, 2016, Petitioner had been employed by Respondent for 32 years. Petitioner was employed as a hoisting engineer.

He is a member of Local 150. He has been a member of the union for 35 years. Petitioner was a journeyman hoisting engineer. Petitioner testified that on September 22, 2016 he weighed approximately 193 pounds and was 5'11" tall. Petitioner is right handed.

Petitioner testified regarding his job duties for Respondent as a hoisting engineer. Petitioner operated various types of equipment, including bulldozers, front-end loaders, Bobcats and cranes. To gain access to the machines, Petitioner generally climbed ladders. Petitioner performed maintenance of the vehicles. He greased, oiled, lubed, cleaned and checked the fluid. Petitioner occasionally lifted chains used for pulling items. The chains are steel and weigh approximately 30 or 40 pounds. Petitioner also lifted and carried steel hooks used for the cranes. They weigh approximately 20 to 30 pounds. Petitioner maintained the beaches on the Chicago lakefront. Petitioner pushed sand onto the beach. He used a bulldozer or front-end loader to maintain the lakefront. Petitioner worked with lifeguard trailers. Petitioner cleaned the bike paths along the beaches.

B. Prior Medical Treatment

Petitioner received medical treatment for his left shoulder prior to September 22, 2016. Petitioner received medical treatment for his left shoulder beginning in June 2010. Petitioner underwent a MRI of the left shoulder on June 9, 2010. The treatment was not related to a work injury. Petitioner was initially examined by Dr. Bowen on June 30, 2010. (PX 1). Dr. Bowen performed surgery for the left shoulder on August 13, 2010. (PX 2). The post-operative diagnosis was left shoulder impingement, rotator cuff tear and SLAP tear. (PX 2). Petitioner participated in physical therapy at Accelerated. (RX 5). His initial evaluation was on October 4, 2010. (RX 5). Petitioner was released from medical treatment by Dr. Bowen on April

20, 2011. (PX 1). Petitioner had no swelling or tenderness and symmetrical range of motion. (PX 1). Petitioner did not have any work restrictions. (PX 1).

Petitioner returned to work for Respondent on May 16, 2011. Between May 16, 2011 and January 23, 2016, Petitioner did not sustain any new injuries involving his left shoulder. While Petitioner was working, he did not have any problems with his left shoulder. He was able to perform all of his job duties for Respondent.

On January 23, 2016, Petitioner was involved in a car accident. Petitioner sought medical treatment at Munster Community Hospital. He was examined by Dr. Hassan and Dr. Nuber. Petitioner underwent an MRI study of the left shoulder on February 9, 2016. (PX 3). The MRI revealed post-surgical changes, some attenuation and irregularity of the supraspinatus and a probable partial-thickness tear. (PX 3). On February 16, 2016, Dr. Nuber examined Petitioner for his left shoulder condition. (PX 5). Dr. Nuber noted that Petitioner had disc protrusions at multiple levels of the cervical spine and some pain at the AC joint with atrophy, swelling and some impingement. (PX 5). The intake note from NorthShore indicated that Petitioner sustained an injury to his left shoulder on January 23, 2016 in an automobile accident. (RX 4). Petitioner participated in physical therapy.

On April 5, 2016, Dr. Nuber released Petitioner to return to work without restrictions for the left shoulder. (PX 5); (RX 2). Dr. Nuber documented that Petitioner's left shoulder was getting worse and he had good range of motion with positive impingement. (PX 5). The medical records documented that Dr. Nuber and Petitioner "talked options." (PX 5). Dr. Nuber stated that Petitioner wanted to return to work and if his condition

was still bothering him in September, Petitioner would undergo surgery. (PX 5). Petitioner's diagnosis was a partial rotator cuff tear. (PX 5). Dr. Nuber explained to Petitioner that surgery was a treatment option; however, he did not recommend that Petitioner undergo surgery for the left shoulder on that date. Petitioner believed that surgery was a treatment opinion, but Petitioner did not require surgery at the time. Following the appointment with Dr. Nuber, Petitioner did not schedule surgery. On April 5, 2016, Petitioner did not have any plans to retire.

Petitioner was also under medical care for his neck condition. He received medical treatment with Dr. Hassan and Dr. Salehi for his neck. From April 5, 2016 through September 22, 2016, Petitioner was prescribed hydrocodone or Norco. He was prescribed the medication for his neck condition by Dr. Hassan and Dr. Salehi. Following April 5, 2016, Petitioner was not prescribed any medication for the left shoulder condition. He did not take any medication for his left shoulder condition.

On September 21, 2016, Petitioner testified that his left shoulder was fine and he did not notice anything about it. As of September 21, 2016, he did not have any appointments scheduled with Dr. Nuber.

C. Work-Related Accident of September 22, 2016

On September 22, 2016, Petitioner was working for Respondent. Petitioner was operating a front-end loader, which is a rubber tire machine with a steering wheel and front bucket. It is 11 feet tall, 15 to 16 feet long and 10 feet wide. To sit in the machine, Petitioner climbed a straight ladder on the side of the truck. While Petitioner was climbing into the truck, about 6 to 7 feet off the ground, Petitioner's right foot slipped off the deck and his right hand slipped off the vertical grab handle. Petitioner's left hand was on the left vertical grab handle. Petitioner slipped, spun around backwards

and his left arm twisted. Petitioner was still holding onto the handle with his left hand. Petitioner's left arm was bent at the elbow at a 90 degree angle and his shoulder was at the same level as his left arm. Petitioner's entire weight was on his left arm. Petitioner jumped about 4 feet to the ground.

Following the accident, Petitioner testified that his left shoulder felt like it was on fire and was burning. His left shoulder was sore and hard to lift.

D. Medical Treatment

Following the work-related accident of September 22, 2016, Petitioner sought medical treatment. Petitioner was initially examined at MercyWorks on September 22, 2016. (PX 4). The medical records documented a history that Petitioner was climbing a pay loader, mis-stepped, grabbed the handle with his left hand and spun around, injuring his left shoulder. (PX 4). Petitioner's body weight was on his left shoulder when he slipped. (PX 4). Petitioner presented with 8/10 pain in the left shoulder, inability to lift his left shoulder, limited range of motion and tenderness over the bicipital tendon and rotator cuff. (PX 4). Petitioner was discharged to the care of a physician of Petitioner's choice and advised to remain off work. (PX 4).

Petitioner was examined by Dr. Nuber on September 27, 2016. (PX 5). Dr. Nuber documented that Petitioner slipped off a pay loader and fell dangling on his left arm. (PX 5). Dr. Nuber documented that Petitioner had weakness with the supraspinatus test, weak abduction, loss of range of motion and weakness with external rotation. (PX 5). Dr. Nuber documented that the MRI in February 2016 showed some attenuation and irregularity of the tendon, but that the tendon was intact. (PX 5). Dr. Nuber recommended an MRI. (PX 5). He was concerned about a larger tear based on the external rotation, weakness and abduction. (PX 5).

Petitioner underwent the MRI study on September 30, 2016 at Chicago Ridge Medical Imaging. (PX 6). The MRI study revealed a full thickness supraspinatus and infraspinatus tear, interstitial tear of the subscapularis, subacromial and subscapularis bursitis, glenohumeral joint effusion, osteoarthritis of the AC joint, lateral down sloping of the acromion process, partial tear of the biceps tendon and degeneration v. partial tear in the superior labrum. (PX 6).

While Petitioner was under the active medical care of Dr. Nuber for his left shoulder, he also received treatment form Dr. Bhavsar for his cervical spine. (RX 3). Petitioner was examined by Dr. Bhavsar on October 4, 2016. (RX 3). He documented a history of neck pain since the car accident on January 23, 2016 for which Norco was prescribed and a left shoulder injury, which occurred at work for Respondent. (RX 3). Dr. Bhavsar noted that Respondent was taking care of the left shoulder injury and only documented an assessment related to the neck. (RX 3). He prescribed Norco for the pain. (RX 3).

Dr. Nuber reviewed the MRI study on October 18, 2016. (PX 5). He noted that Petitioner had a full thickness tear, which was not present in February, and that Petitioner had a distinct change in the rotator cuff consistent with the injury. (PX 5). Dr. Nuber recommended surgery for the left shoulder condition. (PX 5). He released Petitioner to return to work with the restrictions of no lifting greater than 20 pounds. (PX 5).

On November 4, 2016, Dr. Bhavsar examined Petitioner for his cervical condition. (RX 3). He advised Petitioner to consider alternative pain medication, such as anti-inflammatories or tramadol, or pain management. (RX 3). He prescribed Petitioner Norco for the neck condition. (RX 3).

On December 14, 2016, Dr. Bhavsar examined Petitioner. (RX 3). Petitioner wanted a prescription for Norco for his left shoulder condition. (RX 3). He stated that the left shoulder injury was a work injury. (RX 3). Petitioner wanted the prescription to allow him to continue working until he retired. (RX 3). Dr. Bhavsar prescribed Norco to Petitioner. (RX 3).

Dr. Bhavsar examined Petitioner on January 12, 2017. (RX 3). Petitioner complained of chronic neck pain and shoulder pain from a work-related, twisting accident. (RX 3). Dr. Bhavsar noted that the shoulder condition was being treated by workers' compensation. (RX 3). Dr. Bhavsar recommended esomeprazole and a home exercise program. (RX 3).

On February 13, 2017, Dr. Bhavsar examined Petitioner for his neck condition. (RX 3). Dr. Bhavsar recommended Norco. (RX 3). On April 13, 2017, Dr. Bhavsar examined Petitioner's neck. (RX 3). He noted that Petitioner continued to experience chronic neck and back pain, which was maintained with hydrocodone. (RX 3). Dr. Bhavsar set forth a diagnosis of chronic neck and back pain and prescribed Norco. (RX 3).

Petitioner was last examined by Dr. Bhavsar on July 7, 2017. (RX 3). Dr. Bhavsar documented chronic neck and back pain and Barrett's esophagus without dysplasia. (RX 3). Dr. Bhavsar did not examine Petitioner as it relates to his left shoulder condition and did not set forth any diagnosis relative to the left shoulder condition. (RX 3). He prescribed Norco and discussed weaning Petitioner off the pain medication. (RX 3). Dr. Bhavsar also referred Petitioner to pain management for his chronic problems. (RX 3).

Dr. Nuber recommended that Petitioner undergo surgery for his left shoulder. (PX 5). Petitioner has not undergone the recommended surgery. Petitioner would like to undergo the surgery recommended by Dr. Nuber.

E. Medical Opinions of Dr. Nuber, Petitioner's Treating Physician

Dr. Nuber prepared a narrative report dated March 13, 2017. (PX 7). Dr. Nuber noted that Petitioner's left shoulder condition was doing well until the injury of September 2016. (PX 7). The new MRI revealed a full tear of the supraspinatus, which represented a distinct change from the previous MRI. (PX 7). Dr. Nuber recommended an arthroscopy for the shoulder condition. (PX 7). He set forth that there was an exacerbation of the condition by the more recent accident at work. (PX 7).

The evidence deposition of Dr. Nuber was completed on September 6, 2017. (PX 8). Dr. Nuber reviewed the MRI films from February 9, 2016. (PX 8 at 14). The MRI of February 9, 2016 revealed some irregularity of the tendon, which was interpreted as a partial tear of the rotator cuff. (PX 8 at 14). The tear was to the supraspinatus. (PX 8 at 15). Dr. Nuber examined Petitioner on April 5, 2016. (PX 8 at 15). He found that Petitioner had full range of motion and positive impingement signs. (PX 8 at 15-16). Dr. Nuber testified that he advised Petitioner that surgery was one treatment option. (PX 8 at 16). As of April 5, 2016, Dr. Nuber had not recommended that Petitioner undergo surgery for this shoulder and no surgery had been scheduled. (PX 8 at 16). Dr. Nuber released Petitioner to return to work without restrictions. (PX 8 at 17). Dr. Nuber noted that Petitioner had a prior tear to the supraspinatus and infraspinatus that was repaired. (PX 8 at 19).

Dr. Nuber documented a history that Petitioner slipped off a pay loader and dangled from his outstretched left arm with his full weight. (PX 8 at

20). Dr. Nuber understood the accident that Petitioner fell, grabbed something and exerted force on his arm. (PX 8 at 21). Petitioner had weak abduction and external rotation. (PX 8 at 21). Dr. Nuber reviewed the MRI study of September 30, 2016. (PX 8 at 22). Dr. Nuber stated that Petitioner had a full tear, which he did not have at the time of the previous MRI. (PX 8 at 23). The tear was at the supraspinatus and infraspinatus. (PX 8 at 23). Dr. Nuber testified that a partial tear still has some fibers attached, while a full tear does not have any connection. (PX 8 at 24). Dr. Nuber testified that in February 9, 2016, Petitioner had a partial tear, with some fibers intact, and in September 30, 2016, there was a full tear with no fibers attached. (PX 8 at 25). Dr. Nuber recommended surgery for the left shoulder condition. (PX 8 at 25). Dr. Nuber released Petitioner to return to work with restrictions. (PX 8 at 26).

Dr. Nuber testified that the current condition of ill-being in the left shoulder was causally related to the work accident of September 22, 2016. (PX 8 at 30). Dr. Nuber testified that the accident caused an eccentric load on the tendons in the shoulder, causing the muscles to contract. (PX 8 at 31). He testified that this was a common mechanism of injury to the tendons. (PX 8 at 31). Dr. Nuber testified that the accident of September 22, 2016 worsened Petitioner's condition and aggravated the pre-existing condition. (PX 8 at 31). He noted that the condition went from a partial tear to a full tear. (PX 8 at 32).

Dr. Nuber testified that surgery would constitute reasonable and necessary treatment for Petitioner's left shoulder condition. (PX 8 at 32). Dr. Nuber testified that the aggravation of the shoulder condition and accident of September 22, 2016 resulted in the recommendation for surgery. (PX 8 at 33). The need for surgery was related to the accident of

September 22, 2016. (PX 8 at 34). The accident worsened Petitioner's condition causing a full tear of the rotator cuff. (PX 8 at 34). Dr. Nuber's opinions were based on the change in the MRI study. (PX 8 at 35). Dr. Nuber testified that determining whether Petitioner would have needed surgery prior to September 22, 2016 was speculative. (PX 8 at 35). Dr. Nuber had no indication that Petitioner had any change in symptoms prompting the need for surgery between April 5, 2016 and September 21, 2016. (PX 8 at 35).

Dr. Nuber reviewed the report of Dr. Cohen. (PX 8 at 35). The report did not change Dr. Nuber's opinion. (PX 8 at 36).

Dr. Nuber acknowledged that the June 9, 2010 MRI and the September 30, 2016 MRI were similar. (PX 8 at 39). The prior tear was repaired with surgery and the tendon was no longer torn. (PX 8 at 39). Petitioner had pain in his shoulder on April 5, 2016. (PX 8 at 40). Surgery was only an option on April 5, 2016. (PX 8 at 42). Dr. Nuber clarified that partial tears frequently require therapy and only require surgery if they remain symptomatic; however, full tears require surgery to fix them. (PX 8 at 48).

F. Medical Opinions of Dr. Cohen, Respondent's Section 12 Physician

The evidence deposition of Dr. Cohen was completed on November 29, 2017. (RX 1). Dr. Cohen examined Petitioner on December 2, 2016. (RX 1 at 8). Dr. Cohen obtained a history from Petitioner. (RX 1 at 9). He reviewed the medical records. (RX 1 at 14). Dr. Cohen also reviewed the diagnostic studies. (RX 1 at 21).

Dr. Cohen noted that the radiologist set forth that the October 4, 2016 [sic] MRI documented a full thickness tear of the supraspinatus and infraspinatus. (RX 1 at 22). Further, the radiologist noted that "'a

previously noted partial tear at the articular surface of the supraspinatus has turned into a complete tear. Also there is the development of a full thickness tear of the infraspinatus tendon and interstitial tear of the subscapularis tendon.'" (RX 1 at 23). There was also some new partial thickness tearing of the biceps. (RX 1 at 23). Dr. Cohen did not agree with the radiologist's reading of the MRI. (RX 1 at 23). He set forth that he believed that the prior MRI of February 9, 2016 revealed evidence of a full thickness tear. (RX 1 at 23). Dr. Cohen noted that his reading of the MRI report of February 9, 2016 differed from the radiologists reading of the report. (RX 1 at 72).

Dr. Cohen performed a physical examination of Petitioner. (RX 1 at 26). He also reviewed the medical records of Dr. Nuber. (RX 1 at 27). He interpreted Dr. Nuber's progress note of April 5, 2016 to mean that Petitioner was not at maximum medical improvement and had surgery scheduled in September. (RX 1 at 28). Dr. Cohen stated that the current left shoulder condition was not causally connected to the work-related accident of September 22, 2016. (RX 1 at 29). He based his opinion on the fact that the surgery was recommended prior to September 2016 and that Petitioner's condition was worsening in April 2016. (RX 1 at 29). Dr. Cohen agreed that the surgery recommended by Dr. Nuber was reasonable. (RX 1 at 33). Dr. Cohen testified that the surgery was recommended on April 5, 2016. (RX 1 at 34).

Dr. Cohen also testified that Petitioner was filling prescriptions of Norco prior to the accident of September 22, 2016. (RX 1 at 33). Dr. Cohen did not know which doctor prescribed the pain medication. (RX 1 at 63). He acknowledged that it was possible that Petitioner was prescribed medication for the neck condition. (RX 1 at 63). Dr. Cohen did not review

any records from Dr. Bhavsar or Dr. Abdellatif in connection with his examination. (RX 1 at 68). Dr. Cohen testified that the use of pain medication may or may not be significant depending on whether Petitioner was using it for his neck or shoulder. (RX 1 at 69).

Petitioner was cooperative during the examination. (RX 1 at 37). Dr. Cohen testified that Dr. Nuber is a well-respected orthopedic surgeon. (RX 1 at 39). In the letter provided to Dr. Cohen as part of the examination, it was noted that " 'per his direct supervisor and despite the prior left shoulder issues, including a surgical recommendation in April, the supervisor said that he had been working this entire period, from the car accident until now. He had not shown any issues with this either, between April and this injury specifically.'" (RX 1 at 39).

Dr. Cohen acknowledged that the accident caused a traction-type force on the left arm. (RX 1 at 49). Dr. Cohen testified that Petitioner had a strain or force on his left shoulder. (RX 1 at 49). Dr. Cohen testified that Petitioner could have injured his shoulder without hanging off the handle. (RX 1 at 50). The history of the accident was consistent with a traction injury to the shoulder. (RX 1 at 57). Dr. Cohen testified that a traction-type injury could cause an injury to the rotator cuff. (RX 1 at 57).

Dr. Cohen agreed that he had not reviewed any medical records documenting treatment between April 2016 and September 2016. (RX 1 at 60). He agreed that on April 5, 2016, Petitioner was released to return to work without restrictions. (RX 1 at 60). However, after September 22, 2016, he acknowledged that Dr. Nuber released Petitioner to return to work with restrictions. (RX 1 at 60).

Dr. Cohen testified that Dr. Nuber did not specify which tendons he was going to repair in April 5, 2016 versus September 2016. (RX 1 at 75). He

agreed that the surgery was discussed if Petitioner's condition was still bothering him. (RX 1 at 77). He also agreed that the surgery was not scheduled as of September 22, 2016. (RX 1 at 78). Dr. Cohen testified that he did not believe that the accident was a significant causative factor to the shoulder condition. (RX 1 at 80). Dr. Cohen recommended work restrictions for Petitioner. (RX 1 at 81). Dr. Cohen stated that the accident may have aggravated the left shoulder; however, the surgery was recommended prior to the work-related accident of September 22, 2016. (RX 1 at 84).

G. Post- Accident Employment

Dr. Nuber released Petitioner to return to work with restrictions on October 18, 2016. Prior to October 18, 2016, Petitioner had not been released to return to work.

Petitioner is currently performing work for Respondent. Petitioner is working within his restrictions. He does not operate the bulldozer. Petitioner is able to perform most of his other job duties. Petitioner is not able to climb into the bulldozer or lift the window guards. Petitioner cannot lift his left arm up high enough to pull up the window. Petitioner operates the front-end loader. He relies on his right arm to climb into it. He cannot lift his left arm over his head.

H. Current Subjective Complaints

Petitioner testified that his left shoulder condition is "getting worse." Petitioner testified that at work, his pain is increasing and he uses his left arm less. Petitioner testified that he experiences pain in his entire left shoulder. He indicated that the pain was in the top and front of the left shoulder. Petitioner's left shoulder is weak. Petitioner is not taking any medication for the left shoulder. He is taking medication for the neck.

III. Conclusions of Law

In support of the Arbitrator's decision relating to "F," whether Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator makes the following conclusions:

The Arbitrator concludes that Petitioner's current condition of ill-being in connection with his left shoulder, including the full thickness tear of the supraspinatus and infraspinatus, is causally connected to the work-related accident of September 22, 2016. The Arbitrator relies on Petitioner's credible and unrebutted testimony, the medical records, the diagnostic studies and the medical opinions of Dr. Nuber. The Arbitrator accords little weight to the medical opinions of Dr. Cohen, Respondent's Section 12 physician. The Arbitrator finds that the medical evidence supports a finding that Petitioner's left shoulder condition objectively worsened as a result of the work-related accident of September 22, 2016.

To recover under the Act, an employee must show that there is a causal connection between the claimant's employment and the injury. In *Sisbro, Inc. v. Industrial Commission*, 207 Ill.2d 193, 797 N.E.2d 665 (2003), the Illinois Supreme Court held that "even though an employee has a preexisting condition which may make him more vulnerable to injury, recovery for an accidental injury will not be denied as long as it can be shown that the employment was also a causative factor." *Id.* The accident "need not be the sole causative factor, nor even the primary causative factor, as long as it was *a* causative factor in the resulting condition of ill-being." *Id.* (emphasis in original).

In *National Freight Industries v. Illinois Workers' Compensation Commission*, 373 Ill.Dec. 167, 993 N.E.2d 473 (5th Dist. 2013), the claimant was scheduled to undergo back surgery the day before he was

involved in a work-related car accident. As a result of the accident, a different surgical procedure was recommended for the claimant's back condition. *Id.* The court found that following the second accident, Petitioner's symptoms changed, the pathology of Petitioner's condition change, the type of surgical intervention changed and Petitioner's ability to work changed. *Id.* Accordingly, the court found that the claimant's current condition of ill-being and need for surgery was causally related to the work-related automobile accident and not the pre-existing condition. *Id.*

A. Medical Opinion of Dr. Nuber, Petitioner's Treating Physician

Petitioner established medical causation in connection with his left shoulder through the medical records and opinions of Dr. Nuber. Dr. Nuber noted that Petitioner's left shoulder condition was doing well until the injury of September 2016. The new MRI revealed a full tear of the supraspinatus, which represented a distinct change from the previous MRI. He set forth that there was an exacerbation of the injury by the more recent accident at work. The MRI of February 9, 2016 revealed some irregularity of the tendon, which was interpreted as a partial tear of the rotator cuff. The tear was to the supraspinatus. Dr. Nuber stated that the September 30, 2016 MRI revealed that Petitioner has a full tear, which he did not have at the time of the previous MRI. The tear was at the supraspinatus and infraspinatus. Dr. Nuber testified that in February 9, 2016, Petitioner had a partial tear, with some fibers intact, and in September 30, 2016, there was a full tear with no fibers attached. Dr. Nuber's testimony established that the work-related accident caused Petitioner's condition to worsen from a partial thickness tear to a full thickness tear.

Dr. Nuber testified that the current condition of ill-being in the left shoulder was causally related to the work accident of September 22, 2016.

Dr. Nuber testified that the accident caused an eccentric load on the tendons in the shoulder, causing the muscles to contract. He testified that this was a common mechanism of injury to the tendons. Dr. Nuber testified that the aggravation of the shoulder condition and the recommendation for surgery were a result of the work-related accident of September 22, 2016. Dr. Nuber's opinions were based on the change in the MRI study.

Dr. Nuber testified that determining whether Petitioner would have needed surgery prior to September 22, 2016 was speculative. Dr. Nuber had no indication that Petitioner had any change in symptoms prompting the need for surgery between April 5, 2016 and September 21, 2016. As of April 5, 2016, Dr. Nuber had not recommended that Petitioner undergo surgery for this shoulder and no surgery had been scheduled.

In according greater weight to the medical opinions of Dr. Nuber, Petitioner's treating physicians, the Arbitrator relies on *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). Accordingly, the Arbitrator finds that Petitioner's current condition in connection with his left shoulder is causally connected to the work-related accident of September 22, 2016. The accident of September 22, 2016 caused a tear to the infraspinatus and also caused a worsening of the tear at the supraspinatus form a partial thickness tear to a full thickness tear. Dr. Nuber's opinions were supported by the diagnostic studies and objective evidence.

B. Chain of Events Analysis

The Arbitrator further concludes that Petitioner has established that the current condition of ill-being as it relates to the left shoulder condition is causally connected to the work-related accident of September 22, 2016

through the "chain of events" analysis. Proof of prior good health and change immediately following and continuing after an injury may establish that the impaired condition was due to injury. *Ill. Power Co. v. Indus. Com'n*, 176 Ill.App.3d 317, 530 N.E.2d 617 (4th Dist. 1988).

In *Corn Belt Energy v. Illinois Workers' Compensation Commission*, 2016 IL App (3d) 150311WC (3d Dist. 2016) the court held that the Arbitrator could accord more weight to the chain of events analysis than the opinions of the Section 12 physician. In *Kawa v. Illinois Workers' Compensation Commission*, 2013 IL App (1st) 12469WC, 991 N.E.2d 430 (1st Dist. 2013), the appellate court reaffirmed the chain of events analysis. The court found that the claimant established a "causal nexus between the accident and his condition of ill-being" based on the evidence that the claimant's condition had begun no sooner than the work-related accident and continued with no intervening cause that broke the chain of events. *Id.*

The court in *Schroeder v. Illinois Workers' Compensation Commission*, 2017 IL App (4th) 160192, 79 N.E.3d 833 (4th Dist. 2017) applied the chain of events analysis to pre-existing conditions. Specifically, the court upheld a finding of medical causation where the claimant had a significant pre-existing injury. *Id.* The court found it significant that despite any objective changes in the pre-injury and post-injury MRI, the claimant's condition deteriorated following the work injury. *Id.*

In the instant case, Petitioner had a previous injury to the left shoulder resulting in surgery performed on August 13, 2010. Subsequently, he sought medical treatment for his left shoulder condition with Dr. Nuber. On April 5, 2016, Dr. Nuber released Petitioner to return to work without restrictions. Dr. Nuber documented that Petitioner's shoulder was getting worse and he had good range of motion with positive impingement. The

medical records document that Dr. Nuber and Petitioner "talked options." Dr. Nuber stated that Petitioner wanted to return to work and if his condition was still bothering him in September, he would undergo surgery. Dr. Nuber explained that surgery was a treatment option; however, he did not recommend that Petitioner undergo surgery for the left shoulder. Petitioner believed that surgery was a treatment opinion, but that he did not require surgery at the time. Following the appointment with Dr. Nuber, Petitioner did not schedule surgery. Further, Dr. Nuber testified that he did not recommend surgery as of April 5, 2016. Pursuant to the letter from Petitioner's supervisor confirmed that Petitioner did not have any symptoms or difficulty working prior to the work-related accident of September 22, 2016.

Based on the medical records, Petitioner was released to return to work, returned to work without restrictions and had no further medical treatment scheduled for his left shoulder prior to September 22, 2016. However, immediately following the work-related accident, Petitioner sought medical treatment. He was advised to remain off work on September 22, 2016. He continued on a course of medical treatment that included activity modification, diagnostic tests, follow up appointments and a recommendation for surgery. Petitioner was working without restrictions prior to September 22, 2016; however, following September 22, 2016, he has not been released to return to work without restrictions. Further, although surgery was one treatment option discussed prior to September 22, 2016, it was not recommended due to Petitioner's lack of symptoms. Following September 22, 2016, surgery for the left shoulder condition was recommended and Petitioner's symptoms in his left shoulder increased. Accordingly, the chain of events analysis established that Petitioner was

working full duty prior to September 22, 2016 and under work restrictions and active medical treatment with a recommendation for surgery after September 22, 2016. Thus, Petitioner established that the current condition of ill-being in connection with the left shoulder condition was causally connected to the work-related accident of September 22, 2016. In support of this finding the Arbitrator also cites *Steak 'n Shake v. Illinois Workers' Compensation Commission*, 2016 IL App (3d) 150500WC (3d Dist. 2016).

C. Medical Opinions of Dr. Cohen, Respondent's Section 12 Physician

The transcript of the evidence deposition of Dr. Cohen, Respondent's Section 12 physician, was admitted into evidence. The Arbitrator considered the opinions of Dr. Cohen and accorded them little weight. *See International Vermiculite Company,* 77 Ill.2d 1. The Arbitrator finds that Dr. Cohen's opinions were not based on the evidence, inconsistent with the diagnostic studies and not supported by the facts of the case.

Dr. Cohen noted that his reading of the MRI report of February 9, 2016 differed from the radiologist's reading of the report. He set forth that he believed that the prior MRI of February 9, 2016 had evidence of a full thickness tear. With regard to the interpretation of the MRI studies, the Arbitrator relies on the radiologist and the opinions of Dr. Nuber and finds that Petitioner had a partial thickness tear in February 2016.

Dr. Cohen stated that the current left shoulder condition was not causally connected to the work-related accident of September 22, 2016. He based his opinion on the fact that the surgery was recommended prior to September 2016 and that Petitioner's condition was worsening in April 2016. However, Dr. Cohen agreed that the surgery was discussed if

Petitioner's condition was still bothering him. He also agreed that the surgery was not scheduled as of September 22, 2016. Dr. Cohen stated that the accident may have aggravated the left shoulder; however, the surgery was recommended prior to the work-related accident of September 22, 2016.

Dr. Cohen based his opinions regarding medical causation on an incorrect interpretation of the medical records. The Arbitrator finds that Dr. Cohen mistakenly interpreted Dr. Nuber's notes to find that surgery was recommended prior to September 22, 2016. Dr. Nuber and Petitioner both testified that the surgery was a treatment opinion. The surgery had not been recommended as of April 5, 2016. Further, since Petitioner's condition did not worsen between April 5, 2016 and September 22, 2016, surgery was not required. However, following the accident, surgery was recommended. Accordingly, the basis for Dr. Cohen's opinion was incorrect.

Dr. Cohen also relied on the fact that Petitioner was filling prescriptions of Norco prior to the accident of September 22, 2016. Dr. Cohen did not know which doctor prescribed the pain medication. He acknowledged that it was possible that Petitioner was prescribed medication for the neck condition. Dr. Cohen did not review any records from Dr. Bhavsar or Dr. Abdellatif in connection with his examination. Petitioner's unrebutted testimony established that he was taking the pain medication for a neck condition. Accordingly, the use of pain medication was not relevant to Petitioner's shoulder condition and the causation of the condition.

Additionally, Respondent attempts to argue that Petitioner's testimony was not credible based on the medical records of Dr. Bhavsar. Specifically, Respondent argues that Petitioner testified that he was not taking pain

medication for the left shoulder condition and the medical records of Dr. Bhavsar contradict Petitioner's testimony. Respondent's argument is not based on an accurate review of the medical records. Petitioner testified that he was not currently taking pain medication for his left shoulder. The medical records of Dr. Bhavsar documented medical treatment through July 7, 2017. On July 7, 2017, Petitioner was only examined for his neck and back condition. He was not examined in connection with his left shoulder condition. No medical records closer in time to the hearing date were admitted into evidence and Dr. Bhavsar did not examine Petitioner's left shoulder in 2017. Accordingly, the Arbitrator finds that Petitioner's testimony was credible and not contradicted by the medical records.

Dr. Cohen acknowledged that the accident caused a traction-type force on the left arm. Dr. Cohen testified that Petitioner sustained a strain or force on his left shoulder. Dr. Cohen testified that Petitioner could have injured his shoulder without hanging off the handle. The history of the accident was consistent with a traction injury to the shoulder. Dr. Cohen testified that a traction-type injury could cause an injury to the rotator cuff. Thus, it is significant that Dr. Cohen agreed that the mechanism of accident in the instant case was consistent with the type of injury that Petitioner sustained.

Lastly, the Arbitrator finds that the objective evidence supports a finding that the accident of September 22, 2016 caused a worsening of Petitioner's shoulder condition. The Arbitrator relies on the radiologist report and Dr. Nuber's reading of the MRI studies, which show that following the accident of September 22, 2016, the diagnosis of Petitioner's shoulder condition changed from a partial thickness tear to a full thickness tear and he sustained a new tear. Accordingly, Petitioner had an objective change in

his shoulder condition following the work-related accident of September 22, 2016. *National Freight Industries*, 373 Ill.Dec. 167. In light of the MRI reports and totality of the medical evidence, the Arbitrator does not find Dr. Cohen's reading of the February 9, 2016 MRI to be persuasive.

In support of the Arbitrator's decision relating to "K," prospective medical care, the Arbitrator makes the following conclusions:

The Arbitrator concludes that Petitioner is entitled to payment for the medical treatment recommended by his treating physician, Dr. Nuber, including the left shoulder surgery. The Arbitrator concludes that the treatment recommendation constitutes reasonable and necessary medical care. In support of this finding, the Arbitrator relies on Petitioner's credible and unrebutted testimony and the medical records of Nuber. Dr. Nuber recommended that Petitioner undergo left shoulder surgery. The Arbitrator notes that Respondent's only defense to the surgery is medical causation. Dr. Cohen, Respondent's Section 12 physician, testified that the surgery constituted reasonable medical treatment. Accordingly, having found that the current condition of ill-being in connection with the left shoulder was causally connected to the work-related accident of September 22, 2016, the Arbitrator awards payment of the surgery recommended by Dr. Nuber.

Based on the medical records and opinions of Dr. Nuber, the Arbitrator awards Petitioner payment for the medical treatment, including the left knee surgery. In support of her decision, the Arbitrator cites *Plantation Manufacturing Company v. Industrial Commission*, 294 Ill.App.3d 705, 691 N.E.2d 13 (2d Dist. 1997).

In support of the Arbitrator's decision relating to "L," temporary total disability benefits, the Arbitrator makes the following conclusions:

The Arbitrator concludes that Petitioner is entitled to temporary total disability benefits from September 23, 2016 through October 18, 2016. The Arbitrator relies on the credible and unrebutted testimony of Petitioner and the medical records from MercyWorks and Dr. Nuber and the medical opinions of Dr. Nuber. Respondent's only defense to payment of temporary total disability benefits is medical causation. Having found that the current left shoulder condition is causally connected to the work-related accident of September 22, 2016, the Arbitrator awards payment of temporary total disability benefits from September 23, 2016 through October 18, 2016.

In *Freeman United Coal Mining Company v. Industrial Commission*, 318 Ill.App.3d 170, 741 N.E.2d 1144 (2001), the court set forth that "a claimant is entitled to TTD when a 'disabling condition is temporary and has not reached a permanent condition.'" (quoting *Manis v. Industrial Commission*, 172 Ill.Dec. 95, 595 N.E.2d 158 (1st Dist. 1992)). The dispositive test for determining whether a claimant is entitled to TTD is whether the condition has stabilized. *Id.* In *Freeman United Coal Mining Company*, the court held that the condition of the petitioner's knee had not stabilized and that the petitioner was thus entitled to TTD benefits. *Id.* The court based its decision on the fact that the petitioner had not been released to full-duty work and future medical care was being considered by the petitioner's treating physicians. *Id.*

In the instant case, Petitioner was advised to remain off work and referred to an orthopedic surgeon by the physician at MercyWorks on

September 22, 2016. From September 27, 2016 to the present date, Petitioner was under the active medical care of Dr. Nuber. He underwent medical treatment, including diagnostic testing and a recommendation for surgery. Petitioner has not undergone the recommended surgery. He was released to return to work with restrictions by Dr. Nuber on October 18, 2016. On October 19, 2016, Petitioner returned to work for Respondent within his restrictions.

For the period of September 23, 2016 through October 18, 2016, Petitioner was under active medical care and unable to return to work. The Arbitrator finds that Petitioner's condition has not stabilized. Accordingly, Petitioner is entitled to payment of temporary total disability benefits for the period of September 23, 2016 through October 18, 2016. *See Freeman United Coal Company*, 318 Ill.App.3d 170.

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

Marisol Exclusa,

Petitioner,

vs.

NO: 12 WC 22218

Conray Corp.,

19IWCC0205

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 18, 2018, is hereby affirmed and adopted.

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

19IWCC0205

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: APR 2 5 2019
TJT:yl
o 4/23/19
51

Thomas J. Tyrrell

Maria E. Portela

Deborah L. Simpson

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

EXCLUSA, MARISOL
Employee/Petitioner

Case# **12WC022218**

CONRAY CORPORATION
Employer/Respondent

19IWCC0205

On 1/18/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.60% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0328 LEWIS & DAVIDSON LTD
ANNE-LOUISE KLEPER
ONE N FRANKLIN ST SUITE 1850
CHICAGO, IL 60606

1296 CHILTON YAMBERT & PORTER LLP
DANIEL T CROWE
303 W MADISON ST SUITE 2300
CHICAGO, IL 60606

19IWCC0205

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)

MARISOL EXCLUSA
Employee/Petitioner

v.

CONRAY CORPORATION
Employer/Respondent

Case # 12 WC 22218

Consolidated cases: n/a

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **DOUGLAS S. STEFFENSON**, Arbitrator of the Commission, in the city of **CHICAGO**, on **DECEMBER 2, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

19IWCC0205

FINDINGS

On the date of accident, **MAY 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 not* causally related to the accident.

In the year preceding the injury, Petitioner earned $**16,588.00**; the average weekly wage was $**319.99**.

On the date of accident, Petitioner was **45** years of age, ***married*** with **3** dependent children.

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

Respondent shall be given a credit of $**22,395.25** for TTD, $ **0.00** for TPD, $**0.00** for maintenance, and $**22,285.86** for other benefits, for a total credit of $**44,681.11**.

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

ORDER

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

> The Petitioner failed to prove her current condition of ill-being is causally related to her May 18, 2011 work accident. As such, the Petitioner's requests for prospective medical care and other compensation under the Act 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 of Arbitrator

January 18, 2018
Date

ICArbDec19(b)

JAN 18 2018

MARISOL EXCLUSA v. CONRAY CORPORATION

12 WC 22218

FINDINGS OF FACT AND CONCLUSIONS OF LAW

INTRODUCTION

This matter was tried on the Petitioner's Section 19(b) Petition before Arbitrator Steffenson on December 2, 2016. The issues in dispute were causal connection, medical bills, TTD, and prospective medical care[1]. (*Arbitrator's Exhibit* 1). The parties agreed to receipt of this Arbitration Decision via e-mail and requested a written decision, including findings of fact and conclusions of law, pursuant to Section 19(b) of the Act. (*Arbitrator's Exhibit* (hereinafter, *AX*) 1).

FINDINGS OF FACT

On May 18, 2011, the Petitioner was employed by the Respondent as a sales associate. She initially was hired to work the third shift, 11:00 p.m. to 7:00 a.m. However, the Respondent's owner, Mr. Renaldo Ampon, allowed her to work the first shift, 7:00 a.m. to 2:00 p.m. as it was more convenient for the Petitioner to get her children off to school. The Petitioner's job duties included cashier, fast-food preparation, e.g. hot dogs, pizza, accepting deliveries, doing inventory, writing orders, mopping, and sweeping.

On the stipulated accident date[2], the Petitioner was working the first shift and preparing the Respondent's store for the start of the second shift. She was walking back into the store's office area when she reported she slipped and fell on liquid. Mr. Ampon was to her left by the cash register. Mr. Ampon asked her if she was okay. Mr. Ampon and a co-worker, Mr. Juan Rodriquez, helped her up. The Petitioner's right knee struck the floor. She fell on both knees. She noticed a lot of pain in her right knee[3] and her low back. However, the Petitioner did not

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[1] Despite an indication on Issue 10 that the nature and extent of the injury is in dispute, the parties clarified that this issue is not to be addressed in this Arbitration Decision. (Compare *Arbitrator's Exhibit* 1 and *Transcript* at 6). The parties, however, did stipulate the Petitioner suffered a work-related accident "on or about 05/18/2011". (*Arbitrator's Exhibit* 1).

[2] *AX* 1.

[3] Prior to this incident, the Petitioner injured her right knee in 2001 while working for a previous employer. She denied receiving any treatment for her right knee since 2002.

seek medical attention that day. Instead, the Petitioner first sought medical care for this incident on July 17, 2011, some two months after her fall. The Petitioner asserted she did not promptly seek medical care as she had recently separated from her husband, who no longer wished for her to utilize his medical insurance plan.

On July 17, 2011, the Petitioner sought medical care from St. Mary and Elizabeth Hospital's emergency room. Her treatment records indicate her employer was Tony's Finer Foods and she was complaining of pain in her back and right knee after she fell two weeks prior. She reported that her leg was stiff and underwent x-rays[4] of her right knee. The x-ray studies revealed no acute fracture, dislocation, or destructive lesion. The radiologist did note mild tri-compartmental degenerative change with a small suprapatellar effusion. She then was referred to Dr. Michael Triester, who saw the Petitioner on July 29 and ordered an MRI study.

The Petitioner continued to work for the Respondent during the summer of 2011 and appreciated increasing symptoms in her right leg. She testified that she continued to work for the Respondent until she was laid off on October 15, 2011. The Petitioner testified she received unemployment benefits for four to five months and then applied for employment with Andrews Staffing. She stated that Andrews Staffing placed her with a company that made bibles. She could sit down at this job and worked at this facility for two months before Andrews Staffing then sent her to a trophy company to work. However, she indicted she could not do the work at the trophy company and left after only one week.

On March 30, 2012, the Petitioner sought medical care from Dr. Roberto Levi based upon a referral by her primary care physician. Dr. Levi indicated the Petitioner complained only of right knee pain and had undergone two arthroscopic surgeries in the past. His examination of the Petitioner revealed she stood 5 feet 5 inches tall and weighed 250 pounds with a body mass index of 41.6. The Petitioner did indicate to Dr. Levi she had lost 60 pounds over the last year and six months. However, Dr. Levi does not make any mention at all in his report of the Petitioner reporting to him of having sustained an accident on May 18, 2011.

Dr. Levi's physical examination of the Petitioner also discovered a bilateral genu valgum, crepitus in both knees, more on the right than the left, and positive patella compression test bilaterally. He also reviewed x-rays of the Petitioner's right knee that showed a genu valgum and tricompartmental osteoarthritis. Dr. Levi then concluded the only solution to the

[4] As to her lower back x-rays, the radiologist stated there was significant Grade II anterolisthesis of L5 on S1. They also revealed disk narrowing at L4-L5 and L5-S1. The radiologist stated these findings were consistent with degenerative disc disease.

Petitioner's right knee pain complaints would be a total knee replacement. He further reported the Petitioner wished to proceed with an arthroscopic approach to her pain, but also commented such a course of action only could improve her symptoms temporarily.

The Petitioner then returned to Dr. Triester on May 4 and reported she was in a lot of pain and her leg was swollen. Dr. Triester ordered an MRI. The Petitioner then did not return to Dr. Triester until August 23 when she indicated she could barely walk. Dr. Triester again ordered an MRI, which took place at River North MRI, and subsequently recommended the Petitioner undergo arthroscopic surgery to address her leg complaints.

After meeting with Dr. Brian Cole on the September 10, 2012, for a Section 12 examination requested by the Respondent, the Petitioner returned to Dr. Triester on January 17, 2013, and was directed to an in-office pre-surgical physical therapy program by Dr. Triester. She then underwent surgery on February 5, 2013 by Dr. Triester at St. Elizabeth's Hospital and a post-surgical physical therapy course that began on February 14.

The Petitioner then had follow-up appointments with Dr. Triester running from March of 2013 through August of 2013[5], during which time she reported that her on-going therapy and medication programs had improved her leg motion but she continued to have pain and swelling in that leg. Thereafter, in the fall of 2013, she began to treat with Dr. Brian Forsythe at Midwest Orthopedics at Rush for pain in her left knee. During this period[6], she also continued to see Dr. Triester for her right knee symptoms. On February 8, 2014, while discussing with Dr. Triester the possibility of a knee replacement, Dr. Triester recommended she investigate such an option at either Rush or Northwestern. During the spring of 2014, the Petitioner followed-up with Dr. Triester, culminating with a new MRI study on June 5 and a surgical recommendation and referral by Dr. Triester on June 11 to either Dr. Gabriel Levi or Dr. Roberto Levi.

The Petitioner was first seen by Dr. Gabriel Levi on July 12, 2014, and during an August 6 appointment, Dr. Levi recommended a knee replacement procedure. However, on September7, the Petitioner discussed with Dr. Levi a viscosupplementation injection treatment option. This treatment option was carried out by Dr. Levi on January 21, 2015, and the Petitioner reported it improved her leg movement but not her pain symptoms. She then underwent four more injections on February 4, February 11, and February 18, indicating they improved her movement but not her swelling symptoms. Dr. Levi ordered further testing in April and May of

[5] The Petitioner testified, in the fall of 2013, she attended classes at a local high school for training to become a CTA bus driver or train operator. However, she did not complete the training.

[6] In December of 2013 and January of 2014, she reported her left knee was getting better but her right knee and low back were the same.

2015, before prescribing aqua therapy and recommending a knee replacement on June 3, 2015. However, a July 8, 2015 dispute between the Petitioner and Dr. Levi resulted in the termination of their physician/patient relationship.[7]

The Petitioner then was directed, via both Dr. Triester and Dr. Gryzlo, to Dr. David Manning. During her visits with Dr. Manning, he recommended injection therapy and a lifestyle program with a weight loss component. In doing so, Dr. Manning counseled her regarding her weight and he recommended she lose weight before undergoing an arthroplasty. Dr. Manning also stated the Petitioner was very difficult to interview in that she was manic, highly expressive, and would cut him off before he could answer questions.

The Petitioner has not worked 5/4/2012. She testified her right knee is getting worse, it is hard to walk up and down stairs, and perform her chores. She testified that before this accident, she was 55 pounds lighter. She denied both telling Dr. Triester she had not worked since July of 2011 and of being terminated from her employment with the Respondent on 8/2/2011 for excessive absenteeism and tardiness. She admitted she worked for MMDK, Inc. d/b/a Andrews Staffing from December of 2011 thru May of 2012 and that she sustained a laceration to her left hand while working for the trophy company in February of 2012. She acknowledged she settled her workers' compensation case arising out of that February of 2012 accident.

After examining her December 1, 2011, employment application[8] with MMDK, Inc., the Petitioner acknowledged she indicated on that form she worked at 7-Eleven from May of 2009 to October of 2011. The Petitioner also clarified her position by noting she worked for other 7-Elevens before she worked for the Respondent. She also admitted she started to work for the Respondent in February of 2011. The Petitioner also initially denied making a workers' compensation claim against another employer, Costco, but subsequently admitted she settled such a claim for a 22.5% loss of the right leg.

During her testimony, the Petitioner denied telling Dr. Roberto Levi on March 30, 2012 that she did not want to follow up with Dr. Triester. Furthermore, she could not recall if, during that March 30 appointment, she told Dr. Roberto Levi about her May 18, 2011 accident. She also could not recall whether Dr. Roberto Levi told her during that visit that she had a genu valgum deformity in her right knee.

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[7] Dr. Gabriel Levi's July 8, 2015 records indicate the Petitioner used profanities and other disrespectful behavior during that appointment and, as such, Dr. Levi recommended she find another physician.

[8] *Respondent's Exhibit* 3.

The Petitioner acknowledged she was examined by Dr. Kevin Walsh pursuant to the Respondent's Section 12 request[9]. However, she denied telling Dr. Walsh she did not experience any pain in her right knee until the day after her May 18, 2011 accident.

The Petitioner admitted she told the medical staff at St. Mary and Elizabeth Hospital on July 17, 2011 that she worked at Tony's Finer Foods and further acknowledged she did so for 30 to 40 hours per week while also working for the Respondent. She agreed she was working for both the Respondent and Tony's Finer Foods in May of 2011, but could not recall whether she told. Dr. Triester of her employment period with Tony's Finer Foods.

Ms. Sally Moll works as a human resources specialist for MMDK, Inc, a staffing agency also known as Andrews Staffing. Ms. Moll testified the Petitioner was employed by MMDK, Inc. from December of 2011 to February of 2012, and then for one week in May of 2012. She was employed as a general laborer. Ms. Moll testified the Petitioner initially worked at Monastery, a printing/binding company, before being re-assigned to Victory Planter Trophy Company and, subsequently, Primrose Candy. The Petitioner worked at Monastery from December of 2011 to February of 2012 performing general labor binding books. She then went to Victory Planter Trophy where she worked as a machine operator and general laborer before her re-assignment to Primrose Candy, where she was involved in candy production. The Petitioner also suffered a left-hand work injury while at Victory Planter Trophy Company. Ms. Moll, after reviewing her company's wage statements[10], confirmed the Petitioner worked for MMDK, Inc., in a full duty capacity from December 14, 2011 through May 29, 2012.

Mr. Renaldo Ampon is the owner of Conray Corporation, which does business as a 7-Eleven franchise. Mr. Ampon hired the Petitioner in February of 2011 after she had completed and submitted an application for employment[11] on December 17, 2010. The Petitioner began working as a sales associate for the Respondent on February 7, 2011 on the date the Respondent opened its 7-Eleven store. Her job duties included cashier, preparing food, cleaning and mopping. This store was open for business 24 hours a day and seven days a week and the daily work schedule is broken down into three shifts. Although he initially hired the Petitioner for the third shift, Mr. Ampon reassigned her to the first shift due to certain job performance issues and she worked from 32 to 36 hours per week.

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[9] The Petitioner also admitted she began to see Dr. Forsythe at Midwest Orthopedics at Rush after she saw Dr. Cole pursuant to another Section 12 request of the Respondent and that she knew Dr. Forsythe worked with Dr. Cole.

[10] *Respondent's Exhibits* (hereinafter, *RX*) 3 and 4.

[11] *RX* 2.

Mr. Ampon testified he was present when the Petitioner sustained her fall in the late morning on May 18, 2011. He reported he was at the store's front counter filling tubes with currency while the Petitioner was behind him working the register. He heard the Petitioner say, "Oops", and immediately turned around to observe the Petitioner sitting on her buttocks on the floor next to the register[12]. He and another employee, Juan Rodriguez, then assisted the Petitioner back to her feet. After he asked how she was feeling, the Petitioner informed Mr. Ampon she was find and she returned to work and finished her shift. Mr. Ampon stated the Petitioner did not seem to be in any pain and did not ask for medical care. Furthermore, he did not appreciate the Petitioner being in pain while working after the May 18, 2011, incident. However, he indicated he observed the Petitioner began calling off work at the last minute on many occasions after the May 18 accident.

Mr. Ampon reported, after the May 18 incident, he never noticed anything unusual about the way the Petitioner walked or the way she held herself. Further, he testified that, during this period, the Petitioner never made any complaints of pain and never discussed the fall with him. He did indicate the Petitioner was very vocal about many other things but never mentioned the fall. Instead, Mr. Ampon indicated the first time he heard about the Petitioner having a knee problem was approximately two years ago when his insurance company informed him of her claim. Mr. Ampon also stated he never spoke with Dr. Triester about the Petitioner.

Mr. Ampon identified the Petitioner's timecards for the period from May 12, 2011 to August 2, 2012[13]. He reported the timecards revealed the Petitioner's last work day for the Respondent was August 2, 2011 and her work attendance after June 2, 2011 was sporadic[14]. Mr. Ampon testified that he tolerated the Petitioner's tardiness and calling off work at the last minute for months before he finally terminated her employment on 8/2/2011. He had no information the Petitioner applied for unemployment compensation after she was terminated by the Respondent.

Dr. Triester, a Board Certified orthopedic surgeon, has been licensed to practice medicine in the State of Illinois since 1968. In 2002, he began caring for the Petitioner for an

[12] Mr. Ampon further testified the Petitioner's episode did not occur in the "back office" of the store. (*Transcript* (hereinafter, *T.*) at 98).

[13] *RX* 7.

[14] The timecards indicate, for the weeks ending June 2, June 9 and June 16, the Petitioner worked 22.33, 24.7, and 24.74 hours, respectively. For the weeks ending June 23 and June 30, she worked 40.54 and 43.09 hours, respectively. Thereafter, for the remainder of her employment with the Respondent through August 2, she never worked more than 24.87 hours per week. (*RX* 7).

injury she sustained to her right knee while working at Costco. Subsequently, Dr. Triester performed arthroscopic surgery on the Petitioner's right knee on April 10, 2002.

She then returned to Dr. Triester on July 29, 2011, and reported she fell at 7-Eleven and injured her right knee. The Petitioner complained of pain in the medial and lateral aspects of her right knee. She indicated to Dr. Triester she was seen in the emergency room at the St. Mary of Nazareth Hospital on July 17, 2011, and right knee x-rays from that visit revealed no fracture or dislocation, and mild tricompartmental degenerative osteoarthritis with small suprapatellar effusion. Dr. Triester noted the Petitioner was quite heavy when he cared for her in the past but, in July of 2011, she appeared to be doing well and had lost some weight. His physical examination revealed a 3+ pitting edema in the right leg and somewhat less pitting edema on the left leg. He noted marked tenderness of the right knee medial joint space.[15] He ordered an MRI of the Petitioner's right knee.

The Petitioner did not return to Dr. Triester until May 4, 2012, when she reported her right knee was much worse. His physical examination found tenderness at the medial joint space with crepitus which was not noted in his original examination on July 29, 2011. He reported finding crepitus that indicated a degradation of the articular cartilage indicative of arthritis or articular cartilage degeneration. Dr. Triester opined that this arthritis developed due to the delay in treatment of the Petitioner's right knee, listed a diagnosis of reactive synovitis due to a torn meniscus, and again ordered an MRI.

Subsequently, the Petitioner returned to Dr. Triester on August 30, 2012, after having undergone the MRI study on August 24, 2012. Dr. Triester, after reviewing the MRI, noted a radial tear in the posterior part of the lateral meniscus with fluid collection. He recommended an arthroscopic surgery of the Petitioner's right knee.

Dr. Triester next saw the Petitioner on October 26, 2012. He reviewed Dr. Cole's Section 12 report that recommended a trial of injections. However, Dr. Triester disagreed with approach as, in his opinion, the injections only would treat the Petitioner's symptoms, and not her pathology. Instead, Dr. Triester noted the prescribed surgery had nothing to do with arresting the arthritic process, only curing what was damaged in the fall.

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[15] Dr. Triester also examined the Petitioner's lumbar spine and reviewed her lumbar spine x-rays. He noted the presence of degenerative changes at L4-L5 and L5-S1 with spondylolisthesis. He listed his diagnoses as internal derangement of the right knee and lumbar sprain. Dr. Triester subsequently admitted he provided no treatment to the Petitioner for her diagnosed lumbar sprain.

After placing the Petitioner in a pre-surgical physical therapy course in January of 2013, Dr. Triester performed surgery on the Petitioner's right knee on February 5, 2013. His post-operative diagnosis was severely torn lateral meniscus with a large flap of lateral meniscus folded forward and lateralward and wrapping around the lateral wall of the lateral meniscus; interior horn tear of the medial meniscus, extensive synovitis, moderate to severe chondromalacia cartilage deterioration of the medial femoral condyle; chondromalacia of the lateral femoral condyle; grade 1 or 2 chondromalacia in the lateral tibial plateau. During this procedure, Dr. Triester performed an extensive partial lateral meniscectomy and instructed the Petitioner to begin a post-surgical course of physical therapy. He then monitored her surgical recovery during appointments in the spring and summer of 2013.

On October 3, 2013, the Petitioner reported her left knee was bothering her. Dr. Triester noted the Petitioner's right knee was doing better. His physical examination of the Petitioner's right knee revealed a good range of motion, no effusion, no crepitus, and the knee was stable. Dr. Triester also ordered an MRI of the Petitioner's left knee, but did not relate the Petitioner's left knee problems to the May 18, 2011 injury. On November 14, 2013, the Petitioner reported to Dr. Triester her right knee was bothering her. His physical examination revealed edema in both legs, a small amount of valgus malformation of the right knee, 15 degrees.[16] X-rays from that appointment revealed arthritis, osteophytes, and bone spurs.

On January 24, 2014, the Petitioner returned to Dr. Triester with right knee pain complaints. Her physical examination revealed a reduced range of motion. Dr. Triester indicated deterioration of her right knee was occurring and the Petitioner needed a knee replacement "even though x-rays did not show a complete joint collapse". (*Petitioner's Exhibit 2*).

On June 5, 2014, the Petitioner underwent an updated right knee MRI. On June 11, 2014, Dr. Triester reported the MRI revealed additional tearing of the posterior horn of the lateral meniscus; significant interval progression of tricompartmental joint disease; complete cartilage denudation; and subarticular edema. On that date, his last appointment with the Petitioner, he also referred her medical care to Dr. Roberto Levi and Dr. Gabriel Levi.

Dr. Triester testified the Petitioner was not capable of working during the time he saw her that ran from July 29, 2011 through June 5, 2014.[17] His basis for this opinion was that the Petitioner was unable to walk or stand for any period of time. He further opined the

[16] Dr. Triester testified that 7 degrees to 8 degrees of valgus is normal.

[17] Dr. Triester also testified it was his understanding that the Petitioner had not worked since July of 2011 as the Petitioner had informed him she had not worked since July of 2011.

Petitioner's current condition related to the accident of May 18, 2011. This opinion was founded upon his finding that there was no arthritis present in the Petitioner's right knee when he performed the surgery in 2002, and she was asymptomatic from 2002 through May 18, 2011. Dr. Triester indicated if the Petitioner was experiencing symptoms during that period, she would have returned to see him.

Dr. Triester admitted he initially stated that he had seen loose bodies in the Petitioner's knee during her 2002 surgery.[18] During that procedure, he removed a portion of the posterior horn of the Petitioner's medial meniscus. Dr. Triester testified patients with meniscal tears have twice the likelihood of developing arthritic changes in their knees over time than those persons who have not had meniscal tears.

Dr. Triester indicated he found the Petitioner weighed 250 pounds and was 5 feet 5 inches tall in April of 2012. Further, he recalled from his April of 2002 surgical report he had indicated the Petitioner was a 35-year-old heavy-set female. Further, Dr. Triester noted that Dr. Levi stated the Petitioner had genu valgum and tricompartmental osteoarthritis on March 30, 2012. Dr. Triester then admitted that he did not note a genu valgum malformation in his notes on July 29, 2011. He also acknowledged July 17, 2011 x-rays from St. Elizabeth Hospital revealed tricompartmental arthritis, meaning the Petitioner had arthritis in all three compartments of her knee on that date. Dr. Triester testified that the genu valgum malformation would make it more likely that the Petitioner would develop articular cartilage deterioration. Dr. Triester further indicated the Petitioner has genu valgum malformation in her left knee, but he had no medical opinion relative to the Petitioner's left knee condition.

Dr. Triester stated, when determining articular cartilage degeneration and the development of degenerative osteoarthritis, the patient's weight is the biggest factor. He stated that he did not think the Petitioner's genu valgum malformation was significant. Instead, he noted weight is a factor as it contributes to arthritic deterioration and puts the Petitioner more at risk for injury to the cartilage. He explained that if a patient has significant angular deformity, or is obese, then articular cartilage deterioration accelerates more rapidly. He did state the Petitioner may have had deterioration during the 10 to 12 year period after her 2002 injury. Further, he indicated the arthritis could have followed the first surgery and the genu valgum malformation places the Petitioner at a risk for more arthritis.

Dr. Triester attributed the pitting edema he found in both of the Petitioner's legs to be caused by her obesity as circulation is compromised when fat in the belly pushes on the veins,

[18] Dr. Triester testified only the surgical report from 2002 provided by the Petitioner's attorney was available for his review as his office destroys records after seven years. This office policy covered, but was not limited to, chart notes, MRIs, and x-rays performed in 2001 and 2002.

making it difficult for blood to move from the Petitioner's toes back to her heart. He also admitted mild trauma may not aggravate an underlying disease, such as osteoarthritis, and that the underlying disease would remain progressive.

Dr. Walsh, a Board Certified orthopedic surgeon, has been licensed to practice medicine in the state of Illinois since 1984. His practice focuses on the knee and he performs over 140 knee replacements per year. He met with the Petitioner pursuant to the Respondent's Section 12 request, on 1/5/2015. During that visit, he met with the Petitioner, obtained her accident and medical care history, reviewed her medical records[19] and pre-and post-operative MRI films, and performed a physical examination of the Petitioner. She informed Dr. Walsh that she had no problem with her right knee until her fall on May 18, 2011, when she struck both of her knees. The Petitioner also reported her prior knee injury at Costco. Dr. Walsh's physical examination of the Petitioner's right knee found a full extension, flexion to 85 degrees, negative Lachman and drawer signs, diffuse tenderness, and a negative McMurray sign. He appreciated her to be neurovascularly intact and reported no atrophy of her calf or her quads. He also noted her weight at the time of the examination was 275 pounds.

Dr. Walsh testified the Petitioner's condition of obesity affected her right knee joint as it leads to wear and tear on the joint and the predevelopment of osteoarthritis. Dr. Walsh stated that obesity is the leading cause for the increased number of knee replacements being performed. He indicated a genu valgum malformation is a knock-kneed deformity where her knees touch before the ankles. He reported genu valgum malformation is measured radiographically and the average degree of valgus in human beings is 5 degrees, while 12 degrees would be excessive. Dr. Walsh described genu valgum as switching the weight bearing out to the lateral compartment, so the more knocked-kneed a patient, the more likely the patient's weight goes through the lateral compartment and causes it to wear out prematurely. Conversely, a straight leg places the weight on all compartments of the knee.

Dr. Walsh rendered a diagnosis of the Petitioner's right knee consisting of osteoarthritis status post right knee arthroscopy x2; status post thermal chondroplasty of the knee; morbid obesity; genu valgum deformity; tobacco abuse; and tricompartmental osteoarthritis. He testified osteoarthritis is a degenerative joint disease that occurs when a joint is wearing out with age and time. He indicated tricompartmental osteoarthritis means that all three compartments of the knee are wearing out, inside, outside, and beside the knee cap. Dr. Walsh

[19] Dr. Walsh reviewed the Petitioner's 2002 operative report operative report after he prepared his initial report, and prepared an addendum to that initial report. In doing so, he stated the operative report from 2002 does not indicate any loose bodies in the joint nor that any loose bodies chipped off in the knee joint.

stated patients develop osteoarthritis as they age, women have more knee replacements than men, and two-thirds of all knee replacements are performed on women.

Dr. Walsh further testified the Petitioner had osteoarthritis and tricompartmental osteoarthritis in her right knee before May of 2011. He opined the x-rays that were performed in 2011 demonstrated degenerative changes in the right knee that could not have been caused by the accident as described. He stated the period between the injury and the x-ray is too short to have caused the mild degenerative joint disease described by Dr. Triester at the time of his evaluation on July 29, 2011. He also opined obesity and genu valgum are risk factors that lead to osteoarthritis. Dr. Walsh agreed with Dr. Triester that obesity is a leading risk factor. However, Dr. Walsh also indicated genu valgum malformation is an additional risk factor. Dr. Walsh stated the factors that caused the Petitioner's osteoarthritis are obesity, gender, genu valgum malformation, and that a significant portion of the Petitioner's medial meniscus was removed when she was 35 years old.

Dr. Walsh then opined there is no causal relationship between the osteoarthritis contained in the Petitioner's right knee and her May 18, 2011 accident.[20] He further opined it was pre-existing and was not caused by the accident, nor aggravated or accelerated by the accident. Dr. Walsh indicated if there was an aggravation of the Petitioner's osteoarthritis at the time of the accident, the Petitioner would have experienced extreme pain. However, she denied having pain in her right knee to him on the date of her accident. Dr. Walsh added if trauma caused the condition that lead to a potential knee replacement, the Petitioner would have had pain and discomfort at the time of the trauma. Dr. Walsh noted the Petitioner reported no such pain and discomfort. Dr. Walsh went on to note it was not likely that all three compartments would have been affected by the fall. Specifically, assuming the Petitioner fell on her knee, the knee cap of a flexed knee would accept the blunt of the trauma during such an incident, while the weight bearing compartments would not have been affected.

Dr. Walsh testified the 2002 meniscal removal affected the diagnosis of osteoarthritis. He stated the Petitioner was 35 years of age when it was removed along with a large portion of the anterior horn. He indicated this is a set up to develop osteoarthritis. He explained the meniscus is a cushion that protects the knee and its removal likely will cause knee problems in the future. Dr. Walsh added the May 18, 2011 accident did not cause the Petitioner to be a candidate for a right knee replacement and her need for a knee replacement is not in any way related to the accident. Instead, he opined the Petitioner's need for the knee replacement is due to the pre-existing disease. He went on to state the simple slip and fall the Petitioner

[20] Dr. Walsh also opined no problems with the Petitioner's lumbar spine arose because of her May 18, 2011 fall.

experienced on May 18, 2011 did not cause, aggravate, or accelerate her osteoarthritis. Further, he indicated the delay she experienced in treatment did not impact on her arthritic disease in the right knee. Dr. Walsh also noted he was of the opinion at the time of his examination of the Petitioner in January of 2015 that she could work in a sedentary position and she would have reached a state of maximum medical improvement (MMI) in six to eight weeks after 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 claimant has the burden of proving, by a preponderance of the evidence, all of the elements of his or her claim. It is the function of the Commission to judge the credibility of the witnesses to resolve conflicts in the medical evidence. *O'Dette v. Industrial Com'n*, 79 Ill. 2d 249 (1980). In deciding questions of fact, it is the function of the Commission to resolve conflicting medical evidence, judge the credibility of the witnesses, and assign the weight to the witnesses' testimony. *R & D Thiel v. Illinois Workers' Compensation Com'n*, 398 Ill. App. 3d 858, 868 (1st Dist. 2010); See also *Hosteny v. Illinois Workers' Compensation Com'n*, 397 Ill. App. 3d 665, 674 (1st Dist. 2009).

For an employee's workplace injury to be compensable under the Workers' Compensation Act, the employee must establish the fact that the injury is due to a cause connected with the employment such that it arose out of said employment. *Hansel & Gretel Day Care Center v. Industrial Com'n*, 215 Ill. App. 3d 284 (3rd Dist. 1991). It is not enough that Petitioner is working when accidental injuries are realized; Petitioner must show that the injury was due to some cause connected with employment. *Board of Trustees of the University of Ill. v. Industrial Commission*, 44 Ill. 2d 207, 214 (1969).

In this instance, the Arbitrator finds that the Petitioner was not forthright in her testimony and not a credible witness for her claim. Specifically, the Petitioner denied she told Dr. Triester that she did not work after July of 2011. However, Dr. Triester testified it was his understanding, based upon the history provided by the Petitioner, that she had not been gainfully employed since he first saw her on July 29, 2011. Furthermore, as Dr. Triester's opinions were based on the accident and medical histories she provided to him, his opinions are flawed and, therefore, not credible. Additionally, the opinions Dr. Roberto Levi also lack credibility as to any causal connection in this instance as his March 30, 2012, correspondence makes no mention of the May 18, 2011, accident, indicating the Petitioner never directly informed him of that important event.

The Petitioner's testimony concerning her employment history is confusing and, thus, not credible. The documentary evidence clearly demonstrates the Petitioner was gainfully employed after May 18, 2011, and during the summer of 2011 through October of 2011. Further, this evidence clearly demonstrates the Petitioner was employed by MMDK, Inc., as a laborer, from December 14, 2011, through February 29, 2012[21], the date she sustained an injury to her left hand while working for the trophy company.

However, the Petitioner's testimony and documentary evidence she prepared indicates she worked for the Respondent, from 32-40 hours per week, beginning in February of 2011, and for Tony's Finer Foods. On her December 1, 2011 Application for Employment the Petitioner submitted to MMDK, Inc.[22], she stated she worked for 7-Eleven from May of 2009 through October of 2011. However, she also admitted she only started working for the Respondent in February of 2011, but qualified that position by noting she had worked for other 7-Elevens and a White Hen Pantry before February of 2011. The Petitioner's employment with Respondent ended on August 2, 2011, yet her Application for Employment with MMDK, Inc. states she worked for 7-Eleven through October 15, 2011.

Furthermore, while the Petitioner indicated she worked for the Respondent through October of 2011, Mr. Ampon testified he terminated her employment on August 2, 2011, for excessive absenteeism and tardiness. Mr. Ampon's testimony is supported by the Petitioner's time cards[23] that clearly show her last date of employment with the Respondent was August 2, 2011.

From all of this, the Arbitrator only can infer: 1) the Petitioner worked for the Respondent through her termination date of August 2, 2011; 2) the Petitioner continued working for Tony's Finer Foods through October 15, 2011, some five months after her May 18, 2011 accident at the Respondent's store; and 3) the Petitioner is a poor historian and not a credible witness for her claim.

The Petitioner's credibility is further undercut due to her conflicting testimony regarding a prior Workers' Compensation settlements. She initially denied she received a settlement from MMDK, Inc. for a laceration she sustained to her hand on February 10, 2012.[24] However, the

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[21] The Petitioner's wage statement from MMDK, Inc. demonstrates that between December 14, 2011, and February 29, 2012, the Petitioner worked 11 weeks, and in 8 of those weeks, worked 40 hours or more.

[22] *RX* 3.

[23] *RX* 7.

[24] *RX* 3.

Petitioner later recanted and admitted that she did in fact receive a settlement for that incident. She also initially denied she received a settlement for a previous right leg injury she sustained while working for Costco on May 4, 2001. Again, she later recanted and admitted she settled that case for a 22.5 percent loss of use of her right leg.[25]

The Petitioner's own description of her May 18, 2011 fall, landing on both knees, also lacks credibility due to the conflicting and credible testimony of a witness to the incident, Mr. Ampon. Mr. Ampon credibly testified he not only was present in the store on that date, but also was near the Petitioner at the time of her fall. After hearing the Petitioner cry out, he immediately turned around to find her sitting on the floor, instead of on her knees or in some other position associated with a forward-facing fall. As such, the Arbitrator finds the Petitioner's testimony concerning the manner of her accident was not credible.

The Arbitrator also finds the testimony of Dr. Walsh more persuasive than the testimony of Dr. Triester. It is clear from the medical records, the diagnostic films, and the testimony of the physicians that the condition of the Petitioner's right knee was the result of a combination of factors including the surgery she underwent in 2002, her osteoarthritis, her weight, and her genu valgum malformation.

The Arbitrator finds that Dr. Walsh was the only physician who provided opinion evidence in this case who was provided a true history and based his opinion on the available objective medical evidence. Dr. Walsh testified that the fall of May 18, 2011, was insignificant and any injury she sustained would have resolved within six to eight weeks. Dr. Walsh testified that the accident of May 18, 2011 neither aggravated nor accelerated the pre-existing condition of osteoarthritis in the Petitioner's right knee. The Arbitrator also finds it significant that the Petitioner did not seek any medical attention for her right knee until July 17, 2011, almost two months after the fall. Dr. Walsh stated that had the Petitioner sustained a significant injury on May 18, 2011, she would have experienced the immediate onset of pain and, presumably pursued medical treatment. The condition of the Petitioner's right knee is the result of her 2002 surgery, the tricompartmental osteoarthritis, her longstanding condition of obesity, and her genu valgum malformation.

As such, the Arbitrator relies on the above evidence and opinions of Dr. Walsh and finds the Petitioner's current condition of ill-being as it relates to her right leg and right knee is not causally related to the May 18, 2011 work accident.

[25] *RX* 5.

19IWCC0205

Issue J: *Medical bills*

Based upon the findings regarding **Issue F** above, the issue of medical bills is moot.

Issue K: *Prospective medical*

Based upon the findings regarding **Issue F** above, the Arbitrator finds the Respondent is not liable for any prospective medical care, including, but not limited to, any surgical recommendations or a pre-surgical Lifestyle Program under Section 8(a) of the Act.

Issue L: *TTD*

Based upon the findings regarding **Issue F** above, the issue of TTD is moot.

Finally, 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.

Signature of Arbitrator

January 18, 2018
Date

STATE OF ILLINOIS)
) SS.
COUNTY OF KANE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Michelle Bottino,

Petitioner,

vs.

NO: 17 WC 15578

19IWCC0206

Planmeca,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 9, 2018, is hereby affirmed and adopted.

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

19IWCC0206

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 $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: APR 25 2019
TJT:yl
o 4/23/19
51

Thomas J. Tyrrell

Maria E. Portela

Deborah L. Simpson

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

BOTTINO, MICHELLE
Employee/Petitioner

Case# **17WC015578**

PLANMECA
Employer/Respondent

19IWCC0206

On 3/9/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.83% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1836 RAYMOND M SIMARD PC
205 W RANDOLPH ST
SUITE 815
CHICAGO, IL 60606

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

STATE OF ILLINOIS)

)SS.

COUNTY OF Kane)

☐ Injured Workers' Benefit Fund (§4(d))

☐ Rate Adjustment Fund (§8(g))

☐ Second Injury Fund (§8(e)18)

☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION

ARBITRATION DECISION

19(b)

Michelle Bottino

Employee/Petitioner

v.

Planmeca

Employer/Respondent

Case # 17 WC 15578

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 **Ketki Steffen**, Arbitrator of the Commission, in the city of **Wheaton IL**, on **January 23, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were Petitioner's earnings?

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

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

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

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

L. ☐ What temporary benefits are in dispute?

☐ TPD ☐ Maintenance ☐ TTD

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

N. ☐ Is Respondent due any credit?

O. ☐ Other _____

FINDINGS

On the date of accident, **April 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 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 **$200,200.00**; the average weekly wage was **$3,850.00**.

On the date of accident, Petitioner was **41** years of age, ***married*** with **1** dependent children.

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

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

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

ORDER

The Arbitrator awards the additional Orthovist injections as prescribed by Dr. Jeffrey Meisles on March 27, 2017.

Respondent shall pay reasonable and necessary medical services of $406.49 to Dr. Jeffrey Meisles, as provided in Sections 8(a) and 8.2 of the Act.

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

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

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

KSSteffen

Signature of Arbitrator

March 5, 2018

Date

ICArbDec19(b)

MAR 9 – 2018

FACTUAL HISTORY

Petitioner testified that she went to work for Respondent in April 2000 selling dental x-ray equipment. On April 27, 2014, her job involving managing the sale of dental x-ray equipment to government entities. Her job responsibilities required approximately ten sales trips per year which included international destinations.

Petitioner denied having an accident, injury or condition of ill-being in her left knee prior to April 27, 2014. She had never received or had been advised to seek medical care related to her left knee.

The Accident

Petitioner testified that on April 27, 2014, while on a business trip to Tokyo, Japan, while struggling to retrieve her awkwardly placed luggage from the trunk of a car, she stumbled off a curb and twisted her left knee when she placed it on the pavement. She heard a snap in her left knee which was followed with immediate pain. Petitioner completed her six-day trip while experiencing increasing pain and swelling in her left knee. While in Japan, she made an appointment via internet to see a chiropractor upon her return home.

Medical Care

Petitioner saw Dr. David Chelini at Central DuPage Physical Medicine (DuKane Chiropractic) on May 13, 2014. (PX1) Petitioner reported a sudden onset of left knee pain two weeks earlier. Petitioner complained of moderate to severe pain on flexion of the knee. The Appley test and the McMurray tests for meniscal pathology were positive on the medial side of the left knee. Dr. Chelini ordered an MRI study of the left knee.

The MRI performed on May 23, 2014 demonstrated no evidence of fracture or dislocation. The radiologist also noted that "the patellofemoral articulation appears unremarkable with no evidence of degenerative change." There was a tear of the posterior horn of the medial meniscus. The lateral meniscus appeared unremarkable. There was no other evidence of osseous or joint pathology seen. (PX2).

Petitioner saw Dr. Chelini a total of 19 times for therapy, electric stimulation, ultrasound and taping of the left knee. At the last visit of July 21, 2014 Petitioner reported that her knee was giving out.

On July 3, 2014 Petitioner sought care from Dr. Jeffrey Meisles, an orthopedic surgeon, to whom she gave a history of twisting her left knee while stepping off a curb in Tokyo in April. Petitioner complained of severe pain in the medial aspect of the left knee. Petitioner reported no improvement with physical therapy and bracing provided by Dr. Chelini. On examination of the left knee, Dr. Meisles found effusion, medial joint line tenderness and a positive McMurray's test at the medial joint line. Dr. Meisles reviewed x-rays of Petitioner's left knee which he found to be unremarkable. Dr. Meisles reviewed the MRI films of May 23, 2014 which revealed a small medial meniscal tear. Dr. Meisles opined that the tear of the posterior horn of the medial meniscus occurred when Petitioner stepped off a curb while on a business trip. (PX3). Dr. Meisles recommended arthroscopy of the left knee.

Dr. Meisles took Petitioner to surgery at Elmhurst Hospital on July 29, 2014. The arthroscopic examination revealed a 1 cm area of grade III cartilage loss on the distal aspect of the medial femoral condyle. Dr. Meisles delaminated the edges of the lesion. There was no exposed bone. Dr. Meisles repaired a partial thickness tear of the medial meniscus. Examination of the lateral side of the knee indicated no abnormalities of the meniscus and the femoral articular surfaces.

On August 24, 2014, Dr. Meisles ordered a course of physical therapy. Petitioner attended 38 sessions of physical therapy at Midwest Physical Therapy between August 25, 2014 and February 4, 2015. (PX6)

On November 13, 2014 Petitioner reported initial improvement in her left knee symptoms but increasing pain anteromedially in the left knee with certain motions. Dr. Meisles on examination found no effusion or instability and noted that the surgery of July 29, 2014 had revealed a significant chondral fracture which he now suspected to be the cause of her current symptoms. Dr. Meisles ordered a repeat MRI to assess the meniscal repair as well as the lesion in the medial femoral condyle.

On December 17, 2014 Petitioner underwent a repeat study at High Definition MRI of the left knee which the radiologist, Dr. Papa, interpreted as showing no recurrent tear of the medial meniscus, mild-to-moderate arthritic changes in the medial femoral condyle and subtle patchy edema-like marrow signals of the type normally seen with mild stress related changes.

On December 17, 2014, Dr. Meisles reviewed the MRI scan as well as his intraoperative photos from the surgery of July 29, 2014. On examination, Petitioner was exquisitely tender to

palpation over the distal aspect of the medial femoral condyle. There was no tenderness to palpation on the lateral side of the knee. Dr. Meisles ordered x-rays which showed slight narrowing of the medial joint space. Dr. Meisles opined that the residual symptoms were coming from the articular cartilage of the distal medial femoral condyle. Dr. Meisles prescribed an arthrotomy with a fresh osteochondral allograft transplantation (OATS) procedure.

On January 5, 2015 Dr. Meisles responded to a request from Respondent's carrier for clarification for further treatment. Dr. Meisles explained that Petitioner also sustained a significant injury to the articular surface of the medial femoral condyle when she tore her left medial meniscus in the work-related injury. Dr. Meisles explained that he had hoped that the meniscal repair alone would have solved Petitioner's clinical problem. However, in Petitioner's case she continued to experience significant symptoms attributable to the lesion in the articular cartilage of the medial condyle. He recommended the OATS procedures and cautioned that absent such procedure, Petitioner's condition would likely progress to the point where Petitioner would need a partial knee replacement.

Dr. Meisles performed a second surgery on February 6, 2015 consisting of a fresh osteochondral allograft transplantation (OATS procedure) to the distal weight bearing surface of the left medial femoral condyle. Dr. Meisles examined the lateral joint compartment and noted no abnormalities.

Dr. Meisles examined Petitioner on March 5, 2015 and ordered physical therapy. Petitioner attended physical therapy between March 17, 2015 and August 27, 2015 (PX6). Dr. Meisles examined Petitioner periodically during her course of physical therapy. Petitioner reported to Dr. Meisles on May 21, 2015 and June 18, 2015 that she had no left knee pain at rest but increasing pain on weight bearing. On July 16, 2015 Dr. Meisles took comparative weight bearing x-rays of the knees and noted complete the incorporation of the osteochondral allograft but with very slight narrowing of the left medial joint space. Dr. Meisles advised Petitioner to continue wearing a medial off loader brace.

On October 15, 2016, Petitioner reported increasing left knee pain with activity. Dr. Meisles renewed her prescriptions for Mobic and Tramadol and ordered a series of four Orthovisc injections. Dr. Meisles administered the four Orthovisc injections between February 15, 2016 and March 21, 2016. Petitioner returned on April 27, 2016 complaining of pain in the left knee and limping when walking long distances. Dr. Meisles again took lateral and skyline

views of the knees and noted a moderate degenerative change with slight to moderate narrowing of the left medial joint space with early osteophyte formation. Dr. Meisles opined in his chart that Petitioner had early arthritis in her knee that is probably secondary to her trauma. He advised her to return in six months for another round of Orthovisc injections.

Dr. Meisles administered a second series of four Orthovisc injections between October 13, 2016 and November 17, 2016 and advised Petitioner to return as needed. Petitioner returned on March 27, 2017 complaining of increased left knee pain with no new trauma. Dr. Meisles injected cortisone and recommended another series of Orthovisc injections to start in May 2017.

Petitioner saw Dr. Meisles for the last time on August 2, 2017. Petitioner complained of pain in the medial aspect of the left knee affecting her ability to walk. Petitioner advised that further medical benefits were denied by the workers' compensation insurance carrier. Examination was positive for pain on palpation of the left medial joint and pain on varus stressing of the left knee. Standing x-rays showed moderate osteoarthritis of the medial compartment of the left knee which Dr. Meisles stated was posttraumatic in origin stemming from the articular cartilage injury that she sustained in the original accident. Dr. Meisles injected cortisone into the left knee pending insurance approval for further treatment.

Additional Information

Petitioner testified that she left the employment of Respondent in July 2015 to work for, A-Dec selling dental equipment. Petitioner works out of her home except for 10 domestic trips per year.

Petitioner testified that she has constant pain in her left knee which causes her to limp when she walks. She no longer runs. She limits the distance that she walks and the weight that she carries due to left knee pain. She uses a wheelchair to get around in airports. She has greatly curtained her pain medication due to its side effects.

On cross-examination, Petitioner testified that she has no hobbies. She spends her spare time with her daughter at Girl Scouts, play dates or the movies. She does not go out very often. Her husband does the grocery shopping.

Petitioner testified that she wishes to have the Orthovist injections prescribed by Dr. Meisles on March 27, 2017. Petitioner explained on cross-examination that Dr. Meisles told her that she needs a knee replacement which he will not perform until she is 50 years old. The Orthovist injections are administered to relieve her symptoms until that time.

Petitioner submitted into evidence the bill of Dr. Meisles in the fee-scheduled amount of $406.49 for services rendered on August 2, 2017.

Aggie Hellyer

Ms. Hellyer testified that she has been Respondent's Human Resources Manager for 11 years. She testified that Petitioner was the manager of sales to schools, government entities and dealers. She recalls Petitioner sustaining the work injury to her left knee and seeking medical treatment thereafter. Petitioner did not miss any time from work following the accident. There was no change in the quality of her work and she continued to make the required business trips. She recalls seeing Petitioner in a knee brace or on crutches following her surgeries. Petitioner left Respondent in July 2015 to pursue "a better opportunity".

Medical Testimony

Deposition of Dr. Jeffrey Meisles (Pet. Ex. No. 7)

Dr. Meisles testified that he is a board certified orthopedic surgeon. More than one half of his practice is devoted to the treatment of knee conditions. (p. 5-6)

Dr. Meisles first examined Petitioner on July 3, 2014 at which time she was complaining of left knee pain since twisting her left knee while stepping off a curb. Dr. Meisles found tenderness along the medial joint line and an effusion. The x-rays of the left knee were unremarkable. (p. 7) A positive McMurray test suggested a medial meniscus tear. (p. 8) Dr. Meisles reviewed the MRI films which indicated an effusion and tear of the left medial meniscus. Dr. Meisles recommended an arthroscopic examination of the left knee. (p. 8) Dr. Meisles took Petitioner to surgery on July 29, 2014. Dr. Meisles found a torn left medial meniscus and a fracture of the articular cartilage or chondral fracture of the medial femoral condyle. Surgery consisted of a repair of the medial meniscus and a chondroplasty of the medial femoral condyle. (p. 8) Dr. Meisles described the chondral fracture of the medial femoral condyle as a Grade III cartilage loss on the distal aspect of the medial femoral condyle with delamination of the cartilage at the edges of the lesion. (p. 9) Dr. Meisles opined that the chondral fracture was an acute lesion which was consistent with the history of accident and radiographic findings. (p. 9) He testified that the rest of the left knee examination was completely normal and that there were no degenerative changes anywhere in the knee. The chondral defect was to a localized area of the medial femoral condyle that was consistent with

the trauma. The defect did not have a degenerative appearance. (p. 9) Dr. Meisles explained that the defect correlated with Petitioner's history of a twisting injury which caused the torn left medial meniscus and the injury to the cartilage of the medial femoral condyle. (p. 10) The lateral side of the left knee had no abnormalities. (p. 10)

Dr. Meisles testified that he started Petitioner on physical therapy on August 20, 2014. (p. 10) Petitioner made steady progress in physical therapy but on November 13, 2014 she reported that the medial joint line pain had resolved but that she was still getting pain anteromedially with certain motions. (p. 11-12) Examination revealed tenderness over the medial femoral condyle. Dr. Meisles' assessment was that Petitioner's residual symptoms were due to the area of the medial femoral condyle fracture. (p. 12) Dr. Meisles ordered a repeat MRI. (p. 13)

Petitioner underwent a high definition MRI on December 17, 2014 using a machine with 1.5 Tesla magnet strength. Dr. Meisles saw Petitioner on December 17, 2014. His interpretation of the MRI films did not differ from that of the radiologist. Dr. Meisles also reviewed his intraoperative photos of July 29, 2014 which showed a Grade III defect to the articular cartilage of the medial femoral condyle. (p. 14) Dr. Meisles testified that the tear to the medial meniscus was in the same compartment of the joint and that it is not unusual to have concurrent injuries to the meniscus and articular cartilage of the femoral condyle because the force causing the injury to one area is applying the same force across the other area. (p. 15) Dr. Meisles took x-rays of the left knee on December 17, 2014 which showed narrowing of the medial joint space and no abnormalities on the lateral joint space. Dr. Meisles prescribed a second surgery.

Petitioner underwent a second surgery on February 6, 2015. Dr. Meisles removed the damaged cartilage and bone from the medial condyle and transplanted an allograft of bone and cartilage of living tissue to the damaged area. (p. 16-17) Petitioner began physical therapy on March 5, 2015 and reported improvement in her symptoms on June 18, 2015 but still painful enough with weight bearing to require a wheelchair when in the airport. (p. 19-20)

Dr. Meisles testified that he prescribed a series of four Orthovisc injections into the left knee on October 15, 2015 when Petitioner continued to report pain to the medial aspect of the left knee. Dr. Meisles administered four Orthovisc injections between February 15, 2016 and March 21, 2016. On April 27, 2016 Petitioner again complained to Dr. Meisles of pain and limping when walking long distances. Dr. Meisles took x-rays which showed a moderate degenerative change of the medial joint space with a very early osteophyte formation. (p. 24)

The standing or weight-bearing x-rays did not show any abnormalities in the lateral compartment of the left knee or in the right knee. (p. 25) Dr. Meisles testified that his assessment on that date was that Petitioner was getting arthritis in her knee due to the trauma and that she would eventually need a unicondylar knee arthroplasty. (p. 25)

Dr. Meisles opined that if Petitioner had not sustained the trauma to her left knee, she would not have early arthritis in her left knee. (p. 26) Dr. Meisles based his opinion on the absence of arthritis in any other compartment of the left knee or in the right knee. The only area where Petitioner had arthritis was to the localized area where she had a significant traumatic injury to the knee. She had no other abnormalities in either knee. (p. 26)

Dr. Meisles testified that he administered a second series of four Orthovisc injections between October 13, 2016 and November 17, 2016. On March 27, 2017 (erroneously listed as 2016) Dr. Meisles administered a cortisone injection for symptomatic relief because it was too early for another series of Orthovisc injections. (p. 27) He saw Petitioner for the last time on August 2, 2017. Weight bearing x-rays demonstrated moderate osteoarthritis in the medial compartment of the left knee. There were no other abnormalities in either knee. (p. 29) Dr. Meisles recommended another series of Orthovisc injections. He opined that more than likely Petitioner will need an unimpartmental replacement of the left knee. (p. 30)

Dr. Meisles opined that Petitioner's subjective complaints of pain correlated perfectly with the objective findings that he made on physical examination, on radiographic studies and in surgery. There was never any evidence of symptom magnification. (p. 32)

Dr. Meisles opined that there was a causal connection between the accident and the torn left medial meniscus and the chondral fracture of the medial condyle because the mechanism of injury was a classical mechanism for those types of injury and because the history, physical examinations, radiographic findings and the surgical findings all supported the history of a twisting injury. (p. 32)

Dr. Meisles opined that, more likely than not, Petitioner did not have any degenerative changes prior to the accident because she had no history of symptoms prior to the injury and there were no degenerative changes in either knee other than where she injured herself. (p. 33-34) Hypothetically, if there were a pre-existing arthritic condition, the accident exacerbated her symptoms and accelerated her need for further treatment. Such opinion is based on the clinical course of events. Petitioner was asymptomatic prior to the accident and subsequent to the injury

she has experienced symptoms which correlate with the localized findings which have progressed and have required ongoing care. (p. 34)

Cross Examination

Dr. Meisles testified that he had not seen the two section 12 examination reports of Dr. Lieber. (p. 34) Counsel for Respondent provided Dr. Meisles with copies of Dr. Lieber's May 18, 2017 and August 17, 2017 reports plus the AMA Impairment Rating dated August 30, 2017. (p. 34) Counsel for Respondent asked Dr. Meisles on what objective basis did he disagree with Dr. Lieber's opinion that Petitioner sustained only a torn medial meniscus because of the April 27, 2014 event. Dr. Meisles testified in response that he found on arthroscopic examination of the left knee a traumatic-appearing chondral fracture of the medial femoral condyle. (p. 35) Dr. Meisles further opined that Dr. Lieber had no basis to claim this was a pre-existing degenerative condition. Dr. Meisles opined that Dr. Lieber's opinion did not "jive with medial science" because the axial loading and twisting that can cause a meniscal tear is also known to frequently cause damage to the articular cartilage on that side of the joint. (p. 35) The medial meniscus and the articular cartilage of the medial femoral condyle are contiguous. (p. 36)

Dr. Meisles also disagreed with Dr. Lieber's opinion that Petitioner had a pre-existing degenerative condition in the left knee based on the medical records and the absence of any left knee symptoms prior to the accident. (p. 36) Also, there were no degenerative changes in the lateral aspect of the left knee or in the right knee. Petitioner developed degenerative changes only in the area of the trauma. (p. 36-37) Dr. Meisles added that there is no evidence of a pre-existing degenerative condition and that the injury to the articular cartilage occurred at the same time as the torn medial meniscus. Although the meniscal tear healed, the injury to the medial femoral condyle has not only continued but has progressed. (p. 38) The second surgery, the OATS grafting procedure, was for the traumatic chondral fracture and not due to a pre-existing condition. (p. 38) Dr. Meisles added that Petitioner will never be as good as she was prior to injury but that further treatment can help her to be better than she is now. (p. 38)

Dr. Meisles testified that it is not reasonable to assume that Petitioner had already developed arthritic changes by this point in her life because she did not have arthritic changes in her right knee. (p. 41) Dr. Meisles testified that he expected Petitioner to respond favorably to Orthovisc injections until her degenerative changes progressed to the point where she would need reconstructive surgery.

Counsel for Respondent asked Dr. Meisles to state his objective basis for disagreeing with Dr. Lieber's opinion in the report dated August 17, 2017 that Petitioner's current condition is related solely to pre-existing degenerative abnormalities. (p. 43). Dr. Meisles answered that 1) there is no evidence in the record to indicate that the changes in the left medial femoral condyle pre-existed the accident, 2) the mechanism of injury is consistent with an injury to the articular cartilage and the damage to the articular cartilage appeared acute when he examined the knee during surgery, 3) articular cartilage does not repair or regenerate so once this type of injury occurs the progression of pathology is inevitable and the clinical course is immutable and unchangeable. (p. 44) Dr. Meisles opined that the chondral injury caused a process which led to traumatic arthritis of the knee which is progressive and will require ongoing treatment because this is a process that once started does not stop. (p. 46) Dr. Meisles opined that Dr. Lieber's opinions are unsubstantiated by medical evidence.

Deposition of Dr. Lawrence Lieber (Resp. Ex. No. 2)

Dr. Lawrence Lieber testified that he is a board certified orthopedic surgeon. His specialty is sports medicine and arthritis surgery. (p. 6)

Dr. Lieber testified that he examined Petitioner at the request of Respondent on May 18, 2017. (p. 9) Dr. Lieber recorded a history of Petitioner tripping over a curb on April 27, 2014 sustaining an injury to her left knee. Petitioner complained to him of left knee pain upon ambulation and sitting. She complained of pain going up and down stairs and weakness in her left knee with giving way. (p. 10) Examination showed a full range of motion with pain at the extremes of motion and tenderness to palpation at the medial and lateral joint lines. Petitioner had positive McMurray's and Steinmann's tests. All else was normal. (p. 10-11) Dr. Lieber reviewed a first report of injury, the MRI report of May 23, 2014, records of Dr. Meisles, the surgical reports of July 29, 2014 and February 2015 and a High Definition MRI report dated September 17, 2015. (p. 12) Dr. Lieber opined that Petitioner had pre-existing degenerative joint disease in her left knee unrelated to the accident. (p. 12) He based his opinion on the history, his evaluation, the medical records and his medical knowledge. (p. 13) For the same reasons he opined that Petitioner was at maximum medical improvement for the torn medial meniscus injury sustained on April 27, 2014. (p. 14)

Dr. Lieber testified that he re-examined Petitioner on August 17, 2017 at which time he reviewed updated medical records. Petitioner complained of left knee pain, swelling and stiffness. (p. 17) There was atrophy of the left quadriceps muscles. The McMurray and Steinmann tests were again positive. (p. 17) Dr. Lieber opined that Petitioner had degenerative joint disease of the left knee. (p. 18) Dr. Lieber opined that the left knee degenerative disease was not related to the accident based on his examination, the record review and his medical knowledge. (p. 19) Dr. Lieber opined that Petitioner was at maximum medical improvement and did not require any additional treatment related to the accident, such opinion again based on his examination, review of medical records and medical knowledge. (p. 20)

Dr. Lieber opined that Petitioner reached maximum medical improvement in December 2014 based on the MRI of December 17, 2014 showing no recurrent medial meniscus tears and the surgical report of February 6, 2015 (p. 22) Dr. Lieber testified that Petitioner's "major problem" was significant preexisting arthritis which was unrelated to the accident. Dr. Lieber opined that only the left medial meniscus tear was related to the accident based on his exams, record review and medical knowledge. (p. 23)

Over objection, Dr. Lieber testified that he performed an AMA impairment rating and that he is not certified but feels qualified to perform them. (p. 25) Dr. Lieber opined that Petitioner had a 3% impairment of the left leg. (p. 27) and a 1% impairment to the whole person. (p. 28)

Cross-Examination

Dr. Lieber testified that Petitioner had a painful range of left knee motion at the extremes of flexion and extension at the first examination. He did not know what part of the knee was painful. (p. 28) Petitioner had a positive McMurray test which would indicate medial or lateral joint line pathology. He did not know whether it was the medial or lateral meniscus that was positive. (p. 28) The Steinmann's test, also for joint pathology, was positive and he again did not know if the pain was in the medial or the lateral aspect of the joint. (p. 30) He has never really differentiated as it is difficult for the patient to so determine. (p. 30)

Dr. Lieber testified that he reviewed only the report and not the films of the first MRI of May 23, 2014. (p. 31) He reviewed the surgical report of July 29, 2014 where Dr. Meisles found a medial meniscus tear. Dr. Lieber testified that Dr. Meisles found a chondral fracture of the medial femoral condyle. (p. 31) Dr. Lieber testified that he does not know what a chondral

fracture is. (p. 32) He agreed that Dr. Meisles found Grade III cartilage changes on the medial condyle during the first surgery. (p. 32)

Dr. Lieber found two centimeters of atrophy in the left quadriceps muscles when he re-examined Petitioner on August 17, 2017. (p. 33) The McMurray and Steinmann tests were again positive. (p. 34) Dr. Lieber testified that he reviewed only the report and not the actual films of the second MRI from High Definition MRI of December 2014. (p. 34) Dr. Lieber did not take any x-rays during either of his two examinations of Petitioner. He did not review any of the x-rays taken by Dr. Meisles. (p. 35) He did not review the intraoperative photos taken by Dr. Meisles. (p. 35)

Dr. Lieber testified that the basis of his opinion that Petitioner had degenerative arthritis in the medial compartment of the left knee prior to the accident is the fact that the MRI of May 23, 2014 (the first MRI) and the surgical report of July 29, 2014 showed that Petitioner had arthritis which would not occur within three months after the accident. (p. 35-36)

Dr. Lieber testified a trauma sufficient to cause a torn medial meniscus will cause inflammation to the knee and that such inflammation is sufficient to make a pre-existing arthritic condition if one is present, symptomatic. An arthroscopic surgery also produces inflammation which is sufficient to render symptomatic a preexisting arthritic condition. (p. 38)

Dr. Lieber did not believe Petitioner sustained a tear of the articular cartilage because there was no evidence of any chondral or bony injury seen on MRI. Although Petitioner's mechanism of injury could cause a chondral injury, the chondral injury would have to be associated with bony changes such as bony edema consistent with a traumatic event. (p. 40-41) Dr. Lieber testified that a qualified physician looking through an arthroscope would be able to see a tear of the articular cartilage but not bony edema. (p. 42)

FINDINGS OF FACT AND CONCLUSIONS OF LAW

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

For the reasons stated below, the Arbitrator finds that a causal connection exists between the accident and the current condition of ill-being in the left knee of Petitioner.

Petitioner presented the testimony of Dr. Jeffrey Meisles, her surgeon, in support of her claim of causal connection. Respondent presented the testimony of Dr. Lawrence Lieber who conducted two section 12 examinations of Petitioner. Drs. Meisles and Lieber agree that the tear

of the left medial meniscus is causally related to the accident. Drs. Meisles and Lieber offered conflicting expert opinions as to whether the left knee arthritis of Petitioner was causally related to the accident. The Arbitrator finds the testimony of Dr. Meisles to be more persuasive and finds that Petitioner current condition is related to her work accident.

The thrust of Respondent's case is that Petitioner had a pre-existing arthritic condition that is the cause of her current left knee issues. Respondent proposes that this condition is not caused or aggravated by the April 27, 2014 work accident, but rather is the result of a chronic, degenerative and inevitable process. In support, the Respondent relies on the testimony of Dr. Lawrence Lieber and evidence that Petitioner continued to work full duty in an unrestricted capacity since the date of accident to show that Petitioner's current condition is unrelated to her work accident.

The Arbitrator disagrees that Petitioner's return to full duty, unrestricted work is evidence of her full recovery and lack of need for additional medical care. The Arbitrator notes that Petitioner often works from home doing sales calls and choose not to miss any work time for her injury. She was accommodated and had an enviable flexibility regarding her work duties and she rearranged her schedule to benefit herself and her employer while undergoing uncontested medical treatment. Petitioner is a high wage earning, working mother and it is not reasonable and foreseeable that she wanted to continue to work her job. The wisdom and necessity of this when one is in a good but demanding job in a competitive marketplace is obvious and evident. Although our law protects workers from retaliation when they undergo medical treatment, it is prudent to try to continue your work duties if possible. By stating this the Arbitrator, in no way, implies that the employer has or may act against the employee. Rather, the Respondent's conduct in accommodating the Petitioner is commendable. Therefore, the Arbitrator finds that this to be a happy coincidence that inured to the benefit of both sides and not to be evidence that Petitioner's request for additional medical is unreasonable because she did not take any time off work.

The need for additional medical treatment is also supported by medical testimony and objective findings. Initially the Arbitrator notes that the Petitioner's accidental injury to her left knee was traumatic in that it was not a simple sprain/strain but rather, a sustained a tear of the articular cartilage. Contrary to Dr. Lieber's opinion there little or no evidence of pre-existing severe arthritis. On the contrary, Petitioner was only 41 years of age and active in her home and work life. She traveled extensively (domestically and abroad) for work and there is zero evidence

that any slight pre-existing arthritis caused her limitations in her home or work life. Additionally, even if there was pre-existing arthritis, the work-injury caused it to become accelerated and aggravated as explained by Dr. Meisles.

Per Illinois law, it is the singular province of the Commission to resolve conflicts in medical evidence. Barry v. Industrial Commission, 99 Ill. 2d. 401, 406-406-07 (1984). 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 expert and the nature of the case and its facts. Madison Mining Company v. Industrial Commission, 309 Ill. 91 (1923). The proponent of expert testimony must lay a foundation sufficient to establish the reliability of the basis for the expert's opinion. Gross v. IWCC, 2011 Il. App. 100615WC. 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 (2003)

The Arbitrator finds that the opinions expressed by Dr. Meisles are supported by the medical evidence and are consistent with the chain of events in this matter. Dr. Meisles opined that Petitioner did not have any pre-existing condition of ill-being in her left knee. In support of such opinion, Dr. Meisles relied upon his viewing of the left knee x-rays of July 3, 2014, the MRI films of May 23, 2014 and the corroborating report of the radiologist who stated, "the patellofemoral articulation appears unremarkable with no evidence of degenerative change" and that there was no osseous pathology. (PX2) Dr. Meisles examined the left knee of Petitioner through an arthroscope during the first surgery of July 29, 2014, three months after the accident, and found no degenerative changes in the medial femoral condyle. (PX7 at p. 9) Dr. Meisles opined that the mechanism of the accident was the classic mechanisms for a tear to the medial meniscus and for the chondral fracture, a tear of the articular cartilage of the left medial femoral condyle, which he found in surgery on July 29, 2014. (PX7 at 32) Dr. Meisles added that the tear appeared acute and not degenerative when he viewed it during surgery on July 29, 2014. (PX7 at 44) Dr. Meisles testified that once articular cartilage is torn, it does not repair or regenerate. The progression of the cartilage tear to arthritis is inevitable and this clinical course is immutable and unchangeable. (PX7 at 44) Once this traumatic arthritis process has started, it does not stop. (PX7 at 46) Dr. Meisles testified that if had Petitioner not sustained a tear of the articular cartilage, she would not have developed early arthritis in her left knee. Dr. Meisles based his

opinion on the absence of findings in the MRI study of May 23, 2014 taken less than a month after the accident, the x-rays of July 3, 2014 and the subsequent serial x-rays of the left knee followed by the weightbearing x-rays of the knees showing a progressive and very localized arthritic condition in the left femoral condyle at the site of the trauma. The weightbearing x-rays reveal no degenerative findings in the left lateral femoral condyle or in either condyle of the right knee. Dr. Meisles did not find any arthritic changes during the surgery of July 29, 2014.

The Arbitrator finds that the opinions expressed by Dr. Lieber are not credible as they are unsupported and contrary to the medical evidence. Dr. Lieber based his opinion that Petitioner had pre-existing degenerative arthritis in the left knee on the MRI report of May 23, 2014 and the surgical report of July 29, 2014. (RX2 at 35-36) Dr. Lieber admitted that he did not view the films of the MRI of May 23, 2014. (RX2 at p. 31) The MRI report cited by Dr. Lieber as a basis for his opinion directly contradicts his testimony as the report of the radiologist, Dr. Aikenhead, expressly states that there was no evidence of patellofemoral arthritis and no osseous changes seen on the films. (PX2) Dr. Meisles also viewed the films and found no degenerative condition less than a month after the accident. Dr. Meisles viewed the left knee joint through the arthroscope and took intraoperative photos. He testified that there were no degenerative changes in the left knee on July 29, 2024, three months after the accident. (PX7 at p-10) Dr. Lieber's opinion that Petitioner had a pre-existing condition in her left knee is without foundation.

Dr. Lieber also testified that he has never viewed any diagnostic films of Petitioner's left knee. He did not review any of the x-rays taken by Dr. Meisles. He also did not review the intraoperative photos of July 29, 2014. Dr. Lieber chose not to take x-rays as part of his two section 12 examinations of Petitioner. The Arbitrator assigns little probative value to the balance of Dr. Lieber's testimony. Although he recorded complaints of pain in the left knee at each exam, Dr. Lieber did not record and could not recall at his deposition what part of Petitioner's knee was painful. (RX2 at p. 28) He found a positive McMurray test for meniscal pathology but he did not record and could not recall if the pathology was in the medial or the lateral meniscus. (RX2 at p. 28) Dr. Lieber reported that the Steinmann tests for joint pathology was also positive but again could not state if the pathology was in the medial or the lateral aspect of the joint. (RX2 at p. 30) When asked to describe the most common method of how one sustains a chondral fracture of the medial femoral condyle. Dr. Lieber stated "*I don't know, I'm not – I don't know how you make a diagnosis of a chondral fracture. I don't know what a chondral fracture is.*"

(RX2 at 32, lines 9-11). Based on this testimony, the Arbitrator affords lesser weight to Dr. Lieber's findings and opinion.

The Arbitrator finds that the bilateral weightbearing knee x-rays showing the localization of the degenerative changes to the left medial femoral condyle, the site of the injury, to be further proof and compelling evidence that Petitioner's degenerative changes are traumatic and not systemic in origin. Dr. Meisles could not identify any other possible cause for the localized arthritis.

The Arbitrator also finds that the chain of events supports the finding of causal connection. There is no indication of any treatment or condition of ill-being in the left knee prior to the accident. Petitioner sustained an accident on April 27, 2014 which triggered a course of medical care and disability which continued uninterrupted for three years.

Therefore, the Arbitrator finds that Petitioner's current condition is causally related to her work accident.

J. Has Respondent paid all appropriate charges for all reasonable and necessary medical services?

The Arbitrator finds that Petitioner is entitled to receive from the Respondent the sum of $409.49 in additional medical expenses (PX8).

Such award is based on the above finding on the issue of causal connection, the medical records and the testimony of Dr. Meisles.

K. Is Petitioner entitled to any prospective medical care?

The Arbitrator finds that the Petitioner is entitled to the series of Orthovist injections prescribed by Dr. Meisles on March 27, 2017.

Such award is based upon the above finding of causal connection and the testimony of Dr. Meisles that he expects Petitioner to respond favorably to Orthovist injections and based on the Petitioner's credible testimony that she continues to suffer pain and discomfort in the left knee.

There has been testimony and medical evidence presented that Petitioner may potentially need a total knee replacement surgery in five years. The Arbitrator specifically declines to make a finding, either way, in this regard. Both, per Dr. Lieber's testimony and Dr. Meisles opinion, Petitioner would not even be a candidate until age 50. In fact, the only treatment she has received

since October of 2015 are two series of orthovisc injections. These facts are probative to the Arbitrator's finding.

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

Judex Colon,
Petitioner,

vs.

NO: 17 WC 11294

Hudson Precision Products Co.,
Respondent.

19IWCC0207

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 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 16, 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.

APR 25 2019

DATED:
o041819
BNF/mw
045

Barbara Flores

Deborah Simpson

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION

NOTICE OF 19(b)/8(a) ARBITRATOR DECISION

COLON, JUDEX
Employee/Petitioner

Case# 17WC011294

HUDSON PRECISION PRODUCTS CO
Employer/Respondent

19IWCC0207

On 11/16/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

1067 ANKIN LAW OFFICE LLC
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0560 WIEDNER & McAULIFFE LTD
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STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

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

JUDEX COLON
Employee/Petitioner

v.

HUDSON PRECISION PRODUCTS, CO.
Employer/Respondent

Case # 17 WC 11294

Consolidated cases: n/a

19IWCC0207

An *Application for Adjustment 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 **AUGUST 29, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] 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 19IWCC0207

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

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

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

In the year preceding the injury, Petitioner earned **$47,483.28**; the average weekly wage was **$913.14**.

On the date of accident, Petitioner was **60** 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 **$0.00** 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:*

> The Petitioner failed to prove: 1) he sustained an accident that arose out of and in the course of his employment with the Respondent; and 2) his current condition of ill-being is causally related to his alleged accident.
>
> As such, the Petitioner's requests for payment of medical bills and prospective medical care under Section 19(b) and 8(a), as well as any other compensation request under the Act, 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

NOVEMBER 15, 2018
Date

ICArbDec19(b)

NOV 16 2018

JUDEX COLON v. HUDSON PRECISION PRODUCTS, CO.

17 WC 11294

FINDINGS OF FACT AND CONCLUSIONS OF LAW

INTRODUCTION

This matter was tried on the Petitioner's Section 19(b)/8(a) Petition before Arbitrator Steffenson on August 29, 2018. The issues in dispute were accident, causal connection, bills, and prospective medical care. (Arbitrator's Exhibit 1). The parties agreed to receipt of this Arbitration Decision via e-mail and requested a written decision, including findings of fact and conclusions of law, per Section 19(b) of the Act. (Arbitrator's Exhibit (hereinafter, AX) 1).

FINDINGS OF FACT

The Petitioner is a 63-year-old male who has been employed by the Respondent, Hudson Precision Products, approximately for twenty years. Petitioner testified that his current position is machine setup operator and his duties consist of setting up the screw machines, making sure that the machine is running, loading the machine and keeping the product coming out of the machine. (Transcript 13-14). Petitioner testified that on July 7, 2015, he was pulling a tub away from the machine when his work piece broke and he fell backwards and struck another machine. (Transcript (hereinafter, T.) 15). Petitioner testified that his hands were the first part of his body to touch the ground. Petitioner testified that he felt a lot of pain in both of his shoulders and that one of his coworkers helped him up. (T. 15-16). Petitioner testified that he continued working for the remainder of the day and the days after the incident. (T. 16-17). Petitioner testified that his foreman, Gustavo Vega, was on vacation so he could not report an incident to him right away. Petitioner testified that the owner of the company was around on the day of the incident in his office. (T. 17-18).

Petitioner testified that the first doctor he went to was Dr. Eva Dumasia at Cam Medical Group on July 22, 2016. (T. 19-20 and Petitioner's Exhibit 3). Petitioner testified that when he saw Dr. Dumasia on July 22, 2016, he told her he had pain in both of his shoulders. Petitioner testified that prior July 7, 2016, he saw Dr. Dumasia once or twice for symptoms in his shoulders and the most recent visit was May 13, 2015. (T. 19-21 and Petitioner's Exhibit (hereinafter, PX) 4). Petitioner testified that Dr. Dumasia referred him to Dr. Gabriel Levi. (T. 43)

Petitioner testified that he did not recall if he had an MRI of the left shoulder on July 15, 2016. (T. 22). He also stated the Respondent sent him for an evaluation at US Healthworks on August 18, 2016. (T. 22 and PX 4).

Petitioner testified that he was seen by Dr. Levi on August 12, 2016 and told him about an incident that occurred at work on July 7, 2016. (T. 21-22). Petitioner testified that was following followed up with Dr. Levi for pain in his shoulders. Petitioner testified that he received physical therapy and had an MRI of the left shoulder, but he could not recall the date. (T. 23). Petitioner testified that Dr. Levi gave him injections for shoulder pain which provided temporary relief. (T. 24). Petitioner testified that the pain in his right shoulder is uncomfortable. Petitioner testified that Dr. Levi recommended surgery for his right shoulder on February 24, 2017. (T. 25).

Petitioner testified that after the accident, the pain in his left shoulder was different; it was worse. (T. 25-26). Petitioner testified that the pain in his right shoulder was very bad after the accident and that he had to take pills. Petitioner testified that he did not take any pills for right shoulder pain before the accident. (T. 26-27). Petitioner testified that he currently takes over-the-counter Tylenol for pain. (T. 27). Petitioner testified that he has continued to work his same job and is able to do some other routine work. (T. 28). Petitioner testified that the company sent him for an independent medical evaluation with Dr. Kevin Chen on February 13, 2017. Petitioner also stated he had been to a doctor for his shoulders prior to the accident but never had any kind of treatment. (T. 29).

Petitioner then admitted he has worked for Hudson Precision for approximately twenty years and he is familiar with safety procedures and accident reporting procedures. Petitioner testified that he is aware that a workplace accident should be reported right away. (T. 30). Petitioner testified that his floor supervisor, Gustavo Vega was on vacation on July 7, 2016. (T. 30-31). Petitioner testified that other people were working with him on July 7, 2016 and that he was not in charge of the entire floor. Petitioner testified that supervisors from other departments were working on July 7, 2016, as well as the safety manager (David Lee), and the owners of the company. (T. 31).

Petitioner testified that after the incident on July 7, 2016, he felt a lot of pain in his shoulders but did not report anything to a supervisor or the safety manager. (T. 33). Petitioner testified that he did not report the incident to anyone or make a record of anything that allegedly occurred on July 7, 2016. (T. 33 and 35). Petitioner testified that when his supervisor, Mr. Vega, returned from vacation, he notified him of a work incident. Petitioner testified that no investigation took place on the day of the incident or anytime thereafter until he informed Mr. Vega that something occurred on July 7, 2016. (T. 35-36).

Petitioner testified that after he reported the incident to Mr. Vega, he (Mr. Vega) immediately prepared a report based on what he told him. (T. 36-37). Petitioner testified that he was not offered medical treatment at the company clinic. Petitioner testified that he was sent to the company clinic, but he could not remember what day. (T. 37).

Petitioner testified that he told Mr. Vega that a hook broke and he fell on the floor. Petitioner disputed that he made the hook himself and testified that "everybody makes the hooks for us and we use them to pull the tub." (T. 38). Petitioner testified that he gave the broken metal hook to his supervisor, but not on July 7, 2016. (T. 38-39).

Petitioner testified that he did not remember seeing Dr. Eva Dumasia on December 4, 2015 with a history of shooting pains in both knees and shoulders. (T. 29). When Petitioner was asked whether he recalled seeing Dr. Dumasia on January 27, 2016 with a main complaint of shoulder pain, he responded in the affirmative. When Petitioner was asked whether he recalled seeing Dr. Dumasia on May 13, 2016 with complaints of pain in both shoulders, he testified that he did not remember. Petitioner further testified that he did not remember being diagnosed with right and left shoulder pain and being given an orthopedic referral by Dr. Dumasia on May 13, 2016. (T. 39-40). Petitioner testified that he did not recall that Dr. Dumasia prescribed pain medication and ordered x-rays of both shoulders performed on June 10, 2016. (T. 40-41). Petitioner testified that he did not recall seeing Dr. Dumasia on June 18, 2016 for a follow up examination related to bilateral shoulder and hand pain. Petitioner could not remember whether Dr. Dumasia ordered an MRI of the left shoulder when he was seen on June 18, 2016. Petitioner testified that he did not recall whether Dr. Dumasia prescribed the pain medication Meloxicam or recommended an orthopedic referral for his shoulder complaints. (T. 41)

Petitioner testified that he did not recall having an MRI of the left shoulder on July 16, 2016. (T. 41-42). Petitioner did not remember following up with Dr. Dumasia on July 22, 2016, 15 days after his work injury, and denying any current symptoms in his shoulder. (T. 42). Petitioner testified that he did not remember if he provided Dr. Dumasia with a history of an accident that occurred at work on July 7, 2016. (T. 41-43).

Petitioner testified that Dr. Levi is an orthopedic physician and Dr. Dumasia referred him to Dr. Levi. Petitioner testified that he guesses he remembers that Dr. Dumasia made an orthopedic referral for him on both May 13, 2016 and June 18, 2016. (T. 43-44). Petitioner testified that he eventually saw Dr. Levi on August 12, 2016 and provided a history of pulling a metal tub, not lifting. Petitioner denied telling Dr. Levi that he did not have any previous pain in his shoulders or wrists. (T. 44).

Petitioner next recalled that Dr. Dumasia prescribed 800 milligrams of Ibuprofen but did not recall that the medication was switched to Meloxicam. (T. 49). Petitioner testified that

before the July 7, 2016 incident, he was having shoulder symptoms and still working. (T. 49). Petitioner testified that after July 7, 2016, he had shoulder symptoms and still worked. Petitioner testified that he did not miss any time from work and is working full duty as a machine operator. (T. 49-50).

Gustavo Vega-Martinez testified that he has been employed by Hudson Precision for eighteen years. Mr. Vega-Martinez testified that Hudson Precision makes machine components from raw material and everything that's made requires machining, cleaning and inspection. (T. 57-59). Mr. Vega-Martinez testified that his job title is department supervisor for four employees. His main duties include ensuring that the four employees he supervises have everything they need to perform their job; mainly tooling. Mr. Vega-Martinez testified that if there are any issues, he is the person that troubleshoots everything.

Mr. Vega-Martinez testified that he has known Petitioner for the duration of his employment for Respondent, or eighteen years. His relationship to the Petitioner is that of a direct supervisor for the last 7 years. He testified that Petitioner reports to him and when he's not there, he is the second in command so if any issues arise, Petitioner would report them to the operations manager. (T. 59-60). Mr. Vega-Martinez testified that Petitioner's position with Hudson Precision is a setter operator. Mr. Vega-Martinez testified that he is familiar with the job duties of a setter operator because he worked in this position before he became a supervisor. (T. 60)

Mr. Vega-Martinez testified that he was not working on July 7, 2016. He was in Florida due to a family matter. Mr. Vega-Martinez testified that he was absent from July 7, 2016 until August 7, 2016 and returned to work August 8, 2016. (T. 61). Mr. Vega-Martinez testified that all employees are always encouraged to make a report of a work injury. Mr. Vega-Martinez testified that he is not the only person that would receive notice of a work injury. Mr. Vega-Martinez testified that in his absence, his four supervisees had other options to report an injury; specifically, Jack Wittry, the building maintenance employee who is trained in CPR and first-aid. (T. 61-62, and 79). Mr. Vega-Martinez testified that if Jack Wittry was unavailable, the next point people would be the Operations Manager, Jeff Baker or the Safety Manager, David Lee. (T. 62 and 79). Mr. Vega-Martinez testified that as far as he knows, Petitioner did not go to any of these individuals and his first notice was on August 8, 2016. (T. 79-80)

Mr. Vega-Martinez testified that when he returned from vacation on August 8, 2016, he did not receive any reports from Jack Wittry, Jeff Baker or David Lee, that one of his employees had been involved in a work injury. (T. 62-63). Mr. Vega-Martinez testified that when he returned to work on August 8, 2016, he was not given any medical notes or slips from any doctors about an incident involving Mr. Colon. Mr. Vega-Martinez testified that he is not aware

of any investigation of a work incident involving Petitioner between July 7, 2016 and when he came to him on August 8, 2016. (T. 67).

Mr. Vega-Martinez testified that when he returned to the office on August 8, 2016, the Petitioner approached him earlier in the morning while he was at this desk and mentioned that he tripped and fell while he was away. (T. 64-65). Mr. Vega-Martinez testified that he filled out a Supervisor's Incident Report after the incident was reported to him. Mr. Vega-Martinez testified that Petitioner was standing right next to him when he prepared the report and he recorded the description of the incident in the report exactly as it was relayed to him by the petitioner: *"Hook used to pull chip carts broke, and operator (Judex) fell back and landed on a scrap pan."* (T. 65-66 and Respondent's Exhibit 1). Mr. Vega-Martinez testified that Petitioner did not provide him any more detail about the incident such as falling on both hands or outstretched hands. (T. 66) Mr. Vega-Martinez testified that after he prepared the report on August 8, 2016, he offered Petitioner medical treatment and his response was that he was not in any pain and did not need to see a doctor at that point. (T. 66-67).

Mr. Vega-Martinez testified that when saw Petitioner on August 8, 2016, he did not give him a broken metal hook. Mr. Vega-Martinez testified that he conducted his own investigation after Petitioner reported the incident by going around and looking at all the hooks and never saw a broken metal hook. (T. 67-68). Mr. Vega-Martinez testified that Petitioner never asked him about the manufacturer of the hooks and that the hooks are self-made by each operator; they are made in-house by whoever needs them. Mr. Vega-Martinez testified that the reason for this has to do with operators being different heights and having different preferences for their hooks. He explained that some prefer a thicker hook versus others who prefer a thinner hook, so it's left to each individual operator to make a hook that feels best for them in terms of grip and length comfort. (T. 68-69).

Mr. Vega-Martinez testified that when he offered Petitioner medical treatment, his response was that he was not in pain and did not feel that he needed to see a doctor. Mr. Vega-Martinez testified that Petitioner did not ask him for any medical treatment. (T. 78-79). Mr. Vega-Martinez testified that according to his records, Petitioner has worked every day since July 7, 2016, doing his regular job as a set up operator. Mr. Vega-Martinez testified that he remains Petitioner's direct supervisor. (T. 70).

Mr. Vega-Martinez then identified a chip tub as depicted in RX 3. He explained that a chip tub collects scrap from the machines and once the tub gets to a certain level, it's pulled out and replaced with an empty tub. (T. 71). Mr. Vega-Martinez testified that a scrap pan is different than a chip tub in that it is about 12 x 12 and is in front of the machine, whereas the chip tub is under a machine. (T. 71-72). Mr. Vega-Martinez identified the Supervisor's Injury Report that he prepared and signed on August 8, 2016. Mr. Vega-Martinez agreed that in the

report, he described how the injury occurred exactly as it was relayed to him by Petitioner which was that the hook used to pull chip cart broke and he fell back and landed on a scrap pan. (T. 72-73).

David Lee testified that he has been employed by Hudson Precision Products for 24 years. His current job titles are Production Control Manager and Safety Director for everyone who works at Hudson Precision. (T. 86). Mr. Lee testified that as the Safety Director, he is responsible for implementing the company's safety program and following the guidelines of their "Workmen's Compensation Trust Program". (T. 82-83). Mr. Lee testified that his duties as a Production Control Manager include taking customer orders, working with department supervisors and scheduling orders on different machines. He also works with customers regarding deliveries of their parts. (T. 83-84).

Mr. Lee testified that as the Safety Manager, he is familiar with the reporting of workers' compensation claims. Mr. Lee testified that when a workplace incident occurs, the first point of contact is the supervisor. (T. 85). Mr. Lee testified that if a machine operator's supervisor is on vacation, there are alternative individuals to report a workplace incident such as Jack Wittry, the facilities manager who is trained in first aid and has helped people in the past who have been injured. Mr. Lee testified that Jack Wittry is considered a first responder when there's a work injury. Mr. Lee testified that there are other options for an employee to provide notice in the absence of their supervisor to include the operations manager or the owners of the company who are present and accessible. (T. 89-91). Mr. Lee testified that employees are made aware of reporting procedures for work injuries through safety meetings and safety sessions that are scattered throughout the year. During the meetings, employees are reminded that they are to report any hazards or any incidents immediately. (T. 85).

Mr. Lee testified that he has known the Petitioner for as long as he has been employed by respondent. His relationship to Petitioner is that of Safety Manager. (T. 85-87). Mr. Lee testified that Petitioner's department supervisor is Gus Vega-Martinez. (T. 87). Mr. Lee testified that his recollection is that he was working on July 7, 2016. Mr. Lee testified that Mr. Colon did not report a workplace injury to him on July 7, 2016. (T. 88). Mr. Lee testified that on July 7, 2016, he did not receive any reports from any supervisors or the operations manager, of a workplace incident involving Petitioner. Mr. Lee testified that he did not receive any reports about a workplace incident involving Mr. Colon before August 8, 2016. (T. 88-89). Mr. Lee testified that if he had received a report of a workplace incident involving Mr. Colon on July 7, 2016, he would have taken steps to speak to him to see how he was doing and if he required any medical attention. If medical attention was needed, there is a company clinic located approximately four blocks away and he would have sent him there for immediate care. (T. 89).

Mr. Lee testified that he never received a request to send Petitioner for medical treatment between July 7, 2016 and August 8, 2016. (T. 89).

Mr. Lee testified that he first became aware of an incident involving Mr. Colon when Gus Vega-Martinez returned from vacation on or about August 8, 2016. Mr. Lee testified that he and Mr. Vega- Martinez talked with Petitioner to get more details and thereafter, a supervisor's incident report was prepared by Mr. Vega-Martinez. (T. 91) Mr. Lee testified that preparation of the supervisor's incident report is standard procedure once they received notice of the work incident. Mr. Lee testified that Petitioner was offered medical attention on August 8, 2016, and it was declined. (T. 91-92). Mr. Lee testified that he prepared a Workers Compensation Trust form report after he received a work note from a physician's office on or about August 12, 2016. (T. 92-95 and RX 5). Mr. Lee testified that the information he used to make the report was taken from the Supervisor's Injury report. (T. 95 and RX 1). Mr. Lee testified that a claim was entered into the system because the doctor's office wanted a claim number for billing purposes. (T. 96-97). Mr. Lee testified that he is not aware of any lost time by Petitioner since July 7, 2016 and that he continues to perform full-duty work as a setup operator. (T. 97).

Mr. Lee authenticated two photographs. (RX 2 and 3). Mr. Lee testified that he took the photographs on the morning of August 27, 2018 using a cellphone tablet. The photographs were taken in the department were Petitioner works. Mr. Lee testified that he had not tampered with the photographs in any way and that they were the exact photographs that he recalls taking on his phone and printing. (T. 98). Mr. Lee identified RX 2 as a hook and a scrap pan wagon used in Petitioner's department. Mr. Lee testified that it is preferable that operators use hooks to pull the wagons. (T. 99-100). Mr. Lee testified that at no time between July 7, 2016 to the present date, did he receive a broken metal hook like the one depicted in the photograph. (RX 2 and T. 100). Mr. Lee testified that he never received a report from Petitioner, or Petitioner's supervisor, that there had been a broken hook involved in an incident with Mr. Colon. (T. 100). Mr. Lee testified that to his knowledge, a broken hook was never identified on the floor. Mr. Lee testified that as a Safety Director, a broken hook would have been brought to his attention by an employee because employees are supposed to report hazards and a broken hook is a hazard. (T. 101).

CONCLUSIONS OF LAW

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

Issue C: *Accident*

It is well settled that it is the employee's burden to establish all elements of his claim by a preponderance of the credible evidence. *Illinois Bell Telephone Company v. Industrial Comm'n*, 265 Ill. App. 3d 681; 638 N.E.2d 307 (1st Dist. 1994). The claimant has the burden of proving that his injury arose out of and in the course. *County of Cook v. Industrial Comm'n*, 68 Ill. 2d 24; 368 N.E.2d 1292 (1977). A claimant must prove causal connection by evidence from which inferences can be fairly and reasonably drawn. *Caterpillar Tractor Co. v. Industrial Comm'n*, 83 Ill. 2d 213; 414 N.E.2d 740 (1980).

The Arbitrator finds Petitioner's testimony not credible as it relates to a workplace accident that allegedly occurred on July 7, 2016. The Arbitrator finds several notably inconsistencies throughout Petitioner's trial testimony regarding the way an alleged workplace incident occurred on July 7, 2016, in comparison to accident-related paperwork, the medical records and the more credible testimony of Gustavo Vega-Martinez and David Lee. Specifically, Petitioner testified that on July 7, 2015, he was pulling a tub away from a machine when his workpiece broke and he fell backwards and struck another machine. (T. 15). Petitioner later testified that he did not strike anything but fell right to the ground and landed on his hands. Conversely, when Petitioner notified his supervisor about an alleged work incident 33 days later, on August 8, 2016, he stated that the hook he was using to pull chip carts broke and he fell back and landed on a scrap pan. (RX 1). At trial, Petitioner denied stating that he fell on a scrap pan even though he admitted his supervisor prepared the report based on what he told him. (T. 37).

The Arbitrator further notes that Petitioner has worked for Respondent for nearly twenty years and admitted he is familiar with safety procedures and accident reporting procedures. Petitioner further testified that he knows a workplace accident should be reported right away. (T. 30). Despite these admissions, Petitioner did not provide any explanation for failing to report an alleged work accident on July 7, 2016 to any number of alternative employees when his supervisor was on vacation to include, Jack Wittry, the building maintenance worker who is trained in CPR and first aid, Jeff Baker, the Operations Manager, David Lee, the Safety Director, or one of the owners. The Arbitrator further notes that Petitioner did not produce any witnesses to corroborate his claim that he sustained a workplace accident on July 7, 2016. Moreover, Petitioner did not produce the alleged broken

metal hook and Gustavo Vega-Martinez credibly testified that he was never given a broken hook by petitioner and his investigation did not produce a broken metal hook after Petitioner notified him about an alleged accident 33 days later, on August 8, 2016.

The Arbitrator further finds petitioner's testimony not credible regarding not being offered medical treatment when he reported a work injury to his supervisor on August 8, 2016. (T. 37). Instead, the Arbitrator finds the testimony of Gustavo Vega-Martinez and David Lee more credible. Both individuals testified that Petitioner was offered to seek treatment at the company clinic but declined. Specifically, Mr. Vega-Martinez testified that medical treatment was offered, and Petitioner's response was that he was not in pain and did not feel that he needed to see a doctor. (T. 78-79 and 91-92)

The Arbitrator notes that although Petitioner testified that he felt a lot of pain in both shoulders after the alleged incident on July 7, 2016, he admittedly did not seek medical treatment that day. The Arbitrator further notes that the first medical visit after the alleged accident came on July 22, 2016 in the context of a follow up visit with Dr. Eva Dumasia. This visit was 16 days after the alleged accident and the doctor's detailed report does not contain any reference to a workplace injury or recent trauma. (PX 3). In fact, Dr. Dumasia's report specifically references that Petitioner was there for a follow-up visit to review lab results and go over an MRI of the left shoulder. The Arbitrator notes that at the July 22, 2016 visit, Dr. Dumasia made her third referral for an orthopedic evaluation related to Petitioner's continued bilateral shoulder complaints. It is noteworthy that Petitioner testified that he was seen by an orthopedic specialist, Dr. Gabriel Levi, whom he was referred to by Dr. Dumasia. (T. 43). This is consistent with Dr. Dumasia's prior orthopedic referrals on 5/13/16 and 6/18/16, as well as on 7/22/16, when Petitioner was seen for a follow up visit related to previous bilateral shoulder pain. (PX 3). The Arbitrator finds that if Petitioner was involved in a workplace injury on July 7, 2016, he had ample opportunity to tell his doctor when he saw her on July 22, 2016. Dr. Dumasia's records are devoid of any accident or trauma-related history and the Arbitrator finds that he was clearly there for a follow up visit for bilateral shoulder symptoms which pre-dated any alleged work episode on July 7, 2016.

The Arbitrator finds Petitioner's testimony not credible regarding the extent of his pre-injury treatment with Dr. Dumasia for bilateral shoulder pain. (PX 3). Petitioner was seen by Dr. Dumasia on three occasions in the months leading up to the alleged workplace injury on July 7, 2016 and on each occasion, he complained on shoulder pain. He was also seen sixteen (16) days after the alleged injury and no history of a work injury is contained in her records. On each visit, from 12/4/15 to 7/22/16, Dr. Dumasia conducted a physical exam and referenced positive findings referable to both shoulders. She recommended additional testing, physical therapy and prescribed prescription pain medication. The Arbitrator notes that at trial,

Petitioner downplayed any previous shoulder complaints and could not recall almost any of his prior bilateral shoulder treatment with Dr. Dumasia, even though her records show a clear pattern of prior bilateral shoulder complaints one and two months before July 7, 2016.

The Arbitrator further notes inconsistencies between Petitioner's testimony regarding an alleged injury on July 7, 2016, and the histories given to Dr. Gabriel Levi and Dr. Raman Singh. Specifically, the Arbitrator notes that when Petitioner was initially seen by Dr. Levi on August 12, 2016, he reported lifting a tub of material when the object slipped, and he fell onto both shoulders, wrists, and his back. Petitioner denied any prior pain in the shoulders or wrists but did acknowledge some back pain while working and lifting heavy objects. The Arbitrator further notes that when Petitioner was seen by Dr. Raman Singh at U.S. HealthWorks Medical Group on August 18, 2016, he reported lifting a 60-pound steel bar and loading it onto a machine when he slipped and fell backwards. The Arbitrator notes that Petitioner did not advise Dr. Levi or Dr. Singh about any previous bilateral shoulder complaints, previous treatment with Dr. Dumasia, diagnostic studies performed at the direction of Dr. Dumasia, or pain medication that had been prescribed by Dr. Dumasia. (Px 2 and 4).

The Arbitrator further finds petitioner's testimony is not credible as it relates to an alleged broken metal hook. Petitioner testified that he did not make the metal hook and that it was made for him. Petitioner further testified that a metal hook broke while he was pulling a tub and that he gave it to his supervisor, but not on the day of the alleged incident. The Arbitrator finds the testimony of Mr. Vega-Martinez more credible that each individual operator makes their own hooks to account for their different height and grip preference. The Arbitrator further finds the testimony of Mr. Vega-Martinez more credible that Petitioner did not give him a broken hook when he reported the alleged incident on August 8, 2016. Moreover, the Arbitrator finds the testimony of Mr. Vega-Martinez more credible regarding the outcome of the investigation he performed on August 8, 2016 which did not produce a broken hook.

Based on the numerous inconsistencies in Petitioner's testimony regarding an alleged work place accident as summarized above, combined with the lack of evidence presented to substantiate that an accident occurred, the Arbitrator finds that Petitioner did not meet his burden of proving that he sustained an accident that arose out of and in the course of his employment by Respondent on July 7, 2016.

Issue F: *Causal connection*

Incorporating the aforementioned findings that Petitioner did not sustain an accident that arose out of and in the course of his employment by Respondent, the Arbitrator finds no

causal connection between Petitioner's current right or left shoulder complaints and an alleged workplace accident on July 6, 2016. The Arbitrator finds that although Petitioner downplayed any prior shoulder complaints or treatments, the records of Dr. Eva Dumasia clearly reflect that Petitioner had active symptoms in both shoulders and was presenting for treatment in the months leading up to July 7, 2016. Petitioner's shoulder complaints to Dr. Dumasia started on December 4, 2015. (PX 3). On this date, Petitioner presented with right shoulder pain and physical examination was positive for right shoulder pain. Dr. Dumasia ordered a prescription muscle relaxant, Cyclobenzaprine 100 mg for shoulder pain. When Petitioner was seen again on May 13, 2016, he complained of bilateral shoulder pain and his physical exam was positive for decreased range of motion and external rotation, abduction of both shoulders. Petitioner was assessed with bilateral shoulder pain, and Dr. Dumasia proceeded to order x-rays of the left wrist and both shoulders. She also prescribed Meloxicam, a prescription anti-inflammatory medication for shoulder pain. The Arbitrator notes that Dr. Dumasia referred Petitioner to an orthopedic surgeon. When Petitioner returned to Dr. Dumasia's office one month later, on June 18, 2016, it was a follow-up appointment for left shoulder and wrist/hand pain. Petitioner reported continued pain in his shoulders and hands. Despite Petitioner's testimony that that he did not have any pre-injury treatment in his shoulders, Dr. Dumasia ordered an MRI an, arthritis panel and recommended physical therapy which petitioner declined. And for the second time, Dr. Dumasia advised Petitioner to be seen by an orthopedic surgeon. Lastly, she prescribed Ibuprofen, 800 mg for shoulder pain.

The Arbitrator also notes that when Petitioner returned to Dr. Dumasia's office on July 22, 2016, it was a follow up visit to review lab results and an MRI of the left shoulder which was performed on July 16, 2016 and revealed a post-labral tear with supraspinatus tendinopathy. The Arbitrator notes that this office visit with Dr. Dumasia took place sixteen (16) days after the alleged work incident and the records are devoid of any history of a workplace accident or trauma to the right or left shoulder. It is also notable that Dr. Dumasia's records reflect that Petitioner had "no current symptoms." Dr. Dumasia prescribed Acetaminophen 300 mg and Codeine for shoulder pain. The Arbitrator notes that Dr. Dumasia made a third request that Petitioner seek further care with an orthopedic surgeon. The Arbitrator finds that if Petitioner had a true workplace accident on July 7, 2016, he had ample opportunity to tell Dr. Dumasia at the July 22, 2016 office visit. The Arbitrator finds that Petitioner's pre-injury visits with Dr. Dumasia are inconsistent with his testimony that he did not have any shoulder treatment prior to the alleged incident on July 7, 2016. (T. 29).

The Arbitrator also finds Petitioner's testimony regarding the history he presented to Dr. Levi on August 12, 2016 not credible, as well as Dr. Levi's causation opinion. Petitioner was first seen by Dr. Gabriel Levi on August 12, 2016. (Px 2). The Arbitrator notes from Dr. Levi's deposition testimony taken on January 15, 2018, that he is an orthopedic surgeon who

evaluated Petitioner at the referral of his primary care physician, Dr. Dumasia. This would be consistent with the orthopedic referrals made by Dr. Dumasia on 5/13/16, 6/18/16 and 7/22/16 for shoulder pain. (PX 2 at 27-28). Dr. Levi's initial report of August 12, 2016 and his deposition testimony confirm that Petitioner was not forthright about having any prior shoulder pain before an alleged workplace incident that he described as occurring on July 7, 2016. In fact, Dr. Levi's initial report and his deposition testimony confirm that Petitioner affirmatively denied having any prior shoulder pain. The Arbitrator notes that Petitioner's history to Dr. Levi is inconsistent with the treating records of Dr. Dumasia.

The Arbitrator further notes that Dr. Levi testified that his causation opinions and his treatment recommendations are based on the statements made to him by the Petitioner. (PX 2 at 29). During his deposition, Dr. Levi was shown copies of Dr. Dumasia's records which document Petitioner's prior shoulder treatment and he attempted to downplay. The Arbitrator finds that Dr. Levi did not have accurate information of Petitioner's medical history regarding his shoulders to a complete an accurate causation assessment with respect to the right or left shoulder. The Arbitrator further notes that Dr. Levi did not render an opinion that Petitioner exacerbated or aggravated his shoulders because of a workplace injury, and therefore rejects any such causation argument. (PX 2 at 44).

The Arbitrator finds the opinions and testimony of Dr. Kevin Chen more credible regarding the issue of causal connection. Dr. Chen provided his deposition testimony on April 30, 2018. (RX 7). Dr. Chen testified that he had an opportunity to review the treating records of Dr. Eva Dumasia, whom he believed was Petitioner's general practitioner. Dr. Chen testified that the records of Dr. Dumasia revealed that Petitioner had been complaining of bilateral shoulder pain from December 4, 2015 through July 22, 2016 with no history of a workplace injury contained therein. Dr. Chen noted that Dr. Dumasia made a referral to an orthopedic surgeon on several occasions and he believed this was to address a medical problem outside her scope; in this case, shoulder pain. (RX 7 at 16). Dr. Chen testified that he reviewed the initial report of Dr. Gabriel Levi in which Petitioner denied having any pain in his shoulders or wrists prior to a lifting incident at work. Dr. Chen testified that Petitioner's history was inconsistent with the records of Dr. Dumasia which show a clear pattern of bilateral shoulder complaints beginning on December 4, 2015 through July 22, 2016. While Dr. Chen acknowledged that Petitioner has pathology in both shoulders, he testified that he could not state with a competent degree of medical and surgical certainty, that Petitioner's shoulder pain is directly related to the injury he described as occurring on July 7, 2016 for two main reasons, (1) Petitioner had shoulder pain before the alleged incident and, (2) the lack of documentation of an alleged workplace injury after the incident when he saw a physician shortly after the injury; Dr. Dumasia on July 22, 2016. (RX 7 at 28).

19IWCC0207

Issue J: *Medical bills*

Based upon the findings concerning **Issues C and F**, above, that Petitioner did not sustain an injury that arose out of and in the course of his employment by Respondent, and that Petitioner's current condition of ill-being is not causally related to the injury, the Arbitrator finds Respondent not liable for any outstanding medical bills as contained in PX 1. The Arbitrator finds that all medical treatment rendered to Petitioner was not reasonable or necessary to cure or relieve him from the effects of an alleged industrial injury on July 2, 2016 as required by the Illinois Workers' Compensation Act.

Issue K: *Prospective medical care*

Based upon the findings concerning **Issues C, F, and J**, above, that Petitioner did not sustain an accident that arose out of and in the course of his employment by Respondent, that Petitioner's current condition of ill-being with respect to his right or left arms is not causally related to a work injury, that the medical services provided to Petitioner were not necessitated by a work injury and that any outstanding medical bills are not causally related to a workplace injury on July 7, 2016, the Arbitrator finds that Petitioner is not entitled to any prospective medical care to either the right or left shoulder and Respondent is not liable for any prospective medical treatment as he failed to prove that he sustained an accident that arose out of or in the course of his employment by Respondent on July 7, 2016.

Signature of Arbitrator

November 15, 2018
Date

STATE OF ILLINOIS) BEFORE THE ILLINOIS WORKERS' COMPENSATION
) SS COMMISSION
COUNTY OF COOK)

Stacy Ash,
Petitioner,

vs.

NOS. 03 WC 43923
03 WC 49089
15 IWCC 612

Bloomington Public Schools,
Respondent.

ORDER OF RECALL UNDER SECTION 19(F)

A Motion to Correct Clerical Error pursuant to Section 19(f) of the Illinois Workers' Compensation Act to correct an error in the Order of the Commission dated April 17, 2019, having been filed by Respondent herein, and the Commission having considered said Motion, hereby grants said Motion.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Order dated April, 17, 2019, is hereby recalled pursuant to Section 19(f).

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

DATED: APR 25 2019

DLS/rm
46

Deborah L. Simpson

STATE OF ILLINOIS)
) SS.
COUNTY OF PEORIA)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

STACY ASH,
Petitioner,

vs.

No: 03 WC 43923,
03 WC 49089
15 IWCC 612

BLOOMINGTON PUBLIC SCHOOLS,
Respondent

CORRECTED ORDER

This matter comes before the Commission on Petitioner's Motion to Compel Compliance With Order. A hearing was held before Commissioner Luskin on December 11, 2018 in Peoria. The parties were represented by counsel, and a record was taken.

Petitioner filed two separate claims, 03 WC 43923 and 03 WC 49089 alleging accidental injuries to her lower back on June 26, 2003 and April 21, 2003, respectively. On February 2, 2007, an Arbitrator denied compensation in 03 WC 43923, finding that accident caused no permanent injury. Also on that date, the Arbitrator issued another opinion finding Petitioner proved the accident on April 21, 2003 caused the current condition of ill-being of her lower back and awarded her 125 weeks of permanent partial disability benefits representing the loss of the use of 25% of the person-as-a-whole.

Petitioner filed a petition for relief under §8(a) of the Act. On August 10, 2015, the Commission issued an opinion ordering Respondent to authorize and pay for implantation of a trial spinal cord stimulator recommended by Petitioner's treating doctor, Dr. Benyamin. In the decision the Commission found that Petitioner was "entitled to additional medical treatment in the form of a trial spinal cord stimulator and the medical expenses related thereto."

At the instant hearing, Petitioner testified that she went to Dr. Benyamin about the spinal cord stimulator in November 2016. The delay between the Commission Decision on the 8(a) petition and that presentation to Dr. Benyamin was due to Dr. Benyamin's current treatment for a cervical condition. Dr. Benyamin wanted to wait until after he completed treating Petitioner's cervical condition before addressing her lumbar issues. Dr. Benyamin wanted an MRI prior to implantation of the stimulator. Respondent has thus far refused to authorize or pay for the MRI.

On cross, Petitioner agreed that in February 2014 she was a passenger in a vehicle that was struck in the rear. Thereafter, she mostly had neck pain and jaw-pain, but she also had an increase in her lower back pain. She had physical therapy which treated for both her neck and back. She also agreed that Dr. Vales, her primary care physician, had referred her to Dr. Taimoorazy for the spinal cord stimulator, but Petitioner chose to go to Dr. Benyamin because he was her pain doctor. Dr. Vales "was fine with that." Dr. Benyamin had recommended a lumbar spinal cord stimulator prior to the 2014 motor vehicle accident. However, a separate cervical cord stimulator also has been recommended after that accident.

Petitioner submitted into evidence records of Dr. Benyamin from October 14, 2015 through December 4, 2018. On October 14, 2015, Petitioner was referred to Dr. Benyamin on referral from Dr. Vales. She was involved in a motor vehicle accident in February 2014 and had had neck pain, jaw pain, headaches, and blurred vision. Physical therapy had not been beneficial. She had been found not to be a surgical candidate and pain management was recommended. Dr. Benyamin administered numerous injections in Petitioner's cervical spine. In the course of his treatment of Petitioner's neck, on July 7, 2016, Dr. Benyamin noted that he would contact Petitioner's lawyer "about the low back and stimulator approval." On November 23, 2016 Petitioner presented to Nurse Practitioner, Elizabeth Madlem to discuss low back pain. She noted that the last imaging of the lumbar spine was in 2013. Ms. Madlem noted that Petitioner's low back symptoms progressed since she was last treated for her lower back and felt it was "pertinent to order a new lumbar spine MRI." Based on the MRI they would determine whether a spinal cord stimulator was indicated.

Petitioner also submitted records from Dr. Vales. On September 3, 2015, he noted that Petitioner "was recently cleared for a pain similar (sic) for her low back through the disability, and this dates back to a work injury in 2003. They have referred her to Dr. Benyamin for that." Dr. Vales would have preferred Dr. Taimoorazy, "but we may not be able to get around that referral without the risk of getting it withdrawn. So for now, the neck is the priority. We will get her in with Dr. Taimoorazy and go from there."

In its motion, Petitioner requests the "Commission compel Respondent to order the MRI so the spinal cord stimulator trial may be carried out as the commission ordered, and the appropriate attorney fees and penalties to be ordered paid to Petitioner for the necessary enforcement of this order." As the Commission has explained in the past, we do not have any powers to "enforce" an order or "compel" the actions of parties. The Commission can only issue orders and awards and impose penalties when certain condition are met. In the case now before us, the record is a little unclear about whether Dr. Benyamin actually recommended an MRI prior to placement of the lumbar cord stimulator. The record indicates that a nurse practitioner recommended such a study and Petitioner testified that Dr. Benyamin recommended the MRI. In any event, the Commission now orders Respondent to authorize and pay for any prospective treatment recommended by Dr. Benyamin for treatment of her lower back related to her work injury in 2003. In addition, the Commission notes that Petitioner's request for penalties and fees is premature because we do not know what any prospective procedures would cost. If after the issuance of this order, Petitioner believes that Respondent's actions warrant the imposition of penalties and fees, it can pursue such a petition in the future.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent authorize and pay for any and all prospective treatment recommended by Dr. Benyamin for treatment of her lumbar spine condition caused by her work related accident on April 21, 2003.

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: APR 2 5 2019

Deborah L. Simpson

Barbara N. Flores

Marc Parker

DLS/dw
R-12/11/18
46

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

RONALD BERRYHILL,

Petitioner,

19IWCC0208

vs.

NO: 03 WC 56216

STATE OF ILLINOIS – ILLINOIS TOLLWAY AUTHORITY,

Respondent.

DECISION AND OPINION ON REVIEW

This matter comes before the Commission on Petitioner's Petition for Relief Under §8(a) of the Act. In the underlying cases, Arbitrator Dollison issued a Fourth Corrected Decision on May 19, 2009, in which he found Petitioner suffered a work-related accident on August 5, 2003 and awarded him 275&4/7 weeks temporary total disability benefits, $8,830.98 in medical expenses, 250 weeks of permanent partial disability benefits representing 50% loss of the person-as-a-whole, and $3,390.00 in penalties under section 19(l). Medical was left open.

Respondent sought review of the Decision of the Arbitrator. On review the Commission modified the Decision of the Arbitrator to reduce the award of temporary total disability benefits to 109 weeks, to reduce the award of medical expenses to $6,751.23, to reduce the award of permanent partial disability benefits to 200 weeks representing 40% loss of the person-as-a-whole, and to vacate the award of penalties. In reducing the Arbitrator's award to Petitioner, the Commission found not credible Petitioner's testimony regarding Respondent's failure to abide by work restrictions and his explanation for his suboptimal effort as found in a functional capabilities evaluation ("FCE"). The Commission also found that Petitioner's condition "clearly stabilized by" August 22, 2008 and that by that time he was selling cars and incorporated his own business. It used the positive Waddell signs in the FCE and surveillance video to reduce his permanent partial disability award. The Commission concluded that "petitioner had a more favorable recovery from his accident and surgery than he wishes to show."

19IWCC0208

Petitioner filed a Petition pursuant to §§19(h)/8(a). On January 20, 2015, the Commission issued an opinion denying Petitioner's petition finding that Petitioner had not sustained his burden of proving that he suffered any increase in disability since the Decision of the Commission or that the medical treatment provided was causally related to his 2003 work accident. Petitioner appealed the Decision of the Commission. The Circuit Court dismissed the appeal and the Appellate Court affirmed the dismissal by the Circuit Court for lack of jurisdiction.

A hearing on the instant petition was held on September 18, 2018 in Chicago before Commissioner Simpson. Respondent was represented by counsel, Petitioner appeared *pro se*, and a record was taken. Petitioner made an opening statement indicating that he had surgery in 2008 after Respondent agreed to the surgery. He has had pain since the surgery. Doctors have prescribed injections to avoid another surgery. Respondent has refused to pay for the injections or for a back brace. He had a back brace that was not awarded by the Commission. Respondent did not pay for it, it wore out, and now he needed a new one.

Respondent responded by noting the history of the litigation, including the denial of Petitioner's prior §§19(h)/8(a) petition, technical defects with Petitioner's pleadings, and times in which the proceedings were continued because of Petitioner's inability to produce documents. Respondent also noted that the bill for the back brace, and possibly other bills, had been submitted in his prior §§19(h)/8(a) petition which was denied.

Petitioner then "testified" that his pain increased after the prior §§19(h)8(a) hearing in 2014. He kept going back to doctors for pain medication and injections. He believed that "some things may have jarred in [his] back." He was told he would have pain for the rest of his life and there are things that he cannot do because of the pain and that would also last for the rest of his life. He was looking for the Commission to provide him relief. He specifically noted the importance of the back brace.

On cross examination, Petitioner agreed that he had been at the Commission "from time to time" on the instant motion and the matter was continued for him to obtain medical records. There was no "current" bill for the back brace because they would not make one because the prior brace had not been paid for. Petitioner disagreed that Dr. An advised him that no more surgery could be done; Dr. An wanted to perform surgery but wanted to try injections first.

Petitioner submitted various records into evidence. We will only address those which post-dated the prior Decision of the Commission on Petitioner's prior petition pursuant to §§19(h)/8(a). On May 16, 2014, Dr. An issued an open letter indicating Petitioner had an exacerbation of his lumbar and cervical spine as of April 28, 2014 and "excused" him to May 29, 2014. On July 10, 2014, Dr. An issued another open letter indicating Petitioner had chronic low back pain and left-leg pain after his surgery in 2007 which interfered with his activities of daily living.

On February 12, 2015 Petitioner presented to Dr. An, who noted he saw Petitioner about six months previously for similar low back pain radiating into the left leg. He was neurologically intact, and all x-rays and a CT found solid fusion with the instrumentation intact without nerve compression. He prescribed Mobic and pain management. In August 2015, Petitioner reported his pain was getting "quite severe" over the past several weeks. X-rays showed the instrumentation intact, but also showed more evident grade I spondylolisthesis at L4-5. Dr. An ordered an MRI.

On September 1, 2015, Petitioner presented to Dr. Cheng on referral from Dr. An for evaluation of leg pain. He had 32 spinal injections prior to surgery. He used Norco for pain. Dr. Cheng reviewed the MRI which showed degenerative grade I spondylolisthesis at L4-5, a posterior disc protrusion at L3-4, and disc bulges L4-5 causing mild-to-moderate bilateral foraminal stenosis. Dr. Cheng administered an injection at L4. Two months later, Dr. Cheng increased Petitioner's dosage of Gabapentin and refilled Norco but advised Petitioner he would halve the dosage the next month.

On December 6, 2015, Dr. Cheng noted that Petitioner had his current problems since 2002. Dr. Cheng refilled Norco for the last time. Petitioner understood that this medication was not to be used long-term and he might have to be weaned off it. On May 4, 2016, Petitioner returned to Dr. An frustrated with his ongoing low back pain. X-rays showed intact instrumentation. He informed Petitioner that there was no more surgery recommended for him, and that he was a candidate for pain management with Dr. Cheng. He released Petitioner from treatment *prn*.

On January 15, 2017, Dr. Cheng prescribed Prednisone and Flexeril and reassured Petitioner that the fusion was solid. A month later, Petitioner reported his back pain increased. Dr. Cheng recommended facet block injections for degenerative spondylolisthesis, which he administered a month later. A year later, Petitioner returned to Dr. Cheng who noted that he last saw Petitioner in September 17 for a transforaminal epidural steroid injection at L4, the record of which does not appear to be in the transcript. His pain decreased by about 50% but he now had 10/10 pain. He noted that Dr. An had determined he was not then a surgical candidate and Dr. Cheng recommended another epidural steroid injection.

On May 31, 2018, Petitioner presented to Dr. An who noted that "many years ago" he had decompression surgery L3-S1 with fusion at L5-S1. Dr. An had seen Petitioner about a year earlier at which time he some residual back pain. He had some injections from Dr. Cheng several months prior to the instant visit. "Unfortunately, he was involved in [an motor vehicle accident] on April 30, 2018 and his car was rear-ended when he was driving. Since then, his pain is somewhat worse in the low back, but the pattern of the pain is about the same as before." He went to an emergency room at the time and had more x-rays. Dr. An recommended treatment with Dr. Cheng including possible injections. He did not recommend another fusion surgery, which should be considered the last resort.

Respondent submitted a §12 report from Dr. Delheimer dated August 12, 2013. He indicted he had previously examined Petitioner in September of 2007. He did another examination on August 9, 2013 and reviewed medical records up to 2012. Dr. Delheimer indicated Petitioner voluntarily limited his range of motion in his back. He had negative straight leg raises and normal reflexes. He had "excessive grunting and grimacing, as well as excessive pain manifestations during the entire exam as well as while walking onto and out of the exam room." His complaints were all subjective and there were no new objective findings since his previous examination in 2007. There was "no medical reason to increase his previous" permanent partial disability award. Dr. Delheimer opined that Petitioner's current complaints were due to underlying degenerative disc disease with a component of excessive pain manifestation and not caused by the 2003 accident; there were no new objective findings since his previous examination in 2007 or since he case was arbitrated in 2009. The diagnostic studies indicated that Petitioner's condition was stable since 2009.

In his brief, Petitioner simply attacks the IME report of Dr. Delheimer indicating he "falsified" information and "certified" that he was not examined by Dr. Delheimer in 2007. He was "definitely not telling the truth" and made "false accusations." Petitioner also included in his brief additional medical records and letters from treaters which were not submitted into evidence at the review hearing.

In addition, the Commission notes that Petitioner's petition for relief only references medical expenses under §8(a) and does not include any request for any increase in his prior permanent partial disability award under §19h). However, in oral argument, Petitioner repeatedly requested compensation for his "pain and suffering." It is a basic tenant of workers' compensation law, that claimants are compensated only for disability, inability to work, and potential loss of income. Compensation for alleged "pain and suffering" is clearly not allowed under the Illinois Workers' Compensation Act.

The Commission concludes that Petitioner has not sustained his burden of proving any current condition of ill-being or any current medical treatment was related to his 2003 accident. In the previous decision the Commission clearly had difficulty accepting the veracity of his testimony. Petitioner appeared to have exhibited symptom exaggeration throughout. The Commission specifically found that Petitioner's condition had stabilized as of August 22, 2008 and Dr. Delheimer found that his objective findings and imaging tests showed no change in his condition since 2009, when the case was arbitrated. Absent extraordinary circumstances these prior findings of the Commission become the law of the case.

In addition, the notes/letters submitted by Petitioner do not include any definitive statement of a medical opinion indicating the 2003 accident/injury caused his current complaints. Rather the records simply indicate that Petitioner complained of continuing symptoms which he related to his accident.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's Petition for Relief Under §8(a) of the Act is denied.

DATED: APR 2 5 2019

Deborah L. Simpson

Barbara N. Flores

Marc Parker

DLS/dw
O-4/18/19
46

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

CARZIE JONES,

Petitioner,

19IWCC0209

vs.

NO: 17 WC 3918

STATE OF ILLINOIS – CHICAGO REED MENTAL HEALTH CENTER,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties the Commission, after considering the issues of causal connection, temporary total disability benefits and prospective medical treatment, 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 testified she was a registered nurse employed by Respondent. She testified that on January 19, 2017, she "was attacked by an angry, violent [psychiatric] patient." He grabbed her by the hair from behind, threw her to the floor, and beat her. She was hit in her neck and back. Security arrived and stopped the attack. Respondent stipulated to a compensable accident. After the attack, Petitioner was in shock and her whole body hurt. She went home and the next morning her head, neck, arms, and back hurt and she had a bruise on her right knee. Respondent sent her to Physicians Immediate Care. There, she was given a prescription, but she was informed that they could not authorize any time off work. Petitioner did not return to work and presented to Dr. Levi on February 6, 2017. Dr. Levi's diagnosis was cervical strain with degenerative disc disease at C4-5 & C5-6, spondylosis at L4-5, and a possible torn meniscus in the right knee. He prescribed medications, a lumbar corset, and a TENS unit, ordered MRIs of her right knee and cervical spine, and took Petitioner off work.

19IWCC0209

On February 7. 2017, Petitioner presented to a psychologist, Daniel Kelley, Ph.D. He noted that Petitioner presented to the clinic with symptoms of severe anxiety secondary to an attack at work by a male patient. She needed a continued leave of absence from all work due to emotional/psychological dysfunction. Petitioner did not return to Dr. Kelley, nor apparently seek psychological/psychiatric treatment elsewhere.

On March 6, 2017, Petitioner returned to Dr. Levi who noted that cervical MRI showed central disc herniations at C4-5, C5-6, & C6-7, with mild central stenosis at C4-5 and mild spinal stenosis with neuroforaminal stenosis at C5-6 & C6-7. The MRI of the right knee showed a torn meniscus and a large Baker's cyst. He prescribed physical therapy for the neck and arthroscopic surgery for the knee. The recommended knee surgery was never authorized.

The Arbitrator found that Petitioner sustained her burden of proving that her accident caused the conditions of ill-being of her knee, cervical spine, and psychological distress. He awarded Petitioner 72&4/7 weeks of temporary total disability benefits, from the date after the accident to the date of arbitration, and ordered Respondent to authorize and pay for prospective knee surgery recommended by Dr. Levi as well as "prospective emotional/psychological care." Respondent accepted liability for Petitioner's cervical condition but disputed causal connection to Petitioner's knee condition because she had not immediately reported the knee injury. The Commission agrees with the determination of the Arbitrator regarding causation and award of prospective medical and affirms and adopts those aspects of the Decision of the Arbitrator.

As noted above the Arbitrator awarded temporary total disability benefits from the day following the accident through the date of arbitration. Petitioner testified that her initial treaters at Physicians Immediate Care did not authorize any time off work, and their release of her to work at full duty was corroborated by the medical records. Petitioner was not taken off work until February 6, 2017 when Dr. Levi took her off work. Therefore, her absence from work between January 20, 2017 and February 6, 2017 was not authorized, and the Commission concludes that Petitioner has not met her burden of proving she is entitled to temporary total disability benefits for that period of time. Accordingly, the Commission modifies the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $814.31 per week for a period of 70 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 authorize and pay for prospective medical treatment for her right knee as recommended by Dr. Levi and prospective emotional psychological treatment under §8(a) of the Act.

19IWCC0209

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

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

DATED: APR 25 2019

Deborah L. Simpson

Barbara N. Flores

Marc Parker

DLS/dw
O-4/18/19
46

ILLINOIS WORKERS' COMPENSATION COMMISSION

NOTICE OF 19(b) ARBITRATOR DECISION

19IWCC0209

JONES, CARZIE
Employee/Petitioner

Case# **17WC003918**

CHICAGO REED MENTAL HEALTH CENTER
Employer/Respondent

On 9/10/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.24% 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:

0579 FRIEDMAN & SOLMOR LTD
GARY B FRIEDMAN
221 N LASALLE ST SUITE 2750
CHICAGO, IL 60601

5002 ASSISTANT ATTORNEY GENERAL
JOSEPH L BLEWITT
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

SEP 10 2018

GERALD A. PARDIA, Acting Secretary
Illinois Workers' Compensation Commission

19IWCC0209

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)

CARZIE JONES
Employee/Petitioner

v.

CHICAGO REED MENTAL HEALTH CENTER
Employer/Respondent

Case # 17 WC 3918

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 **Watts**, Arbitrator of the Commission, in the city of **Chicago**, on **June 12, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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. [x] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other

FINDINGS

On **1-19-17**, 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 **$63,516.00**; the average weekly wage was **$1,221.46**.

On the date of accident, Petitioner was **61** years of age, ***single*** with **0** dependent children.

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

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

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $814.31 for 72 4/7 weeks, commencing January 20, 2017 through June 12, 2018, as provided in Section 8(b) of the Act. Respondent is granted a credit for such amount of TTD owed up to the amount of benefits it paid to Petitioner pursuant to the Public Employee Disability Act (PEDA) during the time period Respondent was paying benefits under PEDA. Regarding any period of time before PEDA payments commenced and once the period of PEDA payments expires or has expired, Respondent shall pay Petitioner temporary total disability benefits of $814.31 per week through June 12, 2018.

Respondent shall authorize and pay for the prospective right knee surgery as recommended by Dr. Roberto Levi, including any and all reasonable incidental care thereto, and prospective emotional/psychological 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.

Charles M. Watts

Signature of Arbitrator

September 7, 2018
Date

SEP 10 2018

THE ILLINOIS WORKERS' COMPENSATION COMMISSION

CARZIE JONES,

Petitioner

V

NO. 17 WC 3918

CHICAGO REED MHC,

Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

The matter was heard, pursuant to 19(b) by an Arbitrator designated by the Commission in the City of Chicago, County of Cook and State of Illinois, on June 12, 2018.

The Arbitrator renders findings on the following disputed issues:

(F) Is 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) Is Petitioner entitled to any prospective medical care?;

(L) What temporary benefits are in dispute?;

(M) Should penalties or fees be imposed upon Respondent?

Relevant to (F) and (J), Respondent has stipulated that injuries to Petitioner's head and neck occurred and that the medical treatment for these injuries is/was reasonable and necessary. Relevant to (J), Petitioner reserves the right to present unpaid medical bills at a later hearing and Respondent claims a credit for any bills it paid through group medical insurance. Relevant to (L), Respondent claims liability for TTD payments from January 20, 2017 to June 31, 2017.

STATEMENT OF FACTS

Petitioner, CARZIE JONES, age 61, has been a registered nurse for the past sixteen or seventeen years, and she had previously worked as a registered nurse at various facilities in the Chicago area including St. Elizabeth Hospital and Mercy Hospital. On January 19, 2017, Petitioner was employed by Respondent, CHICAGO REED MENTAL HEALTH CENTER, as a registered nurse, and she had been employed in the Respondent's psychiatric unit for approximately six months. On January 19, 2017, at approximately 7:00 p.m., Petitioner was attacked by a male psychiatric patient while on duty for the Respondent on the Respondent's

premises. The attack included being hit from behind in the neck, having her hair pulled throwing her down to the floor, and being beaten on while on the floor until security came to get the psychiatric patient away from Petitioner.

Before the attack, Petitioner testified to feeling fine with no problems with her left eye, head, neck, both arms, lower back, and right knee. On the night of the attack, January 19, 2017, Petitioner was requested by her employer to fill out and sign forms (Resp. ex 1 & 3). Petitioner testified that at the time she filled out the forms she was emotionally distraught and physically in pain. In these forms, Petitioner noted the physical abuse she experienced, and what was bothering her at that time (Resp. ex 1 & 3). The next day, January 20, 2017, her supervisor K. Vinson completed a report form noting the physical abuse experienced by Petitioner after having been attacked on January 19, 2017, and the supervisor noted that Petitioner had a facial injury and that the Petitioner's entire body ached with a pain level of 6/10 (Resp. ex 2).

At the direction of Respondent, Petitioner sought medical care and treatment at Physician's Immediate Care on January 20, 2017 and January 24, 2017 (Pet. ex. 1). At Physician's Immediate Care, Petitioner initially complained of pain and discomfort to her left eye, neck, and right lower extremity (Pet. ex. 1). Petitioner then sought follow-up care and treatment on her own. The follow-up care and treatment included: care from orthopedic surgeon Roberto Levi at Orthopaedic and Rehabilitation Center from February 6, 2017 to June 11, 2018 (Pet. ex. 2); an initial visit with psychologist Daniel Kelley at Integrated Behavioral Medicine on February 7, 2017 (Pet. ex. 3); care from neurologist Mohammed Ghabra on May 14 and May 27, 2017 (Pet. ex.4); and care from neurosurgeon Roger Lichtenbaum on September 28, 2017 (Pet. ex. 5).

When first seen by Dr. Levi at the Orthopaedic and Rehabilitation Center on February 6, 2017, Petitioner explained that she was injured at work on January 19, 2017, when a psychiatric patient hit her in the neck and head, grabbed her hair pulling her to the floor, and kept hitting her until security arrived (Pet. ex. 2). Petitioner complained to Dr. Levi of pain in the neck, in the arms, in the right knee, and in the lumbar spine (Pet. ex. 2). After examination and diagnostic testing (Cervical MRI at Edgebrook Radiology (Pet. ex. 6); right knee MRI and right knee CT Arthogram (Pet. ex. 7 & 8)), Dr. Levi diagnosed Petitioner's condition of ill being as: Cervical - central disc herniations at C4-C5, C5-C6, and C6-C7 with mild stenosis and bilateral neuroforaminal stenosis; Right knee – a torn medial meniscus and a large Baker's cyst (Pet. ex. 2, 6, 7, & 8). Since March 6, 2017 up to Petitioner's most current visit with Dr. Levi on June 11, 2018, Dr. Levi has recommended that the Petitioner undergo arthroscopic surgery to repair the torn medial meniscus in Petitioner's right knee (Pet. ex. 2). During this period of time (3-6-17 to 6-11-18), both Dr. Levi and Petitioner have waited for surgical approval from the Respondent for the right knee surgery to repair the Petitioner's torn medial meniscus (Pet. ex. 2). Petitioner testified she had known of Dr. Levi and sought his care because she had previously worked at St. Elizabeth Hospital where he was associated.

Petitioner reported headaches to Dr. Levi and he referred the Petitioner to neurologist Mohammad Ghabra (Pet. ex. 2 & 4). Dr. Ghabra's May 4, 2017 record indicates that Petitioner explained she was injured at work when a psychiatric patient attacked her; grabbed her hair;

pulled her to the floor landing on her knee; and was hitting her (Pet. ex. 4). Dr. Ghabra noted multiple symptoms including feeling light headed, unsteady, headaches, cervical pain, pain in both shoulders, feeling numbness all over her body, and pain in the right knee (Pet. ex. 4). Dr. Ghabra noted that upon review of Petitioner's cervical MRI, it revealed disc herniations at C4-C5, C5-C6, and C6-C7 with mild cervical stenosis (Pet. ex. 4 & 6). After examination both on May 4, 2017 and May 27, 2017, Dr. Ghabra's neurological diagnosis was "post traumatic syndrome plus post traumatic headache syndrome" (Pet. ex. 4).

At the referral of Dr. Ghabra for consultation of Petitioner's cervical spine, Petitioner was seen and examined by neurosurgeon Roger A. Lichtenbaum on September 28, 2017 (Pet. ex. 5).. Lichtenbaum noted that Petitioner reported she was injured at work when she was attacked by a patient and was knocked to the ground injuring her eye, right knee, and cervical spine (Pet. ex. 5). Dr. Lichtenbaum noted upon examination Petitioner's continued neck and lower extremity pain and weakness,; and the fact that Petitioner was waiting for surgical approval to repair the torn medical meniscus in her right knee (Pet. ex. 5). For the cervical spine condition, Dr. Lichtenbaum did not recommend cervical spine surgery, but did recommend physical therapy for the cervical pain and discomfort experienced by Petitioner (Pet. ex. 5).

In addition to receiving care and treatment from Dr. Levi, Dr. Ghabra, and Dr. Lichtenbaum, for her physical condition, Petitioner was seen by psychologist Dr. Daniel Kelly at Integrated Behavioral Medicine for her emotional/psychological complaints (Pet. ex. 3). When seen by Dr. Kelley on February 7, 2017, Petitioner explained to Dr. Kelley the specifics of her physical assault by a male patient at work on January 19, 2017 (Pet. ex. 3). Dr. Kelley noted that Petitioner presented with severe anxiety symptoms due to the incident at work on January 19, 2017, and he opined that Petitioner requires a continued leave of absence from work due to her emotional psychological dysfunction caused by the incident at work on January 19, 2017 (Pet. ex. 3).

Petitioner testified that she was scheduled for an Section 12 exam on November 1, 2017 at 5:00 p.m. but that when she arrived, the physician had left already for the day. Petitioner testified that she had a Section 12 exam with Dr. Rishi Garg. Dr. Garg, who is not an orthopedic surgeon, only had opinion on the cervical spine conditions of Petitioner and did not examine Petitioner's right knee. (Pet. Ex. 2, February 19, 2018 note).

At the direction of her treating physicians (Pet. ex. 2, 3, 4, & 5), the Petitioner has been off from work for the Respondent from January 20, 2017 through June 12, 2018 (72 4/7 weeks). During this period of time, the Respondent has not paid any TTD to Petitioner. Petitioner testified that she filled out an Extended Benefits Request form (Resp. ex. 3) and received benefits that were delayed three months and then stopped in March 2018. Also, Petitioner and her treating orthopedic surgeon Dr. Levi have sought approval for many months from the Respondent for the right knee surgery recommended and deemed necessary to repair a torn medical meniscus in Petitioner's right knee, the Respondent has not provided approval. The surgery has not occurred. Petitioner wants the right knee surgery recommended by Dr. Levi, and she testified she will undergo the surgery if ordered by the Arbitrator.

On May 4, 2018, Respondent sent Petitioner a "Memorandum" advising her that she is being "Suspended Pending Discharge" effective May 9, 2018, because they claim that she "violated time and attendance policy" with "unexcused absences." (Pet. ex. 9).

CONCLUSIONS OF LAW

The Arbitrator adopts the Finding of Facts in support of the Conclusions of Law.

Section 1(b)3(d) of the Act provides that, in order to obtain compensation under the Act, the employee bears the burden of showing, by a preponderance of the evidence, that he or she has sustained accidental injuries arising out of and in the course of the employment. 820 ILCS 305/1(b)3(d). To obtain compensation under the Act, Petitioner has the burden of proving, by a preponderance of the evidence, all of the elements of his 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)

The Arbitrator finds that the testimony of the Petitioner was credible because Petitioner's responses to questions showed candor and were consistent with the documentary evidence. Petitioner did not speculate in her answers. Her testimony was consistent with the medical records. The Arbitrator also finds it entirely credible that at her initial presentation to Physician's Immediate Care, that Petitioner would not be able to describe each and every area of her body that was in pain, and would instead describe the source of the most pain. Petitioner testified consistently with nearly every medical record that she had pain in her leg/knee area.

(F) In support of the Arbitrator's decision regarding whether Petitioner's current condition of ill being is causally related to her injury, the Arbitrator makes the following conclusions of law:

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).

"A chain of events which demonstrates a previous condition of good health, an accident, and a subsequent injury resulting in a disability may be sufficient circumstantial evidence to

prove a causal connection between the accident and the employee's injury." *Int'l Harvester v. Industrial Comm'n*, 93 Ill. 2d 59, 63-64 (1982). If a claimant is in a certain condition, an accident occurs, and following the accident, the claimant's condition has deteriorated, it is plainly inferable that the intervening accident caused the deterioration. *Schroeder v. Ill. Workers' Comp. Comm'n*, 79 N.E.3d 833, 839 (Ill. App. 4th 2017).

Respondent has stipulated that injuries to Petitioner's head (including eye and ear) and neck occurred and that the medical treatment for these injuries is/was reasonable and necessary.

Petitioner testified that before her attack by a psychiatric patient at work on January 19, 2017, she was feeling fine with no prior problem with her left eye, head, neck, both arms, lower back, and right knee. Petitioner testified that on January 19, 2017, at approximately 7:00 p.m., she was attacked by a male psychiatric patient who hit her from behind in the head and neck; he grabbed her hair; he pulled her down to the floor, and he beat or hit her until security arrived and pulled the male psychiatric patient off of her. Petitioner has further testified that she was injured as a result of the attack at work both physically and emotionally. Petitioner has further testified that as a result of the attack at work her left eye, her head, her neck, both arms, her lower back, and her right knee were injured. In addition, Petitioner has asserted that she was experiencing severe anxiety emotionally after the attack at work.

The Arbitrator deems the aforementioned testimony of the Petitioner on the issue of causal connection credible upon review of the medical records in evidence. When first seen at Physician's Immediate Care on January 20, 2017 and January 24, 2107, where she was sent by the Respondent as a result of injuries sustained at work on January 19, 2017, injury to her left eye, neck, and right lower extremity (right thigh) were noted (Pet. ex 1). Thereafter, when Petitioner sought follow-up care and treatment with orthopedic surgeon, Roberto Levi, Dr. Levi noted on Petitioner's first visit on February 6, 2017, that she complained of pain in her neck, lower back, both arms, and her right knee after an injury at work on January 19, 2017 (Pet. ex 2). The subsequent records of Dr. Levi through June 11, 2018 (the day before our hearing) continue to note care and treatment to Petitioner's neck, lower back, right knee, and developing dizziness and headaches as a result of the Petitioner's injury at work on January 19, 2017 (Pet. ex 2).

In addition to the records of Dr. Levi, when the Petitioner was seen by neurologist Mohammad Ghabra on May 4, 2017, Dr. Ghabra noted injuries to Petitioner's head, neck, both shoulders, and right knee as a result of being attacked by a psychiatric patient at work on January 19, 2017 (Pet. ex 4). Also, when the Petitioner was seen by Roger Lichtenbaum on September 28, 2017, Dr. Lichtenbaum noted injuries to Petitioner's eye, right knee, and cervical spine as a result of being attacked by a patient at work (Pet. ex 5).

Petitioner was seen by psychologist Daniel Kelley on February 7, 2017. Dr. Kelley noted that the Petitioner was suffering from severe anxiety symptoms after being physically assaulted at work on January 19, 2017 (Pet. ex 3).

The Arbitrator notes the fact that the Respondent has not offered any contrary medical evidence on the issue of causal connection with regard to any claimed injury.

Therefore, based on the foregoing, the arbitrator finds that Petitioner's condition of ill-being regarding her emotional/psychological condition and physical injury to her left eye, head, neck, both arms, lower back, and right knee is causally related to her injury of January 19, 2017.

(J) In support of the Arbitrator's decision with regard to whether the medical services that were provided to Petitioner were reasonable and necessary and whether Respondent paid all appropriate charges for reasonable and necessary medical treatment, the Arbitrator makes the following conclusions of law:

The Arbitrator, incorporating the findings made in (F) above, finds that all of the medical services provided to Petitioner were reasonable and necessary.

(K) In support of the Arbitrator's decision with regard to whether Petitioner is entitled to any prospective medical care, the Arbitrator makes the following conclusions of law:

The uncontradicted testimony of the Petitioner is that prior to her employment accident and injury sustained at work on January 19, 2017, she was feeling fine with no prior problem with her right knee. Her further uncontradicted testimony is that she injured her right knee when she was attacked by a male psychiatric patient at work on January 19, 2017, and after diagnostic testing (MRI and CT Arthrogram)(Pet. ex 7 & 8), surgical repair is necessary as prescribed by orthopedic surgeon Roberto Levi to repair a torn medical meniscus and Baker's cyst in Petitioner's right knee (Pet. ex 2). The need for surgical repair of the Petitioner's right knee is verified by the records of Dr. Levi (Pet. ex 2). Since March 6, 2017, after review of the diagnostic tests performed at Edgebrook Radiology on February 22, 2017 (Pet. ex 7 & 8), and up to the present time, Dr. Levi has prescribed and recommended right knee surgery, (Pet. ex 2), and both the Petitioner and Dr. Levi have been waiting for a long time for the Respondent's approval for right knee surgery to repair the tear of Petitioner's right medial meniscus. The Petitioner has testified that she continues to experience significant pain and discomfort in her right knee that affects her ambulation and normal activities of life, and if ordered, she will undergo the surgery recommended and prescribed by Dr. Levi.

The Arbitrator cannot ignore the fact that the Respondent has not offered any medical evidence in contradiction of the Petitioner's need and desire for right knee surgery as testified to by the Petitioner and as noted by the records of Dr. Levi (Pet. ex 2). Nor was evidence presented to rebut Petitioner's need for prospective emotional/psychological care. The Arbitrator orders that Respondent shall authorize and pay for the prospective right knee surgery as recommended by Dr. Roberto Levi, including any and all reasonable incidental care thereto, as well as authorize and pay for the prospective emotional/psychological care.

(L) In support of the Arbitrator's decision with regard to whether temporary benefits are in dispute, the Arbitrator makes the following conclusions of law:

In support of the Arbitrator's finding on the issue of TTD, Petitioner has testified that she has been off from work due to injuries sustained at work on January 19, 2017, and she has been

off from work at the direction of her treating physicians for the period of January 20, 2017 through the present (6-12-18). The Arbitrator deems the aforementioned testimony of Petitioner on the issue of TTD to be credible upon review of the medical records in evidence.

While the records from Physician's Immediate Care on January 24, 2017, suggest that Petitioner return to work without restriction (Pet. ex 1), their return to work without restriction does not seem credible in light of the Petitioner's complaints as well as the findings both diagnostically and upon exam by Petitioner's treating physicians. What is deemed more credible is orthopedic surgeon Roberto Levi's opinion, who has Petitioner off from work from February 6, 2017 through the present, and notes significant objective findings including multiple disc herniations of the cervical spine and a torn medial meniscus and a Baker's cyst in the right knee that requires surgical intervention (Pet. ex 2). Also, neurologist Mohammad Ghabra refers in his notes to the multiple disc herniations found diagnostically along with continuing post-traumatic headaches experienced by Petitioner when she was seen by the doctor on May 4, 2017 and May 27, 2017 (Pet. ex 4). In addition, Dr. Daniel Kelley, the psychologist, notes after his exam on February 7, 2017 that Petitioner presents with severe anxiety symptoms, and Petitioner requires a continued leave of absence due to her emotional psychological dysfunction (Pet. ex 3).

(M) In support of the Arbitrator's decision with regard to whether penalties or fees should be imposed upon Respondent, the Arbitrator makes the following conclusions of law:

Through the Request for Hearing, Petitioner claims entitlement to penalties pursuant to Sections 16, 19(k) and 19(l) of the Act. In support of the Arbitrator's finding that no penalties, pursuant to 19(k), 19(l) or Section 16 of the Act are awarded, the Arbitrator finds that although (1) Petitioner has been off from work as a result of injuries sustained while in the course of her employment for the Respondent from January 20, 2017 through June 12, 2018 (72 4/7 weeks) and (2) Respondent has not paid her any TTD during the entire period of time she was off from work, Respondent has paid benefits to Petitioner under the Public Employee Disability Act (PEDA) and has a good faith basis under PEDA to claim that such payments can be made instead of TTD under the Workers' Compensation Act. Petitioner testified she has received extended benefits pursuant to PEDA, and that those benefits began three months after the date of accident.

In regard to Section 19(l) penalties, where a demand for benefits has been made, the employer has the burden of justifying its good-faith belief that a claim is invalid or that an award is not supported. *R.D. Masonry, Inc. v. Indus. Comm'n,* 215 Ill. 2d 397, 409, 830 N.E.2d 584, 592 (2005). The employer's belief is justified only if the facts which a reasonable person in the employer's position would have would justify it. *Id.* Respondent claims it had a good-faith belief that Petitioner did not suffer a knee injury, as she did not list it among her injured body parts in any of her three contemporaneous written statements. Therefore, penalties are inappropriate under this section with regard to any refusal to pay benefits related to Petitioner's knee.

Further, if Petitioner is seeking 19(l) penalties with regard to the late payment of TTD benefits, the Commission has declined to award such penalties where Petitioner has received PEDA benefits and has not made Respondent aware of a late payment until long after the late

period has passed. *Lenora Rogers, Petitioner*, 12 IL. W.C. 21264 (Ill. Indus. Com'n May 31, 2017). Here, there is no evidence that Petitioner informed Respondent that TTD or PEDA benefits were not timely paid. Therefore, penalties are not appropriate under this Section.

In regard to Sections 16 and 19(k), these remedies addresses situations where there is not only delay, but the delay is deliberate or the result of bad faith or improper purpose. *Zitzka v. Industrial Comm'n,* 328 Ill.App.3d at 849, 262 Ill.Dec. 945, 767 N.E.2d at 408. Section 19(k) penalties and Section 16 attorney fees, therefore, require a higher standard than section 19(l) penalties. Penalties under these sections require more than inadvertence, neglect, or a lack of good and just cause in denying benefits. *McMahan v. Industrial Comm'n*, 289 Ill.App.3d 1090, 1093, 225 Ill.Dec. 292, 683 N.E.2d 460, 463 (1997), aff'd, 183 Ill.2d 499, 234 Ill.Dec. 205, 702 N.E.2d 545 (1998). Further, under *Hollywood Casino v. IWCC,* 2012 Ill. App. 2d 110426, the Appellate Court held that the Commission cannot award 19(k) penalties for Respondent's failure or delay to approve or authorize medical treatment.

Petitioner has not met her burden proving entitlement to Section 19(l) penalties, she did not and could not prove entitlement to 16 or 19(k) benefits, as they require a higher standard of vexatious conduct by the Respondent.

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

Shannon Stiles,
Petitioner,
vs.

NO: 15 WC 02493

LaSalle County Sheriff's Office,
Respondent.

19IWCC0210

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 24, 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: APR 2 9 2019
o040419
SM/mw
044

Stephen J. Mathis
Stephen Mathis

Deborah L. Simpson
Deborah Simpson

Marc Parker
Marc Parker

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

STILES, SHANNON
Employee/Petitioner

Case# **15WC002493**

15WC002494

LaSALLE COUNTY SHERIFF'S OFFICE
Employer/Respondent

19IWCC0210

On 4/24/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.98% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in 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 ET AL
CHRISTOPHER MOSE
77 W WASHINGRTON ST 20TH FL
CHICAGO, IL 60602

0263 HERBOLSHEIMER DUNCAN ET AL
WILLIAM P HINTZ
654 1ST ST SUITE 400
LaSALLE, IL 61301

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
19(b)

Shannon Stiles
Employee/Petitioner

v.

LaSalle County Sheriff's Office
Employer/Respondent

Case # 15 WC 2493

Consolidated cases: 15 WC 2494

19IWCC0210

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Barbara N. Flores**, Arbitrator of the Commission, in the city of **Kankakee**, on **March 16, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, February 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* causally related to the accident as explained *infra*.

In the year preceding the injury, Petitioner earned $47,840.00; the average weekly wage was $920.00.

On the date of accident, Petitioner was 39 years of age, *married* with 1 dependent child.

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

Respondent shall be given a credit of $445.28 for TTD, $2,485.08 for TPD, $0 for maintenance, and $2,760.00 for other benefits (i.e., advanced permanent partial disability payment), for a total credit of $5,690.36. *See* AX1.

Respondent is entitled to a credit of $0 under Section 8(j) of the Act. *See* AX1.

ORDER

As explained in the Arbitration Decision Addendum, the Arbitrator finds that Petitioner's condition of ill-being in the spine is causally related to her undisputed accident at work to the extent opined by Dr. Frank who placed her at maximum medical improvement.

Medical Benefits

Respondent shall pay Petitioner $35.00 for out-of-pocket costs.

Permanent Partial Disability (Person as a Whole)

As explained in the Arbitration Decision Addendum, based on the factors delineated in Section 8.1b of the Act, and the totality of the record, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 1% loss of use of person as a whole (low back) pursuant to §8(d)2 of the Act.

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

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

Signature of Arbitrator

April 23, 2018
Date

ICArbDec19(b) p 2

APR 24 2018

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

Shannon Stiles
Employee/Petitioner

v.

LaSalle County Sheriff's Office
Employer/Respondent

Case # **15** WC **2493**

Consolidated cases: **15** WC **2494**

19IWCC0210

FINDINGS OF FACT

A consolidated hearing was held in both above-captioned cases. Arbitrator's Exhibit[1] ("AX") 1; AX2. The issues in dispute in this case include causal connection, Respondent's liability for certain unpaid medical bills, Petitioner's entitlement[2] to temporary total disability benefits from February 28, 2013 through March 6, 2013, whether she is entitled to prospective medical care in the form of a hip surgery as ordered by Dr. Salehi. AX1. The parties have stipulated to all other issues. *Id.* The issues in dispute related to Petitioner's claimed accident on January 14, 2015, including Petitioner's entitlement to prospective medical treatment are addressed in the concurrent decision issued in Case No. 15 WC 2494.

Shannon Stiles (Petitioner) testified that she was employed as a Deputy Officer by LaSalle County Sheriff's Department (Respondent). On February 16, 2013, she was booking an inmate when she walked around her desk and tripped on an electrical cord. She explained that the inmate offered to assist her.

On February 14, 2013, two days before her accident, the records of Riverside Chiropractic show that Petitioner received manipulations for a dull ache in her low back and neck. PX2. Petitioner acknowledged that she had experienced pain in her back off and on in the years prior to this injury. She testified that her back would hurt on occasion, depending upon what she did. She testified that this injury aggravated her condition and resulted in constant pain across her pelvic area from hip to hip. After this injury, she had never felt pain from her neck to her tailbone as she did after her injury.

On February 25, 2013, Petitioner went to the Emergency Room at Morris Hospital for bilateral lower back pain due to a fall. She was evaluated, given a prescription for Norco and was discharged with a diagnosis of a lumbar strain/spasm. PX1.

Petitioner sought treatment at Riverside Chiropractic. The records demonstrate that she had been a patient at this clinic on several occasions dating back to 2009 for episodic low back pain and received chiropractic manipulations. She was seen on February 14, 2013 reported that she had a local dull ache in the low back and neck. PX2.

On February 26, 2013, she saw chiropractor Dr. Sean Gibbs and reported dull to sharp pain in her low back. She received chiropractic manipulations from Dr. Gibbs on that day and had further manipulations

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

[2] Respondent disputes that Petitioner is entitled to temporary total disability benefits, but acknowledged that Petitioner was paid for 4 days of temporary total disability benefits. AX1.

approximately twice per week through March 25, 2013. On March 25th, she reported that, while she had been experiencing pain while sitting, standing was also becoming painful. PX2. Dr. Gibbs referred her to a Physiatrist, Dr. Lawrence Frank, of Spine & Sports Physicians. PX3.

Petitioner saw Dr. Frank on April 4, 2013. He reported that Petitioner had low back pain bilaterally and also some right trunk pain which started when she tripped on cords at work and fell on February 16, 2013. Dr. Frank diagnosed a lumbar sprain and strain and recommended she be limited to a 6-hour work day, she start physical therapy, and prescribed Flexiril, Daypro, and Prednisone. PX3. She began physical therapy at OSF St. Elizabeth Medical Center on April 12, 2013. PX4.

Petitioner returned to Dr. Gibbs on April 17, 2013 and reported that physical therapy had been helpful and the intensity and frequency of her pain had decreased. PX2. Petitioner returned to see Dr. Frank on April 25, 2013 and he recorded that she felt 80% better. He recommended she increase her work capacity and continue physical therapy. PX3. On April 29th, she returned to Dr. Gibbs and reported that she was feeling a lot better, her pain was less intense and frequent, and was almost back to her pre-injury status. She was able to walk without much pain, though if she sat for an hour and a half she would develop sharp pain in the area of her tailbone. Dr. Gibbs performed manipulations and recommended massage. PX2.

Petitioner completed her physical therapy on May 7, 2013, and she ranked her pain as a 0-2/10. PX4. On May 9, 2013, she saw Dr. Frank again and he recorded that since her last visit she had completed physical therapy, was performing home exercises, and her symptoms were 100% better. He released her to full duty and advised her to continue home exercises and take Tylenol for pain. PX3. On May 14, 2013, she saw Dr. Gibbs and he reported that she had a local dull ache in her low back which was very mild. She also reported a mild dull ache in her neck. Dr. Gibbs recommended massage and Petitioner informed him that her workers' compensation case was closed. Dr. Gibbs recommended a plan consisting of treatment every two weeks. PX2. On May 22, 2013, she returned to Dr. Frank and he found her to be at maximum medical improvement. PX3.

On May 28th, Dr. Gibbs reported that Petitioner was feeling good and was back to full duty work without much pain. She reported that she still had a dull ache in her low back and mid back. Dr. Gibbs released her from care for the "WC" case. Petitioner continued to see Dr. Gibbs on June 11th, June 27th, July 9th. In all those visits, she complained of a dull ache in either her low back or her mid back. PX2.

Respondent had Petitioner examined, pursuant to Section 12 of the Act, by Dr. Mark Levin on May 2, 2017. Dr. Levin performed an exam, though he acknowledged that Petitioner had sustained a second injury on January 14, 2015 and reserved his opinions regarding that injury for a separate report. He reviewed the records from Riverside Chiropractic and noted that she had received treatment there in 2009, 2010, 2011, 2012, and 2013, and had received treatments for back and neck pain prior to her injury of February 16, 2013. He opined that her injury of February 16, 2013, "would have been the potential of an acute lumbar myofascial strain" [sic] but this did resolve and she did obtain maximum medical improvement by May 22, 2013 after which she was capable of full duty work. RX4. On October 4, 2017, Respondent called Dr. Levin as a witness and he provided testimony at an evidence deposition. RX7. Dr. Levin testified consistent with the information contained in his reports and further explained his opinions regarding Petitioner's condition and its relatedness, if any, to his accident at work. *See generally* RX7.

At the request of the Respondent, a Utilization Review was performed to determine whether the chiropractic services rendered by Dr. Gibbs at Riverside Chiropractic were reasonable and necessary. RX5. While the reviewer certified six visits, any remaining chiropractic treatment after March 2013 was non-certified. The

reviewer reasoned that, while there were some initial positive results from massage, subsequent medical records indicated no progress, nor evidence, of functional improvement and, therefore, the massage therapy was not recommended. There was no appeal of the utilization review.

Petitioner testified that after she stopped treatment following this injury she continued to have some pain in her lower back, which was different than her condition before the accident when she only experienced episodic back pain if she was too active physically.

ISSUES AND CONCLUSIONS

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

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

To recover in a preexisting condition case, a claimant need only establish a causal connection between her work-related injury and claimed current condition of ill-being by showing that his injury aggravated or accelerated the preexisting disease. *Sisbro, Inc. v. Industrial Commission*, 207 Ill. 2d 193, 204-206, (2003) (*citing Caterpillar Tractor Co. v. Industrial Commission*, 92 Ill. 2d 30, 36-37 (1982) (an accidental injury will be deemed compensable if it can be shown that the employment was also a causative factor)). It has long been held that an employer takes its employees as it finds them. *Sisbro*, 207 Ill. 2d at 205 (*citing Baggett v. Industrial Commission*, 201 Ill.2d 187, 199 (2003)).

The records reflect that Petitioner had been under conservative medical care with a chiropractor for dull low back symptoms shortly before the undisputed accident occurred at work. She testified that her symptoms after the accident. Specifically, that she never felt pain from her neck to her tailbone as she did after her injury. Petitioner's treating physiatrist, Dr. Frank found that Petitioner reached maximum medical improvement on May 22, 2013. Based on the foregoing, the Arbitrator finds that Petitioner's current condition of ill-being is causally related to her accident at work on February 16, 2013 to the extent opined by Dr. Frank who placed her at maximum medical improvement.

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

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

As explained more fully above, the Arbitrator finds that Petitioner's current condition of ill-being is causally related to her injury at work. The medical bills submitted into evidence related to Petitioner's spine are for reasonable and necessary medical care to alleviate her of the effects of her injury at work. Petitioner submitted the medical bills from Riverside Chiropractic Clinic. PX2. These bills show that after her accident Petitioner received manipulations on 17 occasions from February 26, 2013 through May 14, 2013. The charges for these visits total $1,694.20. However, Respondent submitted a utilization review non-certifying Petitioner's chiropractic treatment beyond six visits. The bills demonstrate that Petitioner paid $35.00 herself on March 9, 2013 and the remainder was paid by Respondent or adjusted by the clinic. Thus, the Arbitrator awards $35.00 for the out-of-pocket cost incurred by Petitioner for treatment that remains unpaid.

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

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

The record reflects that Petitioner was paid for the period of time that she was off work and Respondent is entitled to a credit in the amount of $445.28. Thus, the Arbitrator finds that no temporary total disability benefits are owed.

In support of the Arbitrator's decision relating to Issue (O), whether Petitioner is at maximum medical improvement and, if so, the nature and extent of the injury, the Arbitrator finds the following:

Based on the totality of the record, the Arbitrator finds that Petitioner has reached maximum medical improvement as indicated by her treating physicians and that she sustained a lumbar sprain/strain.

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

> For accidental injuries that occur on or after September 1, 2011, permanent partial disability shall be established using the following criteria:
>
> (a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall report the level of impairment in writing. The report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment. The most current edition of the American Medical Association's "Guides to the Evaluation of Permanent Impairment" shall be used by the physician in determining the level of impairment.

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

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

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

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

With regard to Subsection (ii) of Section 8.1b(b), the occupation of the employee, the Arbitrator notes that Petitioner was employed as a Deputy Corrections Officer. The Arbitrator therefore gives this factor greater weight.

With regard to Subsection (iii) of Section 8.1b (b), the Arbitrator notes the parties' stipulation that Petitioner was 39 years old at the time of accident. The Arbitrator therefore gives this factor greater weight.

With regard to Subsection (iv) of Section 8.1b(b), the Petitioner's future earning capacity, the Arbitrator notes that no credible evidence was proffered regarding any loss Petitioner's future earning capacity. The Arbitrator therefore gives this factor greater weight.

With regard to Subsection (v) of Section8.1b(b), evidence of disability corroborated by treating medical records, the Arbitrator notes that Petitioner has established that she sustained a lumbar strain as a result of her undisputed accident at work with some continuing symptomatology. The Arbitrator therefore gives this factor greater weight.

Based on the above factors, and the totality of the record, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 1% loss of use of person as a whole pursuant to §8(d)2 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
KANKAKEE

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

SHANNON STILES,

Petitioner,

vs. NO: 15 WC 02494

LaSALLE COUNTY SHERIFF'S OFFICE,

Respondent.

19IWCC0211

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b)/8(a) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, temporary total disability, prospective medical care and permanent partial disability, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. Petitioner was a Corrections Officer for Respondent.

2. On January 14, 2015 Petitioner was taking a class which would enable her to work overtime. When she was released for lunch, she went to the restroom, then exited the building carrying her keys in her hand. As she was walking to her vehicle and looking straight ahead, she tripped over a brick and fell. She landed on both hands and knees. She testified that there was snow on the ground at the time.

3. Petitioner had no immediate pain, but by the time she returned from her hour-long lunch she noticed pain in her left knee all around her kneecap. She testified that it felt like a rock had been smashed against her kneecap. She completed her training and had a scheduled day off the following day. She returned to work on January 16, 2015 but had a lot of knee and back pain.

4. Petitioner presented to Dr. Syed at Liberty Medical Center later that day. She complained of knee pain with full extension, swelling and tenderness, and stated that it was painful to sit. She also complained of aching neck, low back and bilateral hip pain. She was taken off work and completed an accident report.

5. On January 22, 2015 Petitioner still had pain and swelling. She was referred for physical therapy and returned to light duty work until she completed a physical therapy evaluation.

6. To fulfill the light duty order, Respondent placed Petitioner in the Master Control Room, where she opened and unlocked heavy doors and checked in visitors and medical staff. This job was difficult for her due to her inability to sit for long periods and having to scoot around in a roller chair. This led to increased knee pain and swelling.

7. On January 27, 2015 Dr. Syed diagnosed a sprain and strain of the left knee. He took Petitioner off work again.

8. Petitioner began physical therapy on February 10, 2015.

9. On March 17, 2015 Petitioner treated with Dr. Chilelli, who examined her and found medial and lateral joint line tenderness. He diagnosed left knee pain and recommended an MRI to check for a meniscus tear. Three days later, an MRI revealed no evidence of a meniscus or ligament tear, but did show mild diffuse thinning and fraying of the patellar articular cartilage.

10. On April 2, 2015 Dr. Chilelli diagnosed a likely left knee soft tissue contusion and released Petitioner to light duty. Petitioner was again given a position in the Master Control Room.

11. On April 7, 2015 the majority of Petitioner's pain was in the anterior portion of her left knee. However, she also had low back pain, radiating pain to her ankle and right knee pain. Dr. Mathew reviewed lumbar X-rays and found minimal disc space narrowing at L4-5 and L5-S1. Three days later a lumbar MRI revealed mild left facet arthropathy at L5-S1, mild left neural foraminal stenosis without mass effect on the existing nerve root and a mild disc bulge and posterior annular fissure at L4-5.

12. On April 17, 2015 Petitioner continued complaining of low back pain. Dr. Mathew opined that the lumbar MRI did not show any significant findings that would require surgery, and that the findings were degenerative.

13. Petitioner underwent trial L4-5 epidural injections on April 29, 2015 and May 13, 2015. Neither injection provided significant relief and Petitioner still had intermittent left knee pain. Dr. Mathew stated that the left knee pain was unlikely to be discogenic since the injections did not reduce pain. She opined that the left knee pain was due to chondromalacia from the patellar.

14. On June 3, 2015 the physical therapist noted Petitioner had deficits in lower extremity strength, swelling and increased pain.

15. On July 6, 2015 Petitioner reported her pain was improving, but sitting for prolonged periods at work still caused pain.

16. On July 21, 2015 Petitioner reported 0 low back and left knee pain on a scale of 1 to 10. She had no pain 95% of the time and was pleased with her functional status. She testified that her pain depended on her amount of activity on a given day. Regarding her back pain, she stated that prolonged sitting was a major issue and standing was an issue.

17. On July 22, 2015 Petitioner testified that she tripped over her dogs at home and did "the splits" and landed on her buttocks. She testified that she experienced a new onset of pain at that time on the right side of her body. A Morris Hospital Emergency Room record on that date diagnosed Petitioner with a right hip strain.

18. On July 24, 2015 Dr. Mathew noted that Petitioner's left knee and low back pain had resolved with physical therapy. Her new symptoms included severe right groin and buttocks pain radiating to her leg and occasionally her foot. She also had associated numbness and tingling. Dr. Mathew diagnosed right lumbar radiculitis.

19. On July 28, 2015 Petitioner complained of severe low back pain radiating to her leg.

20. On August 21, 2015 Petitioner reported that she was doing much better, although she could not sit or walk for long periods. She complained of left knee pain.

21. On September 10, 2015 Petitioner reported worsening pain in her left posterior thigh radiating to her knee, with intermittent numbness and tingling to her left foot. Due to the aforementioned epidural injections, Dr. Mathew opined that disc pathology was probably not the cause of this pain.

22. On October 15, 2015 Petitioner complained of intermittent numbness and tingling in all four extremities. It was acknowledged that Petitioner had a bulging disc at L4. A cervical

MRI revealed a disc bulge at C5-6 causing mild central canal stenosis, and a disc bulge at C6-7 causing mild foraminal narrowing.

23. Petitioner treated conservatively for her cervical and lumbar conditions, but at trial testified that no treatment provided permanent relief.

24. On October 31, 2016 Petitioner presented to Dr. Komanduri, an orthopedic surgeon, complaining of neck, low back, hip and left knee pain. Dr. Komanduri opined that Petitioner sustained left knee, bilateral hip and bilateral shoulder injuries on the accident date. He opined that Petitioner's complaints were not related to a cervical or lumbar injury. He believed instability and muscle spasms in the trapezius and latissimus musculature were near the cervical spine, and thus mis-diagnosed as a cervical condition. A left knee exam revealed joint line tenderness, a positive McMurray's sign, and patellofemoral instability with fixed lateral subluxation consistent with chronic pain associated with a meniscal tear.

25. Dr. Komanduri also found evidence of bilateral shoulder Type II SLAP lesions and instability, as well as a femoroacetabular impingement in Petitioner's left hip with a probable labral tear.

26. Dr. Komanduri opined that Petitioner's twisting injury and direct blow to the knee upon falling caused a meniscal tear. Since the tear had been left untreated, Dr. Komanduri opined that it had since led to chronic patellofemoral instability. Based on the physical exam he performed, Dr. Komanduri opined that the March 20, 2015 left knee MRI revealed a false negative result. He termed the left knee causation "pretty straightforward."

27. Dr. Komanduri acknowledged that, while femoroacetabular impingement is a congenital condition, it is not guaranteed to become symptomatic. He noted that it possibly became symptomatic due to Petitioner's fall.

28. With regards to Petitioner's bilateral shoulder conditions, Dr. Komanduri opined that Petitioner fell directly onto her outstretched arms, which could have caused her injuries.

29. Dr. Komanduri opined that Petitioner did not require any further back treatment, and recommended MRI's for her left hip, left knee and MR Arthrograms for both shoulders. Any further treatment would depend on the results.

30. Dr. Komanduri acknowledged Petitioner's statements in July 2015 that her low back and left knee pain had resolved. He believed this was simply due to temporary relief from physical therapy. He also acknowledged that Petitioner's trip and fall over her dogs at home was an aggravating incident, but did not believe that this negated the accident in question.

31. Petitioner was terminated by Respondent February 1, 2017.

32. Dr. Levin performed an Independent Medical Exam (IME) on Petitioner on May 2, 2017. He noted multiple subjective complaints which could not be corroborated objectively. He noted Petitioner had illogical complaints, such as tingling down her arms when he pressed on her neck, low back pain when he pressed on her ear lobe, and numbness in her fingers when he squeezed her arm. Chiropractic records as far back as 2009 indicated Petitioner was already treating for chronic neck and lumbar pain. Further, Dr. Levin was unable to find any objective corroboration for Petitioner's bilateral shoulder and left hip conditions, and a left knee MRI revealed no acute traumatic changes.

33. Dr. Levin had Petitioner complete pain questionnaires, and stated that her scores were elevated, suggesting symptom magnification. He opined that her score levels were that of a person who was incapacitated and not very functional.

34. Petitioner underwent a left knee MRI on July 6, 2017. Dr. Komanduri reviewed the results and diagnosed a "pretty clear" medial meniscus tear in the left knee with probable anteromedial plica.

35. On August 17, 2017 Dr. Komanduri performed arthroscopic surgery on Petitioner's left knee. He noted a large anteromedial plica impinging on the patellofemoral joint, grade 3 chondral wear of the patella and a small posterior horn lateral meniscus tear.

36. Petitioner began post-operative physical therapy on August 30, 2017. Records indicate that the plan was to have Petitioner treat 2-3 times weekly for 4 weeks. Her long-term goals of decreased pain, increased range of motion to allow for kneeling, increased strength to allow for squatting and sleeping over 6 hours were scheduled to be reached by October 4, 2017. A return to full duty work was also contemplated.

37. On October 27, 2017 Petitioner cancelled all future physical therapy appointments on advice from her Counsel and physician.

The Commission affirms the Arbitrator's rulings on causal connection, medical expenses, temporary total disability and prospective medical care as they pertain to Petitioner's cervical spine, lumbar spine, bilateral lower extremity and bilateral shoulder conditions.

However, the Commission modifies the Arbitrator's award with regards to Petitioner's left knee condition. The Commission views the evidence slightly different than does the Arbitrator, finding Dr. Komanduri's causal connection opinion on Petitioner's left knee condition to be more persuasive than that of Dr. Levin's. Dr. Levin found no objective evidence suggesting an accident or aggravation to Petitioner's left knee occurred on the date in question, including a left knee MRI that revealed no acute traumatic changes. However, Dr. Komanduri examined Petitioner's left knee in October 2016 and found joint line tenderness, a positive McMurray's sign, and patellofemoral instability with fixed lateral subluxation consistent with chronic pain associated

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with a meniscal tear. He opined that Petitioner's twisting injury and direct blow to the knee upon falling on the date in question caused a meniscal tear. Further, since the tear had been left untreated, it had since led to chronic patellofemoral instability. Based on this exam, Dr. Komanduri opined that the March 2015 left knee MRI which revealed no acute injuries was simply a false negative result. Dr. Komanduri's opinion was confirmed during his August 17, 2017 arthroscopic surgery on Petitioner's left knee. The surgery revealed a large anteromedial plica impinging on the patellofemoral joint, grade 3 chondral wear of the patella and a small posterior horn lateral meniscus tear. Accordingly, the Commission modifies the Arbitrator's causal connection ruling, and finds causal connection between the accident in question and Petitioner's left knee condition.

In keeping with the causal connection ruling. The Commission also modifies the Arbitrator's denial of temporary total disability benefits. Petitioner was taken off work from January 17, 2015 through January 21, 2015. She was taken off work again from January 27, 2015 through April 2, 2015. Thus, the Commission awards Petitioner temporary total disability benefits for Petitioner's left knee for a period of 9-3/7 weeks.

Additionally, the Commission finds that Petitioner voluntarily terminated further medical treatment on the advice of her Counsel and physician on October 27, 2017, thus giving rise to a determination of permanent partial disability benefits. Using the factors set forth in §8.1b of the Act, the Commission finds:

i. No reported level of impairment was offered into evidence, thus the Commission gives no weight to this factor;
ii. Petitioner was a Corrections Officer at the time of accident. Her employment lends itself to potentially demanding events. The Commission gives some weight to this factor;
iii. Petitioner was 41 years of age at the time of accident. She could potentially deal with any residual knee issues for the remainder of her career, which could be a significant amount of time. The Commission gives a significant amount of weight to this factor;
iv. Dr. Komanduri opined that there was a high likelihood that Petitioner would be able to return to her duties as a Corrections Officer. Moreover, physical therapy records provided a rehabilitation prognosis of "good" and contemplated a return to full duty work. Thus, there appears to be no change in Petitioner's future earning capacity with respect to her left knee condition. The Commission gives no weight to this factor;
v. Dr. Komanduri performed arthroscopic left knee surgery on Petitioner on August 17, 2017. Petitioner's physical therapy discharge record on October 27, 2017 indicated that she still struggled with getting up from a squat position and still had impairments related to range of motion and strength, although she was making improvements in these areas. Due to the fact that Petitioner has a good rehabilitation prognosis, the Commission gives some weight to this factor.

Based on these factors, the Commission finds that Petitioner sustained a 13.5% loss of

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use of her left leg.

Lastly, the Commission awards Petitioner all reasonable and necessary medical expenses related to her left knee condition from January 14, 2015 through her discharge date of October 27, 2017.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner suffered a left knee injury on January 14, 2015 that was causally related to her employment with Respondent.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $696.35 per week for a period of 9-3/7 weeks, that being the period of temporary total incapacity for work under §8(b).

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner all reasonable and necessary medical expenses related to Petitioner's left knee condition from January 14, 2015 through October 27, 2017 under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $626.40 per week for a period of 29.025 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused a 13.5% loss of use of her left leg.

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: APR 29 2019
O: 4/4/19
SM/wde
44

Stephen Mathis

Deborah L. Simpson

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION

NOTICE OF 19(b)/8(a) ARBITRATOR DECISION

STILES, SHANNON
Employee/Petitioner

Case# **15WC002494**

15WC002493

LaSALLE COUNTY SHERIFF'S DEPT
Employer/Respondent

19IWCC0211

On 4/24/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.98% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in 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 ET AL
CHRISTOPHER MOSE
77 W WASHINGTON ST 20TH FL
CHICAGO, IL 60602

0263 HERBOLSHEIMER DUNCAN ET AL
WILLIAM P HINTZ
654 1ST ST SUITE 400
LaSALLE, IL 61301

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
19(b) & 8(a)

Shannon Stiles
Employee/Petitioner

v.

LaSalle County Sheriff's Office
Employer/Respondent

Case # 15 WC 2494

Consolidated cases: 15 WC 2493

19IWCC0211

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Barbara N. Flores**, Arbitrator of the Commission, in the city of **Kankakee**, on **March 16, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ 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 14, 2015, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $54,288.00; the average weekly wage was $1,044.00.

On the date of accident, Petitioner was 41 years of age, *married* with 1 dependent child.

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

Respondent shall be given a credit of $0 for TTD, $0 for TPD[1], $0 for maintenance, and $0 for other benefits, for a total credit of $0. *See* AX2.

Respondent is entitled to a credit of $29,346.25 under Section 8(j) of the Act. *See* AX2.

ORDER

As explained in the Arbitration Decision Addendum, the Arbitrator finds that Petitioner sustained an accident at work on January 14, 2015, and further finds that Petitioner's claimed conditions of ill-being are not related to said accident. By extension, all other issues are rendered moot and all requested compensation and 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 of Arbitrator

April 23, 2018
Date

ICArbDec19(b) p 2

APR 24 2018

[1] The parties stipulated that there is no overpayment or underpayment at issue with regard to Petitioner's temporary partial disability period. *See* Arbitration Hearing Transcript.

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

Shannon Stiles
Employee/Petitioner

v.

LaSalle County Sheriff's Office
Employer/Respondent

Case # **15** WC **2494**

Consolidated cases: **15** WC **2493**

FINDINGS OF FACT

A consolidated hearing was held in both above-captioned cases. Arbitrator's Exhibit[2] ("AX") 2; AX1. The issues in dispute in this case include accident, causal connection, Respondent's liability for certain unpaid medical bills, Petitioner's entitlement to temporary total disability benefits from January 17, 2015 through January 21, 2015, January 27, 2015 through April 2, 2015, and September 10, 2015 through March 16, 2018, whether she is entitled to prospective medical care in the form of a hip surgery as ordered by Dr. Salehi. AX2. The parties have stipulated to all other issues. *Id.* The issues in dispute related to Petitioner's accident on February 16, 2013 are addressed in the concurrent decision issued in Case No. 15 WC 2493.

Accident

Shannon Stiles (Petitioner) testified that she was employed as a Deputy by LaSalle County Sheriff's Department (Respondent) assigned to the County Jail. On January 14, 2015, she was at Respondent's facility on Etna Road and was attending a class on methamphetamine. She testified that she was paid for this class. Petitioner testified that when the class recessed for lunch she walked through the criminal court building to the parking lot where her car was parked. She hadn't use that entrance very often in the past. She testified that this was the natural egress for her because it would not be prudent to walk through the jail area if she did not have business in the jail, which she did not on that day. This parking lot is open to the general public.

Petitioner testified that after she exited the building she walked towards her car while holding her car keys in her hand. Her car keys had a large black key fob which she estimated was approximately 2-1/2 inches long to 1" wide. She testified that she was not holding her cell phone. She also testified that she was looking ahead as she walked and was not looking at anything in particular. As she was walking, she felt her foot catch on a brick and she fell forward and landed on both hands and knees. She described this as a hard fall which caused a rip in the left knee of here pants. She testified that she also scuffed her new shoes.

After she fell, Petitioner explained that she looked back and saw that she had tripped over an area of landscaping brick which was raised higher than the surrounding cement. She observed that she had tripped on bricks which were raised slightly higher than the surrounding sidewalk. Petitioner acknowledged that nothing obstructed the sidewalk or her path while she was walking and that she was not required to walk over the landscaping brick.

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

Petitioner testified that Donna Ortiz and another individual came out and asked if she was alright. She testified that at that time the only thing she felt was embarrassed. She then went to her car and drove to lunch. During that time, she noticed pain in her left knee located above, below, and on her kneecap. She described it as feeling like a rock had smashed her left knee.

Respondent presented Sergeant Donna Ortiz as a witness. She testified that on January 14, 2015 she was employed as a Deputy Sheriff of court Security and was stationed at the north end entrance of the criminal court building located on Etna Road in Ottawa. She was standing by the metal detector inside the entrance area in the main lobby. At that time, she observed Petitioner—whom she knew to be a Corrections Officer – walk past her and exit the building. She believed Petitioner had something in her hand. She testified that she observed Petitioner fall when she was approximately 12 to 15 feet from the door about where the landscaping bricks start. She testified that she believed Petitioner was looking at her phone at the time she fell. On cross-examination, she acknowledged that she was standing behind Petitioner at some distance and could not really tell what she was looking at.

After Petitioner fell, Sergeant Ortiz testified that she immediately went outside to Petitioner and when she got there Petitioner was already standing. When she asked Petitioner if she needed help Petitioner said, "No. I'm fine." Petitioner was able to walk to her car and was not limping.

Respondent also presented Sergeant David Woolford at a witness. He testified that on January 14, 2015 he was working for Respondent as a day shift corporal at the Sheriff's Office. He was sitting at a desk with video monitors near the front entrance. He testified that he heard a commotion near the front door and looked at a video monitor which showed the front entrance, there he saw Petitioner on the ground outside the office on her knees. He testified that she was on an area of landscaping brick in front of the door. He marked the area where he saw Petitioner toward the middle of the area of landscaping brick. He acknowledged that he did not see Petitioner fall and that camera which provided the video did not record at all. He acknowledged on cross-examination that since he was attempting to remember the event three years prior he could be mistaken about the exact location where Petitioner had fallen.

After Petitioner fell, Sergeant Woolford observed her get up and walk to the parking lot. He later saw her when she came back from lunch. She came up and asked him if the camera had recorded her fall so she could watch it.

Respondent's presented an affidavit from Ms. Lori Missel. According to her affidavit, Ms. Missel was familiar with Petitioner and was present when she fell on January 14, 2015. After Petitioner fell she went out to assist her and saw that Petitioner had her cell phone in her hand. RX16.

Petitioner submitted photos of the entrance area outside of the Sheriff's office which she and her husband took later in the day that she fell. These photos depict that the area between the parking lot and the front door contained sidewalk and also an area of landscaping bricks. There were essentially three strips of sidewalk: one sidewalk which ran along the side of the parking lot, and two other sidewalks which ran from separate areas of the parking lot to the door, converging outside the front door. These three sidewalks created a triangle, the inside of which was occupied by the landscaping bricks. PX18.

Petitioner's photos, demonstrate that the landscaping bricks were not flush with the sidewalks but were slightly higher. There was no measurement to show how much higher the landscaping bricks were than the sidewalk but from the scale seen in the photos, it appears to the Arbitrator than the bricks were a half-inch to perhaps one

inch higher than the sidewalk. Respondent also introduced photos of the entrance area which were taken on January 21, 2015 and these photos also demonstrate that the bricks were a half-inch to one inch higher than the sidewalk. RX6. Both sets of photos show that orange cones were placed around the perimeter of the landscaping bricks, though all witnesses agree that the cones were not there at the time that Petitioner fell.

Petitioner marked the area where she fell on the photos to show that she had fallen at a spot where the landscape bricks met the sidewalk. Donna Ortiz marked also marked a spot on the bricks near the sidewalk. David Ortiz marked a different spot, near the middle of the bricks, but acknowledged that he might inaccurately remember the location. Respondent acknowledged that it owned and maintained the entrance area depicted in these photos.

Petitioner completed an incident report on January 16, 2015. In her report, she wrote:

> I was leaving the Sheriff's office for lunch break, when I exited the building I tripped on the uneven cement/brick pad. I went down on my knees and hands. When I got up I seen the rip in my left pant leg. I looked back to see what I fell on and then started walking to my car. At that time Dep. Donna Ortiz and another woman came outside to see if I was alright. I told them I think so, but very embarrassed. I walked to my car and caught my breath and realized my left knee was aching. I went to lunch and returned back to the Sheriff's office.
>
> When I got out of the car to head back into the Sheriff's Office for class I seen some orange cones near the entrance/exit area where I fell. As I walked in I was asked if I was "ok" by Wendy and Peggy. I stopped to talk to them and had shown them the rip in my jeans. I asked how they knew I fell and they advised Cpl D. Woolford had seen it on the monitor and mentioned that the person who fell hit hard. … I went back to class and the longer I sat there the worst my knee started to feel. I mentioned to Sgt. K. Von Ruden that I fell and after class I came over to the jail in order to get an injury report form. … I took the papers home to fill them out.
>
> On the night of 1/14/15 I had aching in my knee still which kept me up. During the day on 1/15/15 my knee was still aching and my neck and hips/lower back were bothering me. I made a doctor's appointment for 1/16/15.

PX17.

Medical Records

A month prior to her fall, on December 16, 2014, Petitioner saw Dr. Isaac Mezo of the Joliet Headache clinic because she had been noticing problems with memory and was getting lost frequently. She also reported that she was always tired, had frequent mood swings, and could not focus or concentrate. Dr. Mezo ordered bloodwork to check for causes for memory loss and referred her to neuropsychologist Michael Gelbort. PX21. She returned to Dr. Mezo on February 25, 2015 and he noted that her bloodwork was normal and that she had a neuropsychometric evaluation with Dr. Gelbort which revealed that her memory problems were caused by stress, anxiety, and depression. PX21. Petitioner testified that during that time her grandmother had died and her father was very ill.

Petitioner saw Dr. Hassain Syed of the Liberty Medical Center on January 16, 2015. He noted that Petitioner fell at work on 1/14 and had an open abrasion on her left knee and complained of pain with full extension and bending to 90 degrees with some swelling. She also complained of aching pain in her lower back and hips and

neck. Dr. Syed ordered X-rays of the left knee and restricted Petitioner from working. The X-rays were normal and on January 22nd, Dr. Syed referred her for physical therapy and light duty work.

Petitioner testified that she was already scheduled to be off work on January 15th. She reported to work on January 16th and was placed in the Master Control room. She was allowed to sit in a rolling chair but she had to stand up and physically open the door for anyone who wanted to come into the jail area. She also had to sign them in and out. Petitioner testified that the standing up and moving was painful for her knee. She attempted to elevate her leg but there was nothing on which she could prop up her foot.

She returned to Dr. Syed on January 27th and the doctor noted that she her knee pain had worsened while on light duty work. There were heavy doors that she had to open as well as get up and down from sitting to standing which increased her pain and swelling. Dr. Syed restricted her from working and asked her to follow up after she had a physical therapy evaluation. PX5.

Petitioner testified that she called St. Elizabeth Hospital in Ottawa to schedule physical therapy, but was told that they could not perform an initial evaluation for her until February 10th. Petitioner scheduled the evaluation for that date. She further testified that she received a phone call from the therapy department from St. Elizabeth's hospital in early February which informed her the claims adjuster had called them to schedule an earlier appointment for Petitioner the next day. Petitioner testified that this happened after a very heavy snow storm and her driveway was snowed in and was not able to get someone to give her a ride on such short notice and therefore could not attend the therapy appointment the next day.

Petitioner submitted photos that she took of her driveway after this exchange. These photos depict a driveway that is covered in deep snow which reached up to the rear bumper of a car. PX10.

On February 3, 2015, the claims adjuster Carol Gleason left a message with Petitioner's attorney complaining that the initial physical therapy evaluation was not scheduled until February 10th and stating that it was unacceptable. The adjuster acknowledged that she had no idea why the appointment was scheduled so far out and demanding the reason. The adjuster further acknowledged that she had not sent Petitioner a TTD check because Petitioner was a "municipality employee" [sic] and I'm not sure how they work it on that end." The claims adjuster called Petitioner's attorney again on the following day, February 4, 2015 and left a message accusing Petitioner of refusing to go to physical therapy or perform light duty for reasons which she did not "buy" or "like." She asserted that Petitioner's light duty job required her only to sit in a chair, watch a video monitor, and push buttons to open a door, and that since Petitioner earned more than $1,000 per week she should be able to pay someone to shovel her snow. Petitioner's attorney responded to the claims adjuster with an e mail which explained that the February 10th evaluation was set by the facility rather than Petitioner, and that Petitioner could not attend a therapy appointment scheduled by the adjuster at 6:30 the next day because she was snowed in and could not find a ride for so early the next day. He also explained that the light duty job provided to Petitioner required her to get up and down a lot which aggravated her knee. The claims adjuster responded to Petitioner's counsel by stating, "As a result of 'additional investigation' a decision has been made to deny the claim." PX19.

Petitioner began physical therapy on February 10th as scheduled. PX7.

On March 17, 2015, Petitioner saw Dr. Brian Chilelli of the Cadence Physician Group. He reported that Petitioner had fallen at work on 1/14/15 when there was snow on the ground when she slipped, twisted her knee and fell, and has had persistent pain in her left knee since that time. The pain was located diffusely around the

left knee, anterior, medial, and lateral, without any catching, locking, or instability. She reported that she had been in therapy for four weeks but it was not helping. His exam revealed a minimal amount of swelling, a minimal amount of crepitus with range of motion, and also medial and lateral joint line tenderness. He concluded that she had degeneration of cartilage or meniscus, and a possible tear. He ordered an MRI. This was performed on March 20th and did not reveal any tear but did show mild, diffuse thinning and fraying of the patellar articular cartilage and mild lateral shift and tilt of the patella. PX6.

She returned to Dr. Chilleli on April 2nd and he concluded that she likely had a soft tissue contusion. He released her to work for light duty and recommended she follow up with a physiatrist to rule out a myofascial component of her pain. PX6. Petitioner then saw Dr. Vinita Mathew, a physiatrist at Cadence, on April 7th. Petitioner reported that the majority of her pain was in the anterior portion of her left knee, but she also reported pain radiating down her leg to her ankle, and also low back pain and right knee pain which Petitioner attributed to limping from her left knee injury. She also reported that Petitioner said she had previously felt numbness in her shin which had resolved with therapy. Her current pain was worse with standing, walking, kneeling, sitting, and lying down. Dr. Mathew also reviewed X-rays of Petitioner's lumbar spine and felt they showed minimal disc space narrowing L4-5 and L5-S1. She diagnosed Petitioner as having lumbar radiculitis and stenosis and order MRIs of her lumbar spine. PX6.

The MRI was performed on April 10th and was read to show L5-S1 moderate left facet arthropathy resulting in mild left neural foraminal stenosis without mass effect on the exiting nerve root, left posterolateral annular fissure also present, mild disc bulge and posterior annular fissure L4-5. On April 17th, Petitioner saw Dr. Mathew again when it was reported that she continues to have low back pain, new onset of numbness down left leg and shin, and the symptoms have gotten worse since she returned to work light duty. Dr. Mathew felt the MRI did not show any significant findings which would require surgical intervention, and opined that Petitioner's injury had resulted in discogenic pain and recommended a trial of an epidural injection. These epidurals were performed on April 29, 2015 and May 13, 2015. PX6.

Petitioner returned to Dr. Mathew after the epidurals on May 29, 2015 and reported that she received no significant relief, and she still had intermittent left knee pain and low back pain and the pain worsened with standing, particularly in the left knee. Dr. Mathew opined that Petitioner's left knee pain was unlikely to be discogenic because the injections did not reduce it. She concluded that the left knee pain was due to chondromalacia from the patella. She further opined that Petitioner's back pain was due to degeneration of the lumbar intervertebral disc. She recommended physical therapy in order to strengthen Petitioner's musculature and asked Petitioner to follow up in six weeks. PX6.

Petitioner resumed physical therapy on June 3, 2015. The therapist noted that she had deficits in lower extremity strength, swelling, and increased pain. PX7. She continued in therapy and on July 6th she reported that her pain was getting better overall but sitting for prolonged periods at work was still painful. She rated her pain at a 2-3/10 prior to treatment and after treatment she had no pain except muscle soreness. On July 16th, she rated her pain at 2/10 both before and after treatment. On July 21st, she reported her pain was 0/10 in the low back and left knee and had no pain 95% of the time and was pleased with her current functional status though she continued to get back pain after sitting for a couple of hours. She further explained that her pain could get as high as a 7/10 after she has been sitting for a long period. PX7. Petitioner testified that she continued to have some pain in her low back and left leg at that time.

Petitioner testified that on July 22, 2015 she was with her dogs when she tripped over them. She explained that she did "the splits" with her legs going in different directions. She said she experienced a new onset of pain that

was primarily on the right side of her body. She testified that this was different pain than she had before and that it gradually improved, especially with physical therapy.

On July 22, 2015, Petitioner went to the emergency room at Morris Hospital for an evaluation of an injury to her right hip. She reported that she was working with her dog kennel when she slipped and did the splits; she denied direct trauma. She complained of pain in her right hip and her right posterior thigh. X-rays were taken of her pelvis and they were negative. She was discharged with a diagnosis of strain to the right hip. PX1.

On July 24, 2015, Petitioner returned to Dr. Mathew. Dr. Mathew recorded that Petitioner had new symptoms, that her left knee pain and low back pain had resolved with physical therapy which had been completed but the following day she stepped over her dogs and fell onto her hip and had severe pain in her right groin and buttocks radiating down into her leg and occasionally to her foot with some associated numbness and tingling. Her pain is worse with walking or standing, using the stairs and sitting. Dr. Mathew performed a lumbar spine exam and diagnosed Petitioner with right lumbar radiculitis, although she felt the symptoms could also be due to right piriformis syndrome. She prescribed further physical therapy. PX6.

Petitioner returned to physical therapy on July 28, 2015. The therapist reported that Petitioner tripped over her dog and did the splits and hit both of her buttocks and had severe pain in her low back radiating down her right leg. On August 21, 2015, Petitioner reported that she was much better but it still hurt to sit for long periods of time and she could not walk for long periods of time. She was experiencing left knee pain along with radicular symptoms in her right leg. PX7.

Petitioner returned to see Dr. Syed on August 25, 2015. Petitioner reported numbness and tingling in her left hand that began two weeks ago and which she now had consistently in the left and was beginning in the right hand. Dr. Syed recommended an EMG. PX5.

On September 10, 2015, Petitioner called Dr. Mathew's office and advised that her pain was getting worse. Dr. Mathew ordered a repeat lumbar MRI. The MRI was performed on September 14th and was reported to show minimal disc bulging and minor facet arthrosis with minimal bilateral neural foraminal narrowing at L4-5 and a small left posterolateral left foraminal disc protrusion and mild left facet arthrosis with mild to moderate left neural foraminal narrowing without neural displacement at L5-S1. Petitioner saw Dr. Mathew on September 22nd, and Dr. Mathew noted that Petitioner complained that her pain was worse with physical therapy but her right leg pain resolved when she stopped therapy two weeks prior, though Petitioner felt that her right leg was weaker than the left. Petitioner also reported worsening pain in her left posterior thigh that radiated to her knee, with some intermittent numbness and tingling to her left foot and also some numbness into her hands, with the left worse than the right. Dr. Mathew concluded that the fact that her previous epidural injections failed to alleviate her left knee pain showed that disc pathology was probably not the cause of her pain. The doctor recommended an EMG with a follow up with a neurologist. PX6.

On September 29th, Petitioner returned to Dr. Syed and reported pain in her buttocks which prohibited her from sitting more than 30 minutes and which prevented her from performing activities such as cleaning at home or most physical activities for any length of time. The doctor reported that Petitioner was "requesting temporary disability." Dr. Syed completed paperwork indicating Petitioner was disabled from 9/29/15 through 10/29/15. He also referred her for physical therapy and an EMG and to follow up with a neurologist. PX5.

An EMG was performed on October 5, 2015 and revealed minimal left median nerve involvement in the wrist. Petitioner then returned to see Dr. Isaac Mezo on October 15, 2015. Dr. Mezo reported that he had originally

seen Petitioner for memory problems but it had turned out to be all anxiety. She now complained of intermittent numbness and tingling in all four extremities, and a recent EMG was unremarkable. He acknowledged that she does have a L4 bulging disk and low back pain which therapy had not helped. Dr. Mezo ordered a cervical MRI to rule out multiple sclerosis. PX21. The MRI was performed on October 25, 2015, and the radiologist interpreted a right sided disc bulge at C5-6 causing mild central canal stenosis and diffuse disc bulge at C6-7 causing mild foraminal narrowing. PX1 and PX21. When she returned to see Dr. Mezo on November 13th, he noted the cervical spinal stenosis and referred her for physical therapy. PX21.

Petitioner was evaluated at Dr. Syed's office on December 4, 2015 and was advised to continue physical therapy and to follow up with Pain Management for evaluation and treatment. PX35. She continued with physical therapy through January 6, 2016 when she was discharged. At that time, the therapist noted that Petitioner felt that therapy had not worked for her and her neck pain was the same as before. PX7.

On December 18, 2015, Petitioner was seen by Dr. Farooq Khan at the OSF St. Elizabeth Medical Center for cervical stenosis and radiculopathy and lumbar spondylosis and radiculopathy. He recommended a trial of Tramadol as well as over the counter medications as well as continued physical therapy and discussed the possibility of lumbar medial branch blocks, radiofrequency neurotomies and cervical epidural injections. On January 4, 2016, he performed medial branch/facet blocks from L3 to S1 bilaterally. He repeated these blocks on January 22, 2016. Petitioner reported partial relief for at least 8 hours. Dr. Khan then performed a radiofrequency medial branch neurotomy on the right side from L3 to S1 on February 1, 2016. On February 15th, he performed the neurotomy on the left side from L3 to S1. PX11.

Petitioner returned to Dr. Mezo on January 12, 2016 and advised him that she had injections in her low back by a pain specialist but she still had significant symptoms in her neck and low back and she wanted to be referred to a surgeon. Dr. Mezo felt she should continue with a pain management specialist but did refer her for a neurosurgical evaluation with Dr. Pelagia Kouloumberis. PX21.

On February 23, 2016, Petitioner saw Dr. Khan and he reported that she had 60% relief on the right side and 80% relief on the left side and was overall much better. She was experiencing cervical pain radiating into the right arm, however, and Dr. Khan recommended cervical epidural injections. On March 7th, Dr. Khan provided an epidural injection at C5-6. Petitioner reported partial pain relief for about two weeks and he repeated the epidural on March 28, 2016. Petitioner reported 50% pain relief and Dr. Khan performed a third epidural on April 22, 2016. PX11.

On July 6, 2016, Petitioner saw Neurologist Dr. Pelagia Kouloumberis at Presence St. Joseph Medical Center's Neuroscience Institute for neck and back pain that started with a fall in January of 2015. Petitioner reported that she had tried physical therapy and multiple injections without any relief. Petitioner complained of discomfort mostly in her neck and back with some radicular symptoms across her shoulders and down into her arms, which was diffuse and did not follow a specific dermatome. She also reported numbness and tingling in her hands and fingers which caused decreased dexterity and dropping things. Petitioner described that she could not stand for long periods of time because of low back pain. Her pain was greater on the left side than it was on the right. Dr. Kouloumberis reviewed the recent MRIs of her lumbar and cervical spine and concluded they showed minimal degenerative disc disease in the lumbar spine at L4-5 and L5-S1 and straightening of the normal lordosis in the cervical spine with degenerative disc disease at C5-C6 and C6-7 causing mild central canal stenosis and right sided foraminal stenosis which was not consistent with her radicular symptoms. Because of Petitioner's significant neck pain. Dr. Kouloumberis recommended facet injections to see if those relieved her pain. PX9.

Petitioner returned to Dr. Khan for facet injections on July 8, 2016. Dr. Khan performed a medial branch block from C3 to C6 on July 8, 2016 and Petitioner reported 50% relief for one hour. Dr. Khan provided two more medial branch blocks on August 2nd and August 22nd. Petitioner reported 80% pain relief but only for a few hours. She requested further cervical epidural injections for more long lasting pain relief and Dr. Khan provided one epidural and two additional radiofrequency neurotomies from C3 to C6. PX11. Petitioner testified that none of these procedures provided any permanent pain relief.

On July 27, 2016, Petitioner returned to Dr. Kouloumberis who found that Petitioner had no compressive disorder. She also noted that Petitioner's complaints were out of proportion for imaging. PX9.

Section 12 Examination & Deposition Testimony – Dr. Komanduri

At the request of her attorney, Petitioner was evaluated by Dr. Mukund Komanduri, an orthopedic surgeon, on October 31, 2016. He opined that Petitioner had sustained injuries to her left knees, both hips, and both shoulders when she fell on her hands and knees on January 14, 2015. This was based upon his exam which showed joint line tenderness anteriorly with positive load and shirt in both shoulders, positive O'Brien's, Speed's, and Yergenson's tests in both shoulders and he concluded they were consistent with Type II SLAP lesions and instability. His examination of the lumbar spine was benign but her hip range of motion showed restricted left hip flexion and internal rotation and pain with FABER's test and exquisite pain with anterior impingement sign. His examination of Petitioner's left knee revealed joint line tenderness, a positive McMurray's sign, patellofemoral instability with fixed lateral subluxation consistent with chronic pain associated with a meniscal tear and quadriceps atrophy. He explained that Petitioner's complaints were not related to cervical or lumbar injury, which was indicated by the failure of the injections and nerve ablations to relieve her symptoms significantly. He felt that her prior physicians had not accurately diagnosed her injuries, in part because they did not perform examinations of her shoulders or her hips. PX16 (Dep. Ex. 2).

Dr. Komanduri opined that both of Petitioner's shoulders were consistent with Type 2 labrum lesions, possible biceps anchor instability, and chronic hypermobility suggesting capsular laxity. This condition can lead to muscle spasm which is often mistaken for cervical radiculopathy. He further opined that she had femoroacetabular impingement in her left hip with a probably labral tear and while this condition in her left hip could cause radiating pain into the left knee it was more likely that her left knee symptoms were due to a medial meniscal tear and patellofemoral instability which she had evidence for on exam. PX16 (Dep. Ex. 2).

Regarding causation, Dr. Komanduri concluded that Petitioner's injury caused femoroacetabular impingement in her left hip to become painful and resulted in a labral tear. This was born out by the pain pattern – such as buttock pain, groin pain, thigh pain, and difficulty with sitting – which occurred after her injury that clearly matches up with femoroacetabular impingement. He explained that while femoroacetabular impingement is a congenital condition, it is not guaranteed to become symptomatic but appears to have done so after Petitioner's fall. With regards to her shoulders, he further explained that Petitioner fell directly onto her outstretched arms and that could have caused bilateral shoulder injuries. Finally, regarding her left knee, because she sustained a twisting injury and a direct blow to her knee he felt she sustained a meniscal tear which when left untreated in turn developed chronic patellofemoral instability. PX16 (Dep. Ex. 2).

Regarding further treatment, Dr. Komanduri concluded that Petitioner did not need any further pain management for a back injury. He recommended she get MRIs for her left hip, left knee, and MRI arthrograms for both shoulders, and further treatment would depend upon the results but likely her knee should be first

addressed. He opined that she was at a sedentary physical capacity and could not perform her job as a law enforcement agent. PX16 (Dep. Ex. 2).

Dr. Komanduri gave his deposition on June 22, 2017. He is a Board Certified Orthopedic Surgeon who treats various orthopedic injuries. He has been Board Certified since 1998 and was recently re-certified. He performs surgeries for various conditions to the extremities, though he does not perform spinal surgeries. He has a spinal surgeon in his practice and if a patient requires spinal surgery he will refer them to his colleague. PX16 at 5-6. He testified that when he examined Petitioner her complaints were in her neck, lower back, hip, and left knee so he focused on those areas. He felt it was clear that her complaints of neck pain were due to muscle spasms in the trapezius and latissimus musculature, he also found instability in her shoulders on exam. PX16 at 16-17. He explained that because her symptoms were near the cervical spine he felt that she was misdiagnosed as having a cervical problem, but since he found her shoulders to be unstable he felt that was the source of here pain. PX16, p17. He explained that because of the instability her shoulder was moving forward without resistance which caused the trapezius, which is attached to shoulder, to spasm. Because the trapezius sits over top of the cervical spine, it will look and feel like neck pain. PX16 at 18. He further explained that the rest of her exam showed that she had pain in the quadratus muscle on the side of her low back and with hip flexion, abduction, external rotation. She had a positive anterior impingement sign in her hip which pointed to a restriction in range of motion which is usually due to bony overgrowth on the neck of the femur in the hip socket – this process is called femoracetabular impingement, which he shortened to "FAI." PX16 at 19. Petitioner also reported groin pain which is something you see with a labral tear in the hip, and exhibited restricted range of motion with a loss of flexion. PX16 at 19-20. In addition to his exam findings, he explained that he X-rays performed in his office clearly demonstrate excessive bony coverage of the ball of the hip which creates femoroacetabular impingement. PX16 at 30.

Dr. Komanduri testified that Petitioner did not show any signs during his exam did not show any signs of exaggerating her symptoms. He further elaborated that there are some things in an exam which are impossible for a patient to fake such as the loss of internal hip rotation due to the nature of the exam, the "load and shift" exam which tests for mechanical instability in the shoulders, and dislocation of the kneecap and instability, all of which he found on his exam of Petitioner. PX16 at 32-34. He further noted that his exam of her cervical spine was completely normal, which further indicated that she was not attempting to fabricate any symptoms. PX16 at 33.

Dr. Komanduri stated that his review of the records did not demonstrate that any prior physician had examined Petitioner's shoulders for instability. He noted that Dr. Chilelli had only examined her knees. Dr. Mathew had examined her lower back. She did perform a FABER test but he explained that this test is really designed to identify SI joint pain. She performed general medical testing but did not perform any tests to evaluate the function of Petitioner's hip and its range of motion. PX16 at 23-24. Nor did Dr. Mathew perform any specific testing of Petitioner's knee or shoulders. PX16 at 24. None of her prior doctors had performed an impingement test on her hip or documented its range of motion. PX16 at 24. Dr. Komanduri testified that he couldn't say whether Petitioner had ever had lumbar radiculopathy or if her complaints of back pain were always related to her hip. PX16 at 37. He did note that the records indicated that Petitioner did receive as much as a 60% reduction in her symptoms when she had radiofrequency ablations. Her pain levels always returned back, however, which he indicated meant that something else was causing her pain besides the nerves in her back. PX16 at 61.

The doctor acknowledged that femoroacetabular impingement is a congenital condition but explained that it is often not symptomatic until patients sustain a trauma. He stated that it was possible that she jammed her knee

when she fell which also impacted her hip and that would be a potential cause for injury to her left hip. PX16 at 50. He explained that whether the symptoms from Petitioner's femoracetabular impingement were related to her fall would depend on whether there was a labral tear in the hip. PX16 at 50-51. If there is a tear present, he opined that it is more likely true than not to be related to her fall because of the clear evidence of a traumatic injury that is capable of producing such an injury. PX16 at 53.

Regarding Petitioner's left knee, Dr. Komanduri acknowledged that an MRI was performed in March 2015 which did not show a meniscal tear. He explained that MRIs can have false positives and false negatives and that his exam had shown a positive McMurray's sign, joint line tenderness, chronic atrophy of her quadriceps, and kneecap instability, which you would see in an untreated condition over the years. PX16 at 36, 39-40. He also acknowledged the possibility that Petitioner is suffering from the sequelae of the trauma causing patellofemoral instability and quadriceps atrophy which could exist in isolation without a meniscal tear. PX16 at 40.

Regarding the issue of causation, Dr. Komanduri observed that Petitioner had an acute blow to her left knee and the MRI on March 20, 2015 showed evidence of cartilage loss behind her kneecap. PX16 at 47. He asserted, based upon a reasonable degree of medical certainty, that her condition of her left knee was causally related to her injury. He further observed that as a Sheriff's deputy she was functioning at a physical job prior to her injury which indicated that her sudden trauma played a role in her ongoing pathology. PX16 at 49.

Regarding the issue of instability of Petitioner's shoulders, Dr. Komanduri observed that Petitioner did fall onto her outstretched arms and this was a competent cause for a labral tear resulting in shoulder instability. PX16 at 55. Because Petitioner had shoulder instability bilaterally, it would be unlikely that this would be due to a disease process. PX16 at 56. Based upon her history of falling onto both hands, he felt based upon a reasonable degree of medical certainty that this caused her bilateral shoulder instability. PX16 at 55-56.

On cross-examination, Dr. Komanduri acknowledged that the fraying of the cartilage in Petitioner's left knee seen on the March 20, 2015 MRI could have been degenerative and could be an incidental finding. PX16 at 70. The instability of her left knee could have been congenital or degenerative. PX16 at 70. He continued to opine that her problems in her knee were due to the traumatic injury, describing it as "pretty straightforward." PX16 at 71. Regarding her femoracetabular impingement, Dr. Komanduri explained that Petitioner's mechanism of injury was consistent with a forced hip flexion maneuver which is why he thought the causality was possible, though he could not "close the door" on an aggravation of a pre-existing condition. PX16 at 72. Dr. Komanduri did express doubt that Petitioner could have aggravated her left hip if she had fallen on her right hip though it would depend upon the position of the limb. PX16 at 73.

On further cross-examination, Dr. Komanduri reviewed the record of Dr. Mathew on July 24, 2015 after Petitioner tripped over her dog at home. He acknowledged that Petitioner was indicating that her left knee and low back pain had resolved when she was released from physical therapy. Dr. Komanduri felt this indicated that Petitioner did have momentary relief in physical therapy but seemed to be back to square one because Dr. Mathew's exam findings were the same as they had been previously except for a positive straight leg raising on the right side. PX16 at 76-77. The doctor acknowledged this was an aggravating incident for Petitioner but felt that such a re-aggravating event did not negate the initial injury. PX16 at 77-78.

Dr. Komanduri reviewed the physical therapy report from July 21, 2015 when she was released – and before she tripped over her dog – and found that Petitioner was reporting that she still had intermittent pain which could rise as high as 7 out of 10 and still had pain with sitting which would be expected with a labral tear in the hip.

PX16 at 82-83. After she fell over her dog, her pain was on the right side and this would not be related to her left hip. Based upon these, he felt that she had a different symptom complex after she fell over her dog. PX16 at 84. The symptoms which he diagnosed, however, appeared to be a continuation, even if intermittently, from her left hip. PX16 at 84.

Section 12 Examination & Deposition Testimony – Dr. Levin

On May 2, 2017, Petitioner presented for a medical evaluation at Respondent's request pursuant to Section 12 of the Act with Michael D. Levin, M.D. (Dr. Levin). RX12 & RX15. Dr. Levin opined that Ms. Stiles had multibody complaints of a subjective nature which did not correlate to an alleged work injury of January 14, 2015. Her findings were not from an objective orthopedic cause and he could not substantiate the need for any treatment to the cervical or lumbar spine, or the evaluation of the knee from any work injury related to January 14, 2015. Dr. Levin further opined that there was no evidence of any work-related injury preventing her from returning to full duty.

At his deposition, Dr. Levin said the petitioner's statement that the long-standing history of treating with the chiropractor for ten years prior to these accidents for allergy conditions did not make medical sense. The chiropractic records indicated she was having treatment for chronic pain to her back and neck over a period of time. The doctor also noted some inconsistencies in the examination, which were previously documented in this decision. Her statements of discomfort had no objective, anatomical, or orthopedic pathological basis, and were not substantiated by true, objective, organic, orthopedic findings RX7 at 9-11. There were no objective spasms noted throughout the entire spine. RX7 at 11-12. There were inconsistent, objective reports on the pin-prick sensation tests. The x-rays and diagnostic studies were typical for degenerative conditions. Her QuickDash Score, which is a report of her pain, was not consistent with some of the functioning at the level she reports she was functioning. RX7 at 15-16. These findings were out of proportion to the objective findings. Her pain disability questionnaire was 139/150, which he considered to be very high. With a score that high, someone should be severely incapacitated and not functional. Her left knee MRI showed a small Baker's cyst, but no acute traumatic changes. RX7 at 18. A Baker's cyst is not a result of trauma. Testing of her arms by squeezing her forearms caused numbness in her right hand. He squeezed her left forearm and it gave her right hand numbness, which did not anatomically fit. RX7 at 22. He flexed her wrist and she cried out in severe neck pain. While sitting up, her legs were flexed to 90 degrees without complaint. However, when they placed her on her back in a supine position doing the straight leg raise test, again bringing the hip up to 90 degrees, she complained of pain. RX7 at 23. This was inconsistent with any objective findings. Flexing her toes bilaterally would give her low back pain. Extending the toes caused cervical pain. These findings did not make any anatomical sense. Her diagnostic studies showed some degenerative cervical changes at C5/C6, but no disc herniation or impingements. The lumbar MRI's showed some chronic degenerative changes, but no objective, acute pathology. RX7 at 26. An EMG from October 5, 2015 was unremarkable.

Ultimately, Dr. Levin opined that Petitioner's complaints could not be correlated with any alleged work injury of January 14, 2015. There was no true, objective, orthopedic pathology.

ISSUES AND CONCLUSIONS

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

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

An employee's injury is compensable under the Act only if it arises out of and in the course of the employment. 820 ILCS 305/2 (LEXIS 2003). The "in the course of employment" element refers to "[i]njuries sustained on an employer's premises, or at a place where the claimant might reasonably have been while performing his duties, and while a claimant is at work...." *Metropolitan Water Reclamation District of Greater Chicago v. IWCC*, 407 Ill. App. 3d 1010, 1013-14 (1st Dist. 2011). The "'arising out of' component refers to the origin or cause of the claimant's injury and requires that the risk be connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury." *Metropolitan Water Reclamation District*, 407 Ill. App. 3d at 1013-14 (*citing Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill. 2d 52, 58 (1989)). A claimant must prove both elements were present (i.e., that an injury arose out of and occurred in the course of her employment) to establish that her injury is compensable. *University of Illinois v. Industrial Comm'n*, 365 Ill. App. 3d 906, 910 (1st Dist. 2006).

The presence of uneven surface on the ground is a hazardous condition. *Litchfield Healthcare Center v. Industrial Comm'n*, 349 Ill.App.3d 486, 491 (5th Dist. 2004) (claimant tripped on uneven pavement in an area of the employer's premises when arriving for work). More recently, the Appellate Court has affirmed that the proposition that the presence of a hazardous condition which causes an accident is a risk which arises out of employment. *Dukich v. Ill. Workers' Compensation Comm'n*, 2017 IL App (2d) 160351WC, 86 N.E.3d 1161, 416 Ill.Dec. 876 (2nd Dist. 2017).

It is undisputed that Petitioner was on Respondent's premises on January 14, 2015 at a training session. Petitioner testified that she was carrying her work key fob while walking across Respondent's property to her car. Petitioner completed a detailed injury report describing her accident. Sergeants Ortiz and Woolford generally corroborate Petitioner's recitation of events and otherwise fail to contradict Petitioner's testimony; that is, that they did not see what caused Petitioner's fall and that there was an uneven surface or raised brick on Respondent's property at the time and location of the accident. Based on the foregoing, the Arbitrator finds that Petitioner sustained a compensable accident on January 14, 2015 as claimed.

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

Based on the totality of the evidence, the Arbitrator finds that Petitioner's current condition of ill-being is not causally related to her accident at work as opined by Dr. Levin. In so concluding, the Arbitrator finds the opinions of Dr. Levin to be reflective of objective medical evidence regarding Petitioner's condition of ill being, and to be persuasive in consideration of the record as a whole.

"Liability cannot be premised upon imagination, speculation or conjecture but must arise from facts established by a preponderance of the evidence." *Illinois Bell Tel. Co. v. Industrial Comm'n*, 265 Ill. App. 3d 681, 685 (1st Dist. 1994). "Expert opinions must be supported by facts and are only as valid as the facts underlying them."

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

WILLIAM SCOTT GREGORY,

Petitioner,

vs. NO: 14 WC 33179

RHL INSULATION & FIRE STOP,

Respondent.

ORDER

This cause comes before the Commission on a "Petition for Attorneys' Fees and Costs by Anesi, Ozmon, Rodin, Novak & Kohen, Ltd.," filed on March 2, 2018, and a "Supplemental Petition for Attorneys [sic] Fees and Costs," filed on September 5, 2018. On September 21, 2018, before Commissioner DeVriendt in Chicago, Illinois, John Popelka appeared on behalf of Anesi, Ozmon, Rodin, Novak, & Kohen, Ltd. (hereafter "Anesi") and James Hardy appeared on behalf of Taxman, Pollock, Murray & Bekkerman (hereafter "Taxman"). A record was made.

The evidence reflects that Anesi was the initial firm handling Petitioner's case and an Application for Adjustment of Claim was filed on September 30, 2014. Anesi prepared the case for trial, including the taking of depositions, and represented Petitioner at the Arbitration hearing on September 7, 2016.

The Arbitrator's decision, issued on November 28, 2016, found that Petitioner's right and left knee osteoarthritis were causally related to his work injury. Petitioner was awarded temporary total disability benefits and medical expenses, including prospective right and left total knee replacements and a weight loss program. The Arbitrator denied Petitioner's claim for penalties and attorneys' fees.

On December 27, 2016, Anesi filed a Petition for Review, on Petitioner's behalf, on the issue of penalties and fees and, on April 7, 2017, submitted a Statement of Exceptions in support of that Petition. Respondent had also filed a Petition for Review on the issues of causation, medical expenses, and temporary total disability. On April 25, 2017, Anesi filed a reply brief in response to Respondent's Statement of Exceptions.

On February 15, 2018, Petitioner terminated his relationship with Anesi and was subsequently represented by Taxman. *Anesi Ex. 1.*

On May 23, 2018, Taxman represented Petitioner at Oral Arguments relating to the parties' respective Reviews of the Arbitrator's decision.

On July 16, 2018, the Commission issued a Decision and Opinion on Review which affirmed on the issue of causation, temporary total disability, medical expenses previously incurred, and the denial of penalties and attorneys' fees. The Commission affirmed the prospective right knee replacement surgery but modified the decision and found that a formal weight-loss program had not actually been prescribed as a prerequisite to the right total knee arthroplasty and also found that the issue of the left knee arthroplasty was premature.

Respondent did not pursue any further review of the Commission's decision which became final. On August 28, 2018, Respondent issued a check for $161,241.60 to Petitioner and Anesi, jointly, for "3 YEARS OF TTD PER AWARD" from "08/17/2015 – 08/17/2018." *Anesi Ex. 4.* On September 4, 2018, Anesi returned the check to Respondent, since it was no longer Petitioner's attorney, with instructions to have the check reissued to Petitioner's current attorneys. *Id.*

The Commission finds that Anesi did the vast majority of the work on Petitioner's case, and deserves most of the attorneys' fees. Anesi obtained a favorable decision from the Arbitrator, filed the Petition for Review, and prepared the briefs on Review which the Commission considered in its decision. However, Taxman's involvement was also instrumental in preserving the Arbitrator's award since it was this firm that appeared and argued Petitioner's case at Oral Arguments.

Although Anesi argues that it should receive the 20% attorneys' fee for all of the Arbitrator's medical award and all of the temporary total disability payments through the date it was discharged by Petitioner on February 15, 2018, the Commission finds that this does not adequately reflect the contribution that Taxman made in preserving the award. Likewise, Taxman's argument that it should receive two-thirds and Anesi should receive one-third, seriously diminishes Anesi's major contribution in obtaining and preserving the award for Petitioner. Therefore, based on the above and the record as a whole, the Commission finds that Anesi is entitled to 75% of the attorneys' fees and Taxman is entitled to 25%.

Regarding the temporary total disability, attorneys' fees are calculated as follows:

$161,241.60	Disputed TTD paid by Respondent
x 20%	
$ 32,248.32	Attorneys' fees earned

Of this amount, $24,186.24 (75%) is awarded to Anesi and the remaining $8,062.08 (25%) is awarded to Taxman.

The Arbitrator also awarded, and the Commission affirmed, $52,147.34 in medical expenses but this was subject to the medical fee schedule in Section 8.2 of the Act. No evidence was introduced as to how much the medical award was reduced after the fee schedule was applied. The

Commission awards Anesi 75% of the attorneys' fees earned on the awarded medical expenses, after the fee schedule was applied, and Taxman the remaining 25%.

Finally, it is noted that Mr. Popelka indicated costs were no longer an issue. T.4.

IT IS THEREFORE ORDERED that the firm of Anesi, Ozmon, Rodin, Novak, & Kohen, Ltd. is entitled to 75% of the disputed attorneys' fees that were earned in this case and the firm of Taxman, Pollock, Murray & Bekkerman is entitled to 25%, as outlined above.

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

DATED: APR 30 2019

Maria Elena Portela

Maria E. Portela

MEP/se
49

STATE OF ILLINOIS)
) SS.
COUNTY OF ADAMS)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Miguel A. Cancel,

Petitioner,

19IWCC0212

vs.

NO: 13 WC 38515

ADM,

Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission reverses the Arbitrator's finding that Petitioner is permanently totally disabled and finds Petitioner failed to prove he is permanently totally disabled. "[T]he Commission is not bound by the arbitrator's findings and may properly determine the credibility of witnesses, weigh their testimony and assess the weight to be given to the evidence. [citation omitted]." *R.A. Cullinan and Sons v. The Industrial Commission*, 216 Ill. App. 3d 1048, 1054, 575 N.E.2d 1240 (1991).

The Commission notes there are three ways a claimant can demonstrate he is permanently totally disabled, *ABB C-E Services v. Industrial Commission*, 316 Ill.App.3d 745, 737 N.E.2d 682 (2000):

(1) by a preponderance of medical evidence. Here, Dr. Reynolds opined Petitioner is permanently disabled from any gainful employment. However, the Commission disregards this opinion as there was no basis for this opinion. Petitioner had not undergone a functional capacity evaluation to determine what his capabilities were. On April 16, 2014, Dr. Reynolds completed an Aetna Life Insurance Capabilities and Limitations Worksheet. PX1, (DepEx)PX4; RX7. Dr. Reynolds indicated the percent of the day the following activities can be performed: Climbing (never); Crawling (never); Reaching above shoulder (occasional); Forward reaching (frequent); Carrying (never); Bending (never); Twisting (never); Stooping (never); Walking (occasional); Sitting (occasional); Standing (occasional). Maximum weight patient is capable of lifting: 1-5 pounds (frequent); 6-10 pounds (occasional); above 11 pounds (never). Dr. Reynolds commented Petitioner is permanently and totally disabled due to his lumbosacral neuritis. Dr. Petkovich disagreed with Dr. Reynolds' opinion that Petitioner is permanently totally disabled. RX4, page 76. Dr. Petkovich opined Petitioner is not permanently totally disabled, based upon his experience and practice for the past 36 years, Petitioner's medical records and his examination. *Id.* Based on the medical records and Petitioner's testimony, the Commission finds that Petitioner is capable of functioning to some degree.

(2) by showing a diligent, but unsuccessful job search. Here, Petitioner did not search for work.

(3) by demonstrating that because of his age, training, education, experience and condition, no jobs are available to a person in his circumstances. The Commission notes that Petitioner was 56 years old at the time of the July 20, 2013 accident. Petitioner testified he went to school in Puerto Rico through sixth grade. T. 67. He moved to the U.S. when he was about 14 or 15 and had family in Chicago. *Id.* He has no other formal education and no formal training in any profession. T. 68. Petitioner moved to Quincy, IL on December 23, 1999. *Id.* His first job there was for a company in Rushville, IL, building tanks and conveyor for beans; he did a little bit of everything, including welding. T. 68-69. Petitioner started working for Respondent around 2000 doing sweeping and cleaning. T. 70-71. He speaks English. T. 71. Through his 13 years of employment with Respondent, Petitioner had been regularly promoted and received pay increases. T. 72. The Commission finds Petitioner has failed to prove that no jobs are available to a person in his circumstances.

Pursuant to Section 8.1b of the Act, the Commission weighs the following five factors accordingly (*820 ILCS 305/8.1b(b)* (West 2014); *Corn Belt Energy Corp. v. Illinois Workers' Compensation Commission*, 2016 IL App (3d) 150311WC, ¶ 52, 56 N.E.3d 1101):

Section 8.1b(b)(i) – level of impairment

Neither party obtained an impairment rating; as such, the Commission assigns no weight to this factor.

19IWCC0212

Section 8.1b(b)(ii) – occupation of the injured employee

At the time of the July 20, 2013 accident, Petitioner was employed as an Operator II, working in the prep building. T. 71. There is conflicting evidence whether Petitioner can perform this job. Dr. Reynolds opined Petitioner is permanently disabled from any gainful employment. Dr. Petkovich opined Petitioner could work at the regular job he was doing prior to July 20, 2013 without any restrictions with regard to the lumbar disc herniation at L3-L4 level and subsequent surgical procedure for that disc herniation. RX1. The Commission finds while Petitioner would probably not be able to work his pre-injury job, he is capable of functioning to some degree. The Commission finds this factor in favor of an increased permanence.

Section 8.1b(b)(iii) – age of the employee at the time of the injury

Petitioner was 56 years-old on the date of accident. The Commission observes Petitioner has a lesser work life expectancy which will require him to manage the effects of his injury for a lesser period of time. The Commission finds this factor weighs in favor of a decreased permanence.

Section 8.1b(b)(iv) – employee's future earning capacity

Petitioner has not worked since the July 20, 2013 accident. Petitioner claims he cannot work as a result of his accident, but he has not attended a functional capacity evaluation or looked for any work. The Commission recognizes Petitioner's earning potential is compromised by his injury. However, his ability to pursue other occupations is unknown. The Commission finds this factor weighs in favor of an increased permanence.

Section 8.1b(b)(v) – evidence of disability corroborated by treating medical records

According to the medical records, Petitioner was seen at Blessing Hospital emergency room by Dr. Pyatt on July 20, 2013 shortly after his accident. Petitioner gave a history of severe back pain into the left buttock and left leg posteriorly, which was worse with movement. Past back pain was noted. Dr. Pyatt ordered CT scans of the abdomen and pelvis, which were performed and were essentially unremarkable. DepExRX1.

Petitioner saw Dr. Davis, his primary care physician, on July 22, 2013. His chief complaint was left sided sciatica, back pain with radiation. It was noted he had a history of lumbar surgery for herniated disc a few years ago and also a low back injury earlier in 2013. Petitioner complained of severe burning-type of discomfort in his low back in the area of the pelvic crest and below and then going down the posterolateral aspect of his thigh, posterior aspect of his calf, and making his whole foot numb. He had a kind of electrical shock feeling in his foot and leg at times. On examination, Dr. Davis found tenderness to palpation over the left paraspinals at the level of L5-S1 and also over the left SI joints; straight leg raises were positive for low back pain; ankle DTR was absent on the left and normal on the right; left dorsiflexor in

the great toe seemed to cause him discomfort and there might have been some weakness with dorsiflexion as well; sensory testing of left lower extremity to sharp demonstrated normal sensation in the L2, L3 and L4 dermatomes, but reduced sensation on the L5 and S1 in the left foot compared to the right; there was atrophy of the left calf musculature compared to the right, however, this was an old and chronic finding. Dr. Davis' assessment was lumbar radiculopathy involving S1 and possibly L5. Dr. Davis prescribed Percocet and Neurontin and gave an IM injection of Toradol. Dr. Davis ordered a lumbar MRI and was to consider a referral. DepExRX6.

Petitioner underwent a lumbar MRI on July 25, 2013. A clinical history of sciatic, low back pain and left lower extremity pain was noted, as was a history of lumbar spine surgery in 2006. This MRI was compared to a lumbar MRI done November 22, 2011. The radiologist found there was a severe loss of T2 signal intensity of the L2-L3 and L3-L4 intervertebral discs. No focal disc herniations were identified at L1-L2 or visualized at L2-L3. A mild left lateral disc bulge at L2-L3 could not be excluded. No disc herniations were visualized at L3-L4. However, a lobular structure was detected posterior to the left aspect of the L4 vertebral body and it had the appearance of an extruded disc fragment. This structure measured approximately 13 X 7 mm in diameter and abutted the contiguous thecal sac and likely the left L4 nerve root. A mild right lateral disc bulge was visualized at L4-L5 without significant neural encroachment. A left lateral disc bulge was detected at L5-S1, narrowing the left L5 neural foramen. No acute fractures were seen. There was mild retrolisthesis of L2 on L3, L3 on L4 and L4 on L5. The conus medullaris terminated at L2. A right renal cyst was visualized. The radiologist's impression was: (1) Extruded disc fragment in the left L4 lateral recess measuring 13 X 7 mm in diameter abutting the contiguous thecal sac and likely the left L4 nerve root. Clinical correlation was suggested. (2) A left lateral disc bulge at L5-S1 narrowing the left L5 neural foramen. (3) Right lateral disc bulge at L4-L5. (4) Mild retrolisthesis of L2 on L3, L3 on L4 and L4 on L5, similar compared to the previous study. (5) No acute fractures. (DepEx)PX3.

In a Blessing Hospital History and Physical report dated July 31, 2013, the impression is noted as: (1) Lumbar disc disease with radiculopathy; (2) Microcytic anemia. Petitioner was medically cleared for surgery. DepExRX3. The same day, Petitioner was seen by Dr. Reyburn at Blessing Hospital for consultation. Dr. Reyburn was part of Quincy Medical Group, the same group to which Dr. Reynolds belonged. Dr. Reyburn noted Petitioner had previous back surgery in 2006 by Dr. Reynolds. Petitioner complained of low back pain with left leg pain. He had pain in every position possible, worse while walking and standing. He had a decreased walking tolerance and weakness in his left leg. Dr. Reyburn noted the lumbar MRI was personally reviewed by Dr. Reynolds. Dr. Reyburn's diagnostic assessment was left L3-L4 disc herniation. He noted Petitioner had discussed this with Dr. Reynolds. Dr. Reyburn noted Petitioner needed a left L3-L4 microdiscectomy with a possible open discectomy. Surgery was scheduled for the next day. DepExPX5.

According to the August 1, 2013 Operative Report, Dr. Reynolds' pre-operative diagnosis was left L3-L4 disc extrusion with acute left L4 radiculopathy. Dr. Reynolds performed: (1) Left L3-L4 microdiscectomy with removal of disc; (2) Microdissection. On August 5, 2013, Petitioner followed-up with Dr. Reynolds and reported tightness in his low back, but significant improvement of pain since prior to surgery. He had some numbness and tingling and his left big toe was numb. Neuropathic pain was present and expected. Dr. Reynolds' assessment was status post-op and healing lumbar wound. Petitioner was to remain off work and continue prescribed medications. On August 19, 2013, Dr. Reynolds noted the incision was healing and granulation tissue had formed. His assessment was the same and he prescribed medications. Dr. Reynolds noted the same on August 21, 2013. DepExPX5.

On August 26, 2013, Petitioner reported continued ongoing numbness, tingling and burning sensations in both legs, right greater than left. Petitioner denied any recent injury or falls. Dr. Reynolds' assessment was the same along with healing radiculopathy. Petitioner was to continue to walk 30 minutes each day. Dr. Reynolds noted on September 3, 2013 the incision had nicely healed. Objectively Petitioner had good lower extremity strength and improved gait, but continued to have neuropathic nerve pain. Dr. Reynolds' assessment was the same. Petitioner was to continue walking 30 minutes, his lifting was restricted to 10 to 15 pounds and he was to avoid bending at the waist. On September 16, 2013, Petitioner reported some bleeding at the incision site, some increased low back pain, the neuropathic pain was more annoying than actually truly painful and he continued using a cane. Objectively the incision was slightly erythematous where the scabbed site had been, but there was no active bleeding; no tenderness to palpation; no drainage; lumbar tightness without acute spasms; good lower extremity strength. Petitioner reported Lyrica was not very helpful and Dr. Reynolds discontinued this medication. Petitioner was to continue walking for 30 minutes, avoid waist bending and had a weight lighting restriction 15 to 20 pounds. DepExPX5.

Petitioner reported to Dr. Reynolds on October 2, 2013 he continued to have numbness and tingling to a burning sensation throughout both legs, right greater than left. He had low back pain in stretching and tightness and spasms when trying to put on socks. He still was using a cane. Objectively the incision was well healed; there were lumbar spasms bilaterally; there was tenderness to palpation; neuropathic pain was moderate to significant; his gait was steady; lower extremity strength appeared slightly weaker than on the previous visit. Dr. Reynolds assessment was status post-op and healing radiculopathy. Dr. Reynolds ordered physical therapy two to three times a week for four to six weeks, prescribed Flexeril as needed and Tegretol for neuropathic nerve pain. Petitioner was to continue walking, his weight lifting was restricted to 20-25 pounds, he was to avoid excessive bending at the waist and avoid any excessive twisting mechanisms. Dr. Reynolds noted Petitioner was not able to return to 100% work duty and was to remain off work. DepExPX5.

On November 5, 2013, Dr. Reynolds noted Petitioner was making steady progress, but still had some burning pain in his feet. Pool therapy was helping. Dr. Reynolds assessed nerve healing post-operatively and L4 radiculopathy. Petitioner was to continue current management.

Dr. Reynolds was to get approval for therapeutic massage to loosen left leg lateral band. On November 26, 2013, Petitioner reported increased low back pain and bilateral leg pain, left worse than right. Petitioner reported electrical shock sensation at times going down his legs and his legs constantly had a state of uncomfortableness to being painful. Petitioner reported physical therapy had definitely increased his strength and had helped, but two hours after the session he had increased tightness, which resulted in increased discomfort. Objectively there was lumbar tightness without acute spasm, left leg lateral band tightness was improved with physical therapy and his gait was steady. Dr. Reynolds ordered a lumbar MRI to determine if there was any epidural fibrosis that may be adding to his overall discomfort. He was to remain off work. DepExPX5.

Petitioner underwent a lumbar MRI on December 6, 2013 and this was compared to the July 25, 2013 lumbar MRI. It was noted motion degraded some images. Mild intervertebral disc space narrowing was visualized at L2-L3 and L3-L4. There was no disc herniation at L1-L2. There was a mild anterior disc bulge at L2-L3 with mildly prominent left lateral and left paracentral component deforming the contiguous thecal sac. A mild posterior disc bulge was visualized at L3-L4 abutting the contiguous thecal sac. The extruded disc fragment posterior to the L4 vertebral body on the previous study was not present today. A linear focus of low signal was noted in this region however, which may represent a small amount of granulation tissue. There was some enhancement in this region on the postcontrast images. There were no disc herniations at L4-L5. A left lateral disc bulge was detected at L5-S1 narrowing the left L5 neural foramen. There was narrowing of the L4 neural foramina, similar compared to the previous MRI. No acute fractures were seen. There was retrolisthesis of L2 on L3 and L3 on L4. The conus medullaris terminated at L2. No paraspinal soft tissue masses were identified. There was enhancement of the soft tissues at the surgical site. The patient was status post left L4 hemilaminectomy. The radiologist's impression was: (1) The extruded disc fragment in the left L4 lateral recess on the previous study was not present. A small amount of granulation tissue was identified in this region. (2) Mild posterior disc bulge at L2-L3 without significant neural encroachment. (3) Mild left lateral disc bulge at L3-L4. (4) Left lateral disc bulge at L5-S1 narrowing the left L5 neural foramen. This disc bulge abutted the left S1 nerve root. Correlation with left L5 and S1 radiculopathy was suggested. DepExPX5.

On December 20, 2013, Dr. Reynolds reviewed the December 6, 2013 lumbar MRI. Dr. Reynolds noted the 3-4 disc had been nicely removed and there was no evidence of residual nerve root compression; there was minimal scar tissue. Dr. Reynolds noted, "His delayed recovery is related to his slow healing neuropathy from the severity of the nerve root compression." Petitioner reported on January 9, 2014 he continued to have ongoing low back pain and tightness and neuropathic nerve pain of a burning quality in both legs, left greater than right. He also reported a stabbing sensation behind the knees and pins and needles to burning pain in his feet. Dr. Reynolds noted he had recently been discharged from physical therapy. On examination, Dr. Reynolds found lumbar tightness with spasms in the left low back; good strength in lower extremities; gait slow and steady; neuropathic nerve pain was significant. Dr. Reynolds again review the latest lumbar MRI. His assessment was the same. Dr. Reynolds

prescribed Lyrica, Flexeril, a home exercise program and Petitioner was to continue 30-minute walking, avoid bending at the waist and twisting mechanisms. DepExPX5.

Petitioner reported on February 4, 2014 he continued with paresthesias in both legs, worse in feet, a little worse in left foot. He also reported paresthesias in his lateral thigh. Dr. Reynolds noted Petitioner had a slip and fall on the ice without change in his examination. Dr. Reynolds noted careful attention was spent on the left L5 and left S1 roots and there was no weakness detectable; in addition, arachnoiditis was visualized in the intrathecal nerve roots with clumping of the nerve roots. Dr. Reynolds diagnosed post laminectomy syndrome due to a combination of: (1) Arachnoiditis; (2) Epidural fibrosis consistent with lumbosacral neuritis. He referred Petitioner to pain management Dr. Dedes and ordered an EMG. Dr. Reynolds assessed back pain with radiation. On April 8, 2014, Petitioner reported he had some injections by Dr. Dedes, but they had not changed the pain significantly. Petitioner was getting a little relief and some sleep. There was no change in his examination. Dr. Reynolds noted the EMG did not show any evidence of ongoing neuropathy or radiculopathy. Dr. Reynolds noted, "Discussion: I have discussed the fact that he is going to hurt for the rest of his life on the last 5 or 6 different visits. I think he is finally getting to the point where maybe he is starting to believe it a little bit." DepExPX5.

On July 15, 2014, Petitioner reported he was still having a lot of pain, but his medication was effective, but it also made him very tired. Dr. Reynolds noted Petitioner continued to have the expected back and leg pain secondary to lumbosacral neuritis following a second back surgery. On December 9, 2014, Dr. Reynolds noted Petitioner continued to suffer from lumbosacral neuritis due to arachnoiditis and epidural scar tissue following his second back surgery. The following medications had been prescribed: Ibuprofen 800mg every six hours, Lyrica 50mg twice a day, Tizanidine 2mg every 8 hours and Tramadol 50mg 1 or 2 every six hours. His examination remained unchanged; the usual patchy sensory loss in the legs, very dense in the feet; mild weakness; positive straight leg raises; rigid lumbar spasm; occasional spasms in the legs. Petitioner was to follow-up in April 2014. DepExPX5.

Petitioner saw Anita Arnold, nurse practitioner at Dr. Reynolds' office, on January 28, 2015. Petitioner reported an increase in pain in his left leg of an electrical shock sensation. Ms. Arnold noted Petitioner continued to suffer from issues from lumbosacral neuritis secondary to arachnoiditis and epidural scar tissue. Petitioner was to continue with pain management. Ms. Arnold noted Petitioner reported over the last few months he had developed an increase in electrical shooting sensation that would go down his left leg and occasionally radiate across his pelvis and into his penis. He has had issues with maintaining an erection. On examination, Ms. Arnold found rigid lumbar tightness with occasional spasms in his legs; no pain with palpation of lower muscle groups; good lower extremity strength; sensory loss of a patchy nature in his legs and in feet. Ms. Arnold assessed: (1) Lumbosacral neuritis secondary to arachnoiditis; (2) Erectile dysfunction. Medications were prescribed. DepExPX5.

On April 7, 2015, Dr. Reynolds noted Petitioner was unchanged and refilled his medications. Petitioner reported on August 12, 2015 he continued to have burning sensations throughout his legs, worse with activity. Lyrica helped, but made him drowsy. On examination, Dr. Reynolds found lumbar tightness without acute spasms; good lower extremity strength; gait was steady. Dr. Reynolds noted Petitioner had moderate to significant neuropathic nerve pain related to arachnoiditis. Dr. Reynolds assessed: (1) Lumbosacral neuritis; (2) Arachnoiditis. Petitioner was to continue the current plan of care. DepExPX5.

Petitioner last saw Dr. Reynolds on December 1, 2015 and reported his back and leg pain were unchanged, as was his impotence. Dr. Reynolds noted that for the last several years Petitioner has had classic failed back syndrome. On examination, Dr. Reynolds found rigid lumbar paravertebral muscle spasm; severe limitation of lumbar range of motion; extension, flexion, lateral bending and rotation were all 5% to 10% of normal; positive straight leg raises bilaterally. DepExPX5. The Commission finds the above weighs in favor of an increased permanence.

Based on the above factors and the record in its entirety, the Commission finds Petitioner sustained a 40% loss of use of the person as a whole pursuant to Section 8(d)2 of the Act. The Commission otherwise affirms the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's April 12, 2018 decision is modified for the reasons stated herein and otherwise affirmed.

IT IS FURTHER ORDERED BY THE COMMISSION that the Arbitrator's award of permanent total disability is hereby vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $561.89 per week for a period of 51-3/7 weeks, representing July 21, 2013 through July 15, 2014, that being the period of temporary total incapacity for work pursuant to §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $505.70 per week for a period of 200 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the permanent disability of the person as a whole to the extent of 40%.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury. The Commission notes the parties stipulated Respondent is due a credit of $29,356.48 for benefits paid to Petitioner.

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 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:
DLS/maw
o04/09/19
46

APR 30 2019

Deborah L. Simpson

Deborah L. Simpson

Stephen J. Mathis

Stephen J. Mathis

D. Douglas McCarthy

D. Douglas McCarthy

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

19IWCC0212

CANCEL, MIGUEL A
Employee/Petitioner

Case# 13WC038515

ADM
Employer/Respondent

On 4/12/2018, 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 1.88% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1211 GOEHL SCHUERING CASSENS & BIER
DONALD R SCHUERING
506 VERMONT ST
QUINCY, IL 62301

0771 FEATHERSTUN GAUMER ET AL
EDWARD F FLYNN
225 N WATER ST SUITE 200
DECATUR, IL 62525

19IWCC0212

STATE OF ILLINOIS)
)SS.
COUNTY OF Adams)

- ☐ 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

Miguel A. Cancel
Employee/Petitioner

v.

ADM
Employer/Respondent

Case # 13 WC 38515

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 **Quincy**, on **February 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. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ Other **Is Petitioner entitled to compensation for total permanent disability?**

FINDINGS

On **July 20, 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 **$43,827.00**; the average weekly wage was **$842.83**.

On the date of accident, Petitioner was **55** years of age, ***married*** with **0** dependent children.

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

Respondent ***has*** paid all appropriate charges for all reasonable and necessary medical services, as stipulated to by the parties.

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$29,356.48** for other benefits, for a total credit of **$29,356.48**, as the parties have stipulated to such credit.

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 $561.89 per week that have accrued from July 21, 2013, through July 15, 2014.

Respondent shall pay Petitioner permanent total disability benefits of $561.89 per week for life commencing July 16, 2014, as provided for 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 for 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

April 12, 2018
Date

APR 12 2018

Miguel A. Cancel v. ADM, No. 13 WC 38515

Findings of Fact

Miguel A. Cancel (Petitioner), a 55 year old male, worked for ADM (Respondent) since 2000. He was described by his supervisor, Randy Ranabarger, who testified at trial, as being considered a very good worker, always on time, always did his job, and worked a 12 hour night shift. Petitioner testified he was regularly promoted and got pay increases. In July 2013, he worked the press building as an Operator II. Petitioner described his job as in charge of the west side building of Respondent's Quincy Plant, of 4-5 floors, bringing soybeans from silo to prep, making sure everything was running normally, making flake, sending flake to the extractor building, then when he received meal from that building, he sent it to the silo. Equipment is maintained with a grease gun of some three feet long, with the bearings of each piece of equipment having to be greased. Petitioner traveled all floors of the building during his shift. Miguel A. Cancel v. ADM, No. 13 WC 38515 Transcript of Proceedings on Arbitration at 70, 10, 33, 72, 71, 10, 82, 12.

Before the accident, and injury, on July 20, 2013, after having finished the Friday shift, Petitioner came home, took a shower, talked to his wife Cathleen, went to sleep about 1:30 p.m. and woke up feeling uncomfortable with his back. He took a couple of aspirin, and went back to sleep until around 5:30 p.m. and then went to work. His wife testified Petitioner made no mention of any discomfort when he woke up and drove himself to work. Both Petitioner and his wife testified there were no accidents, falls, or trips at home. At work before beginning his shift, Petitioner testified he had no problems, and was ready to start work. Ranabarger testified he saw Petitioner prior to his shift, July 20, 2013, in the break room at the west plant. Petitioner was sitting and joking with other employees, having normal conversation. He saw Petitioner get up and walk around. He seemed fine and normal. Another employee, Greg Kamphause, testified he saw Petitioner before the shift, sitting in a chair, and he appeared fine. Petitioner seemed normal. Ranabarger watched Petitioner punch in, and walk up an outside stairwell in the prep building. Cancel at 79-80, 49, 80, 82, 13-16, 41-42, 16.

Petitioner testified he started going around the building, gathered his grease gun, and walked up the stairs to the floors in the building. When he got up to the fourth floor, he started greasing equipment, having to reach and twist his body. At one point, when he twisted, he felt a sharp pain in his back, like he was stabbed in the back with an ice pick. Petitioner called Ranabarger with his radio and asked him to come to the west side. Ranabarger testified he got a call from Petitioner a little over an hour into the shift wanting him to call on the phone in the office. Rather than call, Ranabarger got in his truck and drove over. Petitioner testified he told Ranabarger he thought he hurt his back, it was hard to sit down or stand up. Ranabarger testified he saw Petitioner very agitated and could see he was in pain, walking around. Petitioner told him he felt like he injured his back while greasing equipment on the roof. Ranabarger said he tried to calm Petitioner down, he could tell he was in a lot of pain. Ranabarger decided

Petitioner had to show him where he was injured, and they took the elevator to the fourth floor, went out on the roof, and Petitioner showed him. Petitioner testified when he showed Ranabarger where the accident happened, His grease gun was still there. In a subsequent report, the location was referred to as sc-4122 trash screw. There were no witnesses. Cancel at 83-86, 87, 107, 87, 21, 22, 88, 23, 24, 25, 88; Petitioner's Exhibit 2.

Back in the office, Petitioner told Ranabarger he needed to take him to the hospital. Ranabarger called Don Hendrian, the safety supervisor, to take Petitioner to the hospital. Hendrian testified he got a call from Ranabarger and went to the facility. Ranabarger testified when Hendrian got there, Petitioner went down the stairs to meet him and left the office in a lot of pain. Hendrian took Petitioner to the emergency room in his truck. Petitioner testified he told Hendrian he hurt his back, he thought it happened on the roof. Hendrian testified Petitioner said he was greasing a conveyor belt, felt a twinge or sharpness in his back and said it was bothering him when he got up. Hendrian testified he saw Petitioner walking and appeared in pain and was bent over. Ranabarger testified Petitioner never indicated, at any time, he hurt himself at home prior to coming into work that day. Cancel at 89, 27, 127, 28-29, 89, 128, 135, 29-30.

Petitioner was taken to Blessing Hospital and seen in the emergency room. His wife and Don Hendrian were there. Neither party offered complete records from Blessing Hospital. For example, nursing documentation referred to on page 2 of the ED Assessment is missing. The records presented in evidence are scattered throughout the evidence depositions of two doctors and Petitioner's Exhibit 3. All that can be gleaned from the ED Assessment, billing records, and Face Sheet is that Blessing Hospital admitted Petitioner at 8:49 p.m. on July 20, 2013; discharged him at 12:48 a.m. on July 21, 2013; Petitioner complained of back pain; the insurance was listed as both "workmens comp" and Blue Cross of Illinois. Petitioner was given a CT scan of his abdomen and pelvis. The reason is unknown. He was diagnosed with back pain/sciatica. Some sort of blood test was given, as well as an IV and urinalysis. A nurse asked him what happened and he said he hurt his back. A nurse asked if this was in relation to his job and Hendrian said yes. Petitioner's wife testified she saw Petitioner in the waiting room, in pain. Hendrian testified he told the hospital it was not work related because Petitioner was just greasing the conveyor. We do not know the nature of the treatment at the hospital. Petitioner's Exhibit 1, Respondent's Exhibit 1; Cancel at 52, 129; Respondent's Exhibit 4, Petitioner's Exhibit 2; Cancel at 91-92, 53, 129, 130; Petitioner's Exhibit 3.

Petitioner's wife, Cathleen, testified she left the hospital with Petitioner and went home. Petitioner was tired and exhausted, and under pain medication. Petitioner slept most of Sunday and did not go to work Monday. Cancel at 56-57.

Ranabarger testified he filled out a First Report Data Worksheet. It is not signed or dated. Petitioner, said Ranabarger, never indicated an incident occurred at home. In the full description, it reads, "He said it was bothering him some at home before he came to work." Ranabarger testified he does not remember typing it up that way. He turned in the report to Don Hendrian that night. Hendrian testified he read the report Monday morning and denied altering the report. He admitted the report indicated an accident happened at work. Scott DeJong, the plant manager, testified he met Ranabarger Monday, July 22nd, about the incident. He heard about the

injury and was concerned because nobody contacted him. He wanted to know immediately and let corporate know. Prior to meeting Ranabarger, he had met with Hendrian about the work relatedness of Petitioner's injury. DeJong testified Ranabarger said Petitioner told him before the shift in the break room his back was sore and he wanted to give it a try at work. He testified Ranabarger said Petitioner said his back was sore and DeJong told Ranabarger he had to be fit for duty, and Ranabarger put his head down and said Petitioner wanted to give it a try. After seeing Ranabarger and assessing his credibility and demeanor, this Arbitrator finds this not credible and completely discounts it. DeJong did not file a report on this alleged statement, it does not appear in the report itself or the testimony of Ranabarger, and Petitioner expressly denied saying it. Ranabarger does not seem the kind of man to "hang his head." It is also disturbing that at the conclusion of Ranabarger's testimony, counsel for Petitioner asked if Ranabarger, under subpoena, could be released. This Arbitrator indicated that if no one needed him, Ranabarger would be released. It seems likely counsel for Respondent knew what DeJong would say, and had to suspect Ranabarger would be called in rebuttal since he had failed to testify to that conversation or be crossed examined as to what Petitioner had said. Nonetheless, he said "No, I'm fine." Ranabarger was released. After DeJong's testimony, Petitioner was called in rebuttal. No doubt Ranabarger would have been called as well if he were still there. I give the testimony of DeJong no weight whatsoever. Petitioner's Exhibit 2; Cancel at 30, 33, 31, 133, 134, 140, 142, 144, 143, 145, 148, 38.

Petitioner testified he saw his primary care physician, Dr. Larry Davis. Davis first saw Petitioner, as to this accident, two days after, on July 22, 2013. Petitioner complained of back pain with radiation. Davis noted Petitioner's left low back and left lower extremity discomfort started two days ago. Petitioner told Davis his pain was a severe burning type of discomfort in his lower back going into his thigh and calf making his whole foot numb. Davis assessed Petitioner with lumbar radiculopathy involving S1, possibly L5. Petitioner was prescribed Neurontin and Percocet. Davis's plan was to schedule Petitioner for an MRI of the lumbar spine and a referral for surgery. Petitioner was placed off work, possibly 2-4 weeks. Respondent's exhibit 3 at 67-69, 83; Cancel at 93.

The MRI was done July 25, 2013. It found: an extruded disc fragment in the left L4 lateral recess measuring 13x7mm in diameter abutting the contiguous thecal sac and likely the left L4 nerve root; a left lateral disc bulge at L5-S1 narrowing the left L5 neural foramen; right lateral disc bulge at L4-L5; mild retrolisthesis of L2 on L3, L3 on L4, and L4 on L5, similar compared to the previous study; and no acute fractures. Respondent's Exhibit 3 at 73.

Petitioner followed up with Dr. Davis on July 30, 2013. He reported persistent pain without improvement. Davis noted the MRI demonstrated a disc herniation at L3-L4 with an extruded disc fragment in the left L4 lateral recess measuring 13mm x 7mm and abutting the contiguous thecal sac and L4 nerve root. Petitioner was to see Dr. Arden Reynolds. Respondent's Exhibit 3 at 64; Cancel at 93.

Petitioner saw Dr. Reynolds July 31, 2013, complaining of back pain. Reynolds noted Petitioner was in an acute amount of distress. Reynolds diagnosed Petitioner with left L3-4 disc herniation and set surgery for August 1, 2013, a left microdiscectomy. Reynolds operated on

Petitioner August 1, 2013, performing a Left L3-L4 microdiscectomy with removal of disc and microdissection. Reynolds, Board Certified in Neurosurgery and Chief of Surgery with the Quincy Medical Group, testified via evidence deposition. He testified the CT scan at Blessing Hospital, done July 20, 2013, also showed the disc herniation. He said the L3-4 disc was herniated and the tissue pushed out of the way went down over the body of L4. He found an extremely large, huge he said, disc fragment. Reynolds said after his examination, the MRI, and the CT, Petitioner needed surgery, and quickly. He said the Petitioner couldn't go to work, the disc was so large, the pain was awful, pressing on the L3 and L4 nerve roots. Petitioner's leg wouldn't have been strong enough to hold him up. Reynolds found, to a reasonable degree of medical certainty, Petitioner's twisting and turning with the grease gun would have definitely caused the fresh extrusion. He said it fit precisely what Petitioner described to his supervisor and what he saw in surgery. Reynolds testified the operative findings support the history of Petitioner's account of the injury on July 20, 2013, and fit precisely. Petitioner's Exhibit 1, Petitioner's Exhibit 5; Petitioner's Exhibit 1 at 12, 13, 16, 15, 19.

Following surgery, Petitioner followed up with Dr. Davis through December 2013. Most of the follow up was for incision check and continued pain. Petitioner was using a cane into October 2013. Davis issued Work Ability Reports of August 5, 2013, and October 22, 2013, of no work due to lumbar surgery. An MRI of the lumbar spine was done December 6, 2013. It revealed: mild posterior disc bulge at L2-L3 without significant neural encroachment; mild left lateral disc bulge at L3-L4; and left lateral disc bulge at L5-S1 narrowing left L5 neural foramen. Respondent's Exhibit 3.

Petitioner testified he saw Dr. Reynolds after surgery, and that he still sees Reynolds as needed. He calls for medication. Cancel at 94, 107-108.

Reynolds testified as to those follow up visits and his records of August 2, 2013, through December 1, 2015, were introduced into evidence. Some of the records are incomplete and the dates in 2014 are hard to follow. However, those records show 10 visits from August 2, 2013, through January 9, 2014. In that January visit, the MRI results were discussed, and Petitioner had complained of an increase in low back pain and leg pain. Reynolds thought Petitioner would be disabled for at least a year. By April 2014, Reynolds noted Petitioner "...will be permanently and totally disabled from his lumbosacral neuritis. He has 2 evidences of that. One is arachnoiditis on his MRI. The other is epidural fibrosis." Reynolds noted he did not see Petitioner ever being able to go back to work. In the April visit, Reynolds discussed with Petitioner that he was going to hurt for the rest of his life, as he had in the last 5 or 6 visits. Reynolds noted, "I think he is finally getting to the point where maybe he is starting to believe it a little bit." There are records of five more visits from July 15, 2014, to December 1, 2015. Petitioner is always in pain, and five times Reynolds noted Petitioner remained permanently and totally disabled. He viewed Petitioner's condition as a classic disorder of failed back syndrome/lumbosacral on the right caused by arachnoiditis and epidural scar seen on the lumbar MRI. Petitioner's Exhibit 1, Petitioner's Exhibit 5.

Dr. Reynolds testified, "I don't for a second think he [Petitioner] has ever been trying to scam the system or augment his symptoms. If anything, he is always trying to find a way to get back

to doing something, because he doesn't like to hang around." Reynolds said, by July 2014, he became convinced Petitioner was going to be permanently and totally disabled, really convinced Petitioner had lumbosacral neuritis, and made that diagnosis. Reynolds testified the outcome of Petitioner's surgery was not what he or Petitioner hoped it would be. Petitioner has lumbosacral neuritis as a result of the disc removal, a result of the injury of July 20, 2013. Reynolds testified based on the examinations and treatment rendered Petitioner, his permanent disability is related to the injury he suffered at work. Petitioner's Exhibit 1 at 29, 30, 22, 31-32.

Three years post-accident, on July 20. 2016, Petitioner submitted to an independent medical evaluation by Dr. Frank Petkovich. By that time, he had not worked in three years, had back surgery and still saw his physician as needed and for continuing pain medication. By that time, for over two years, his surgeon had noted Petitioner was permanently and totally disabled.

Prior to the examination, counsel for Respondent wrote to Dr. Petkovich, an unconventional, highly opinionated and argumentative letter, with 2 ½ pages devoted to quoting the deposition of Dr. Reynolds. The letter asked for a response to four questions, none of them medical opinions on Petitioner's injury or disability. The issue in the case was posited as whether Petitioner was injured while working for Respondent on July 20, 2013. Respondent's Exhibit 4, Petitioner's Exhibit 4.

Dr. Petkovich saw Petitioner on July 20, 2016, for one hour and forty-five minutes, conducting a physical examination, taking a history from Petitioner, and reviewing medical records. Petkovich, who testified via evidence deposition, testified he does not specifically remember the details of his examination. His subsequent report opines that he cannot determine when the lumbar disc herniation at L3-L4 occurred. He said it is possible the disc herniation could have been present long before the incident Petitioner described as occurring at work. It was Petkovich's opinion Petitioner could work at the regular job he was doing prior to July 20, 2013, without any restrictions with regard to the lumbar disc herniation and subsequent surgical procedure. His report offers no amplification, explanation, or basis for that opinion. Respondent's Exhibit 4 at 59, 8-10, 63; Respondent's Exhibit 1 at 5, 6.

Petkovich testified the operative report on Petitioner described a disc herniation at the L3-4 level with extruded and sequestered material that had come out of the disc space. He said there was no evidence of annular tearing or disruption of the posterior aspect of the disc, so it was impossible to tell when the disc herniation occurred. He believed it was not an acute injury. Petkovich testified he disagrees Petitioner is totally and permanently disabled because Petitioner has recovered from previous lumbar spine surgeries. He based his opinion on his experience, the medical records, and his examination. He said he had performed many of these operations and people have gone back to doing very physical types of work. He does not believe lumbosacral neurosis is a permanent condition. Respondent's Exhibit 4 at 30, 48, 76, 87.

At hearing, Petitioner testified he has not been back to work, he has a lot of problems with his back, legs, and feet. He is in pain when he stands and sits. He takes medication daily. He has not looked for other employment, he has too many problems. He has been receiving Social Security Disability since 2014. Cancel at 95, 96, 98, 100.

Conclusions of Law

At the commencement of trial, this Arbitrator reviewed the Request for Hearing Form indicating the issues in dispute. The parties agreed the disputed issues were: whether or not the Petitioner sustained injury that arose out of and in the course of employment; whether Petitioner's current condition of ill-being is causally related to the injury; the length of time for temporary total disability; the nature and extent of the injury; and any compensation for total and permanent disability. Cancel at 5-7; Arbitrator's Exhibit 1. The stipulations bind the parties. Walker v. Industrial Commission, 345 Ill. App. 3d 1084 (2004).

Disputed issue **C** is did an accident occur that arose out of and in the course of Petitioner's employment by Respondent. This Arbitrator finds, as a conclusion of law, it did.

To obtain compensation under the Act, Petitioner bears the burden of showing, by a preponderance of the evidence, that he has sustained accidental injuries arising out of and in the course of the employment. 820 ILCS 305/1(b)3(d). For an accident to arise out of employment, there must be a causal connection between the employment and the injury, in that the injury must originate in a risk that is connected or incidental to the employment. Union Starch v. Industrial Commission, 56 Ill. 2d 272, 274 (1974). Generally, an accident happens in the course of employment when the employee is doing a duty he is employed to do. Ceisel v. Industrial Commission, 400 Ill. 574, 580 (1948).

In support of this finding, I rely on the testimony of Petitioner that during his shift on July 20, 2013, while performing his duties in the west side building, he felt a sharp pain in his back. As corroborated by his supervisor, he told his supervisor he hurt his back, identified the location of the accident, and was taken to the hospital. I also rely on the testimony of Petitioner, Ranabarger, and Greg Kamphause, that prior to beginning his shift, Petitioner exhibited no signs of injury, he seemed normal, and ready to go to work. Moreover, after Petitioner reported the injury, Ranabarger testified Petitioner was in a lot of pain. Even Don Hendrian testified Petitioner appeared in pain, bent over. Ranabarger's report, with all its flaws, indicates the accident happened when Petitioner was greasing sc-4122 trash screw. Finally, the causal connection was firmly established by Dr. Reynolds, who performed surgery on Petitioner and testified his operative findings support Petitioner's history of his account of the injury on July 20, 2013, saying it fit precisely with what he saw in surgery and what Petitioner described to his supervisor and at the emergency room. The twisting and turning with the grease gun would have, said Reynolds, caused the fresh extrusion observed during surgery. Cancel at 87, 88-89, 23-24, 82, 13-20, 41-42, 23, 25, 26, 29, 135; Petitioner's Exhibit 2; Petitioner's Exhibit 1 at 16, 19, 15.

Although not required or obligated to give more weight to a treating physician's testimony than that of an examining physician, See Prairie Farms Diary v. Industrial Commission, 279 Ill. App. 3d 546, 550-51 (1996), I do here, based on the length of time Reynolds has treated

Petitioner, his 40 years of practice, his current surgical practice and expertise, his knowledge of Petitioner and his condition through the years, and certainty of opinions. Petitioner's Exhibit 1 at 5, 7, 8, 20-22, 15, 16, 19.

Disputed issue F is, is Petitioner's current condition of ill-being causally related to the injury. This Arbitrator finds, as a conclusion of law, it is.

A claimant must establish, among other things, that the condition of ill-being is causally connected to a work related injury. The injury need not be the sole causative factor in the resulting condition. Elgin Board of Education School District U-46 v. Illinois Workers' Compensation Commission, 409 Ill. App. 3d 943, 948-49 (2011).

In support of this finding, I rely on the testimony of Dr. Reynolds. Reynolds testified Petitioner's L3-4 disc was herniated and pushed tissue out of the way, with the tail end of the disc going over the body of L4. This was an extremely large disc fragment, he called it "huge." Reynolds testified Petitioner's account of twisting and turning using his grease gun would have "definitely" caused the fresh extrusion he observed when he went in and did the surgery. Moreover, Reynolds testified the herniation, extrusion, injury to Petitioner's nerves and lumbosacral neuritis are all the result of the injury of July 20, 2013. Petitioner's Exhibit 1 at 13, 15, 16, 19, 21, 22.

As stated above, I give more weight to Dr. Reynolds than that of the examining physician. Looking at the report of the independent medical examination of Petitioner by Dr. Petkovich, he indicates he does not know when the disc herniation occurred. Then he equivocates saying, "It is certainly *possible* that the above disc herniation *could* have been present long before the above incident Mr. Cancel described as occurring while at work on July 20, 2016 [sic]." His lack of certainty and ambiguity in contrast to the certainty of Petitioner's surgeon weighs heavily in favor of Reynolds. Respondent's Exhibit 1 at 5 (emphasis added).

Disputed issue K is, what temporary benefits are in dispute. Here, it is temporary total disability. This Arbitrator finds, as a conclusion of law, Petitioner is entitled to temporary total disability benefits in accordance with 820 ILCS 305/8(b).

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. 609 (1984). Compensation begins, where temporary total incapacity for work continues for a period of 14 days or more from the day of the accident on the day after the accident. 820 ILCS 305/8(b). An employee is temporarily totally disabled from the time the injury incapacitates him from work until such time as he is as far recovered or restored as the permanent character of the injury will permit. Once an injured employee's physical condition stabilizes, he is no longer eligible for temporary total disability benefits. Archer Daniels Midland Co., 138 Ill. 2d 107, 18 (1990).

In support of this finding, I rely on the testimony of Petitioner, that he has not been back to work since the accident, and has not looked for other employment because of his physical condition. I also rely on the records of Dr. Larry Davis, who placed Petitioner off work as of

July 22, 2013, and continued to reflect Petitioner was unable to work from then through November 26, 2013. Those records also support the fact that Petitioner was unable to work. I also rely on the testimony and records of Dr. Reynolds that as of April 16, 2014, Petitioner had no ability to work. Reynolds testified that by July 15, 2014, he became convinced Petitioner was going to be permanently and totally disabled, and made that diagnosis. Petitioner's condition stabilized to a point of permanency by July 15, 2014. Thus, Petitioner is entitled to an award for temporary total disability from July 21, 2013, through July 15, 2014. The parties have stipulated Petitioner's average weekly wage at $842.83, consequently, pursuant to 820 ILCS 305/8(b)1, the compensation rate, per week, for Petitioner is $561.89.

Disputed issue **L** and its related inquiry, issue **O**, is what is the nature and extent of the injury. This Arbitrator finds, as a matter of law: Petitioner sustained, as a result of the accident on July 20, 2013, a lumbar disc herniation with a large disc fragment which injured nerves in Petitioner's back. He has lumbosacral neuritis; and the extent of the injury is permanent total disability as of July 16, 2014. Being found totally disabled, pursuant to 820 ILCS 305/8(f), Petitioner is entitled to permanent total disability benefits for life at the rate set forth in Section 8(b)2. The compensation rate for Petitioner is $561.89 per week.

To recover benefits under the Act, a claimant has the burden of proving all the elements of his case, including extent and permanency of injury, by a preponderance of the evidence. Arbuckle v. Industrial Commission, 32 Ill. 2d 581, 585 (1965). An employee is totally and permanently disabled, for the purpose of benefits, when he is unable to make some contribution to industry sufficient to justify payment of wages. The burden is on Petitioner to establish, or present facts from which it can be inferred that he is permanently disabled. A.M.T.C. of Il., Inc. v. Industrial Commission, 77 Ill. 2d 482, 487-88 (1979).

In support of these findings, I rely on the testimony of Petitioner, the testimony and records of Dr. Reynolds, and the records of Dr. Davis.

Petitioner testified he has a sixth grade education, with no formal schooling since then. He has no formal training in any profession. He moved to Quincy in 1999 and started with Respondent soon thereafter. Petitioner understands English, and as I saw at hearing, it is possible to understand Petitioner when he is speaking, but it takes effort and concentration. His wife testified he has no formal schooling in English. Petitioner testified he has not worked since the accident, due to his physical problems. Everything he does has limitations. He is now 60 years old, without computer or retail training. Cancel at 67-68, 69-70, 53, 95, 98, 96, 98.

As to Dr. Reynolds, Petitioner's surgeon, he testified because of the size of the herniated disc, and the degree of injury when it came out, Petitioner was developing scar tissue which would bind the nerves down, so after surgery instead of getting better, Petitioner started getting worse and has gotten to a point where Petitioner is incapacitated by pain and loss of motion. Whenever Petitioner tries to move normally, the nerves bound down on the scar tissue and make the pain worse. Reynolds testified Petitioner has lumbosacral neuritis, which can wax and wane. He established that diagnosis July 15, 2014, and became convinced Petitioner was going to be permanently and totally disabled, and made that diagnosis. Reynolds testified the permanent

disability is related to the injury at work. The records of Dr. Reynolds, of visits from July 15, 2014 to December 1, 2015, note permanent and total disability. Petitioner's Exhibit 1 at 21, 22, 30, 31, 31-32; Petitioner's Exhibit 1, Petitioner's Exhibit 5.

As to the records of Dr. Davis, a Functional Status Summary was done on Petitioner as far back as December, 2013. It indicated Petitioner had extreme difficulty or could not: do his usual work; put on his shoes or socks; drive; lift a box of groceries; stand for an hour; or go up a flight of stairs. Petitioner indicated he needs help every day in most aspects of his personal care, can't sit for more than an hour; can't stand for more than 10 minutes, restricts his travel to under ½ hour, and can't work or perform homemaking chores. Respondent's Exhibit 3 at 75-78.

Under these circumstance, the evidence is sufficient to support a claim for total disability. Ceco Corp. v. Industrial Commission, 95 Ill. 2d 278, 288 (1983).

Although Dr. Petkovich rendered a contrary opinion in his testimony, the issue was not part of his report. He simply said, without explanation, Petitioner could work at his regular job without restrictions. Under cross examination of his testimony, Petkovich first raised his disagreement with Dr. Reynolds, essentially saying he has done these types of operations and people go back to work. He did not address any specifics of Petitioner's case, nor why Petitioner had been off work for years, or how long he might have taken to recover by the time he examined him for less than two hours. I resolve any conflict between Reynolds and Petkovich in favor of Reynolds for the reason previously stated.

Respondent offered no evidence any suitable employment was reasonably available to Petitioner, or seriously addressed the issue in any way at all.

Arbitrator

4/12/2018

Date