09WC030456
09WC030457
20IWCC0335

STATE OF ILLINOIS) BEFORE THE ILLINOIS WORKERS' COMPENSATION
) SS COMMISSION
COUNTY OF COOK)

Catherine Jacobs,

Petitioner,

vs. NO. 09WC030456 & 09WC030457
20IWCC0335

Echo Joint Agreement, and the Rate Adjustment Fund,

Respondent.

ORDER OF RECALL UNDER SECTION 19(f)

A Petition under Section 19(f) of the Illinois Workers' Compensation Act to Correct Clerical Error in the Decision and Opinion on Review dated June 17, 2020 has been filed by Petitioner's herein. Upon consideration of said Petition, the Commission is of the opinion that it should be granted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision and Opinion on Review dated June 17, 2020 is hereby vacated and recalled pursuant to Section 19(f) for clerical error contained therein.

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

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

DATED: JUN 2 9 2020
SM/sj
44

Stephen J. Mathis

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

CATHERINE JACOBS,

Petitioner,

vs.

NOS. 09WC30456 &
09WC30457
20IWCC0335

ECHO JOINT AGREEMENT,and THE RATE ADJUSTMENT FUND,

Respondent.

CORRECTED DECISION AND OPINION ON REVIEW

Timely Petitions for Review having been filed by the Petitioner and Respondent herein and notice given to all parties, the Commission, after considering the issues of and being advised of the facts and law, modifies the Decision of the Arbitrator in case number 09 WC 30457 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 Decision of the Arbitrator in 06 WC 30456.

09 WC 30456

The Commission hereby affirms and adopts the Arbitrator's denial of benefits in this consolidated matter.

09 WC 30457

The Commission notes that on February 26, 2014 Petitioner's treating physician, Dr. Lubenow reported that Ms. Jacobs was able to return to light duty with a 20- pound weight restriction. Dr. Lubenow found that Petitioner achieved maximum medical improvement

effective February 26, 2014. Petitioner was a Special Education teacher working in an elementary school. Petitioner was limited to a 4- hour workday with incremental monthly increases of 1 hour per day, up to 8 hours per day. Restrictions on lifting, carrying and other physical activities i.e. kneeling, crouching and stair climbing were maintained. Lisa Helm, the certified vocational counselor with Vocamotive who evaluated Petitioner concluded in her report that Petitioner was not employable by virtue of her restrictions. Based upon this evidence the Commission hereby reclassifies the award of benefits to conform to the evidence.

Based upon the foregoing the Commission hereby modifies the Arbitrator's award of temporary total disability benefits in part to commence October 28, 2010 through February 26, 2014, that being the date Petitioner achieved maximum medical improvement according to Dr. Lubenow. Petitioner shall be awarded maintenance commencing February 27, 2014 through June 17, 2014. The award of permanent total disability benefits is hereby modified to commence June 18, 2014. The denial of penalties and fees is affirmed.

All else is affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay reasonable and necessary medical services of $321,368.95, as provided in Section 8(a) of the Act, and subject to Section 8.2 of the Act where applicable.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $717.97 per week for a period of 228.287 weeks, commencing March 24, 2009 through January 13, 2010; June 1, 2010 through August 23, 2010; and October 28, 2010 through February 26, 2014 that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner temporary partial disability benefits of $464.06 per week for 28 weeks, commencing January 21, 2010 through May 31, 2010, and August 24, 2010 through October 27, 2010, as provided in Section 8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner maintenance benefits of $717.97 per week for 15.857 weeks, commencing February 27, 2014 through June 17, 2014, as provided in Section 8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner permanent and total disability benefits of $717.97 per week for life, commencing June 18,2014 as provided in Section 8(f) of the Act. Commencing on the second July 15th after the entry of this award, Petitioner may become eligible for cost-of-living adjustments, paid by the *Rate Adjustment Fund,* as provided in Section 8(g) of the Act.

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

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit

of $43,653.35 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 credit, as provided in Section 8(j) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that the Arbitrator's denial of penalties under Sections 19(k) and 19(l) and fees under Section 16 is hereby affirmed.

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: JUN 2 9 2020
SJM/msb
O:5/6/20
44

Stephen Mathis

Douglas McCarthy

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

JACOBS, CATHERINE M Case# **09WC030457**

Employee/Petitioner

09WC030456

20IWCC0335

ECHO JOINT AGREEMENT

Employer/Respondent

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

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

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

0311 KOSIN LAW OFFICE LTD
DAVID X KOSIN
134 N LASALLE ST SUITE 1340
CHICAGO, IL 60602

0863 ANCEL GLINK
W BRITTON SALY
140 S DEARBORN ST 6TH FL
CHICAGO, IL 60603

20IWCC0335

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

- [ ] 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

Catherine M. Jacobs
Employee/Petitioner

v.

ECHO Joint Agreement
Employer/Respondent

Case # **09** WC **30457**

Consolidated cases: **09 WC 30456**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Steven Fruth**, Arbitrator of the Commission, in the city of **Chicago**, on **1/10/2018** and **2/22/2018**. After reviewing all of the evidence presented, **Arbitrator Brian T. Cronin** hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **3/23/2009**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**38,770.20** for **a 36-week school year**; the average weekly wage was $**1,076.95**.

On the date of accident, Petitioner was **45** years of age, ***single*** with **1** dependent child.

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

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

Respondent shall be given a credit of $**217,550.50** for TTD, $**12,993.64** for TPD, $**0.00** for maintenance, and $**8,272.45** for other benefits, for a total credit of $**238,816.59**.

Respondent is entitled to a credit of $**43,653.35** under Section 8(j) of the Act for medical benefits paid through their group carrier.

ORDER

Respondent shall pay reasonable and necessary medical services of $**321,368.95**, as provided in Section 8(a) and subject to Section 8.2 of the Act where applicable.

Respondent shall be given a credit of $**43,653.35** for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $**717.97**/week for **244-1/7**weeks, commencing **3/24/2009** through **1/13/2010**, **6/01/2010** through **8/23/2010**, and **10/28/2010** through **6/17/2014**, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner temporary partial disability benefits of $**464.06**/week for **28** weeks, commencing **1/21/2010** through **5/31/2010** and **8/24/2010** through **10/27/2010**, as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner temporary partial disability benefits of $**549.99**/week for **3** weeks, commencing **1/11/2016** through **1/31/2016**, as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner maintenance benefits of $**717.97**/week for **83-3/7** weeks, commencing **6/18/2014** through **1/10/2016** and **2/1/2016** through **2/12/2016**, as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner permanent and total disability benefits of $**717.97**/week for life, commencing on **2/13/2016**, as provided in Section 8(f) of the Act.

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

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

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

Signature of Arbitrator

3/6/2019
Date

MAR 7 - 2019

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

CATHERINE JACOBS,	)	
	)	
Petitioner,	)	
	)	
v.	)	Case Nos. 09 WC 30457
	)	Consolidated with
	)	09 WC 30456
ECHO JOINT AGREEMENT,	)	
	)	
Respondent.	)	Arbitrator Steven Fruth

ADDENDUM TO ARBITRATION DECISION

I. Findings of Fact

Introduction/Procedural History

On July 22, 2009, Catherine Jacobs ("Petitioner") filed an Application for Adjustment of Claim and then an Amended Application for Adjustment of Claim and was assigned a case number of 09 WC 30457. In both the original and Amended Applications, Petitioner alleged that on March 23, 2009, she sustained an accident while working for Echo Joint Agreement ("Respondent") when she was assaulted by a mentally challenged student and injured her "neck, head, shoulders, mid back, low back and bilateral legs" as a result.

Respondent's Exhibit 14 shows that Respondent last paid Petitioner TTD/maintenance benefits on January 8, 2016 for the period ending that day. Petitioner then worked in an accommodated, modified-duty job for Respondent. On February 12, 2016, Dr. Lubenow opined Petitioner was permanently and totally disabled. In a letter dated April 4, 2016, written by Bonnie Jordan of Respondent, and sent to Petitioner, Ms. Jordan stated that Petitioner's position was terminated based on Dr. Lubenow's opinions.

Thereafter, the parties prepared this case for trial. Respondent made a PPD advance to Petitioner in the amount of $8,272.45.

Before Arbitrator Fruth, Petitioner and Respondent proceeded to trial on January 10, 2018 and closed proofs on February 22, 2018. Commission records indicate that on August 9, 2018, Arbitrator Fruth recused himself from writing the decision for this case and submitted the case to the Commission for reassignment. The Commission reassigned the case to Arbitrator Cronin. Arbitrator Cronin was on medical leave from July 24, 2018 through October 8, 2018 and was first made aware of this reassignment sometime after his return to the Commission. The parties did not object to Arbitrator Cronin carefully reviewing the evidence and writing the decision. The parties sent their proposed findings to Arbitrator Cronin on October 24, 2018.

Testimony of Petitioner, Catherine Jacobs

Petitioner testified that in March 2009, she was 45 years old, is currently 54 years old, and was born on March 30, 1963. (T. 23)

Prior to March 2009, the condition of her low back, legs, torso, shoulders, mid-back, upper back and lower back was completely fine and healthy. (T. 24) Before March 2009, she had had no problems with those body parts. (T. 24) Likewise, she had never had any condition of chronic pain in her life prior to March 2009. Prior to March 2009, her activities included walking at least 5-7 times per week with her girlfriends for 1-3 hours, motorcycle riding with her boyfriend, Bill Izzo, 3-4 times a week, boating in the summer, playing volleyball 2-3 times per week 9 months out of the year in a competitive league. (T. 25) Petitioner testified that none of these activities caused any sort of pain or discomfort. Also prior to March 2009, she had no restrictions as to the length of time or distance that she could drive a vehicle. (T. 26) Likewise, with standing, walking, and sitting, she had no limitations. (T. 26) In March 2009, she was employed by Respondent, which educates children with special needs. (T. 26-27) Her job title was Special Education Teacher, meaning that she was hired to teach children who had an IQ of

70 or below, and her children were even lower functioning than that, in the 50 – 60 range of IQ. (T. 27) The end of the school year, 2009, would be the end of her fourth year working for Respondent. In March 2009, she was assigned to the Academy for Learning (AFL) facility at ECHO, located in Dolton, Illinois, at 306 East 144th Street, Dolton, Illinois. (T. 28-29) Her students were aged 13 - 21 years old. (T. 29) Although high schools and grammar schools already have special education programs, if the children have any gang affiliation, problems with guns, violence, behavioral, or severe emotional problems, then they would be brought over to ECHO. (T. 29-30) The behavioral problems of these children include throwing desks, chairs, books, or hitting other students or teachers. (T. 30) The size of the students was between 5' and 100 lbs. and 6'3" and 300 lbs. (T. 31) Petitioner was 5'6" tall and weighed 122 lbs. (T. 31)

Her job description required her to participate in lifting students and the physical restraint of students. (T. 32, *see* Px. 26) She would either hold the student down in a chair, get him on the floor and put his hands behind them and wait for someone to come to the classroom, or if two children were fighting, an Aide would take 1, she would take the other, they would physically pull the 2 students apart. (T. 34) Her aide at the time was Judy Daniels and she was 180 – 200 lbs. and 5'6" and about 12 years older than her. (T. 34-35) If she did not have access to an Aide, she would need to complete the restraint on her own, which was a requirement of her job. (T. 35)

Petitioner further testified that 98% of her job involved her being on her feet and moving about. In March 2009, her work was not confined to activities at the Academy of Learning but included off-campus activities such as grocery shopping, banking, and recycling. For example, they would visit Sam's Club or Ultra Foods to learn functional life skills, which included money handling.

On March 23, 2009, a little after 10:00 a.m., Petitioner was at Ultra Foods along with her Aide, Judy Daniels, and her students, which included Kevin. (T. 45-47) She testified that Kevin was behind her in the store and she felt things being thrown off the shelves, so she turned around and then he threw her onto a pallet jack. (T. 47) She landed with her rear end caught between the two forks of the pallet jack; the underpart of her thigh was caught on one side and her back was caught on the other side. (T. 48) She felt that she had been struck extremely hard by Kevin. She remembers her feet coming up entirely off the floor. (T. 49) She got up with the assistance of her Aide and because she saw another lady shopping, she needed to restrain Kevin. She restrained him with Judy, which took about 10 minutes, in a bed of lettuce. It took them about 20 minutes to calm him down and then they were able to get him back on the bus. (T. 50) Once on the bus, she remembers saying to her Aide that her back was really bothering her and that she felt like she had the flu. (T. 51) Everything was aching from her neck, her left shoulder, and then her lower back. She was also bleeding on her left hand from where he bit her. (T. 51)

Once back at the Academy, she provided notice that she had been involved in this incident, with the nurse. (T. 52)

Petitioner first went to MacNeal Hospital with complaints of left shoulder and lower back pain. (T. 53) She was advised to stay off work and to seek further treatment from her family physician and an infectious disease doctor because of the bite to her hand. (T. 53) On March 25, 2009, she saw her family physician, Dr. Hsieh, with complaints of low back and shoulder pain. She noticed that her pain was getting worse than ever. He advised her to stay off work and to consider physical therapy. (T. 54)

She also saw Dr. Levin, an infectious disease specialist, and he tested her since she had been bitten. The test results came back negative. (T. 55)

On March 26, 2009, she was seen by Dr. Lorenz at Hinsdale Orthopaedics. (T. 56) At that time, her pain symptoms had not changed. Dr. Lorenz advised her to stay off work, provided her with medications and recommended physical therapy. He also asked her to see his associate, Dr. Kirincic. (T. 56)

Her first round of physical therapy was 2-3 time a week at ATI. (T. 57) While going to physical therapy, Petitioner complained that she was tender to the touch, which meant that when her back was touched, it hurt. (T. 58)

On April 9, 2009, Dr. Kirincic first saw her and recommended that she continue physical therapy and use a TENS unit. Petitioner testified that the TENS unit did not provide any benefit. Dr. Kirincic also performed a myofascial release and administered acupuncture and injections. However, Petitioner had issues with sensitivity, so the doctor placed the needles about her shoulder blade and closer to the sides of her back than to the mid back. She was able to tolerate this. (T. 58-60)

Petitioner continued to see Dr. Kirincic once a week thereafter. Petitioner started to feel a burning sensation for the first time in her lower back and her buttocks. (T. 61) At that point, Dr. Kirincic suggested that she stop formal physical therapy and go to a facility run by Dr. Gelband, a chiropractor. (T. 61) She treated with Dr. Gelband for about 8 months; he performed chiropractic care and therapies, which were very limited therapies. (T. 62) On May 11, 2009, Dr. Kirincic ran a rheumatological battery on her that came back negative. (T. 63) Dr. Kirincic also ordered MRIs of her shoulders, thoracic spine and lumbar spine. On May 21, 2009, Petitioner had an MRI of her left shoulder. (T. 63)

On June 1, 2009, she was sent for an examination by Respondent's Section 12 physician, Dr. Wehner. (T. 63-64)

Petitioner continued to have pain in her back, particularly between her shoulder blades and down to her belt buckle. She was feeling more intense pain in her "sit" bones, i.e., her pelvic bones. (T. 66) Also, it was hard putting clothes on because she could not be touched. She was having troubles wearing anything like a bra or anything with elastic in it. (T. 66) She felt severe pain and if someone touched her, she would start crying. (T. 67) It would take a while for her nerves to calm down and then her back would feel okay after she wore clothes. (T. 67)

Around July 13, 2009, her benefits were terminated based on Dr. Wehner's reports. However, it was eventually worked out that her back benefits would be paid, and she continued with her treatment. (T. 69)

On July 16, 2009, Dr. Kirincic referred Petitioner to Dr. Zindrick for a work up on her spinal condition. (T. 69) During that entire time, her doctors continued to take her off work. (T. 70) Petitioner testified that she was having problems with the two joints in the top of her hips whenever she would walk. (T. 72) Dr. Zindrick then prescribed an MRI of the hips. On July 30, 2009, she was examined by a general surgeon to rule out any sort of internal pathology of the hips. (T. 72)

On August 3, 2009, she returned to Dr. Zindrick who referred her to his associate, Dr. Louis. On August 4, 2009, she saw Dr. Louis, who saw her only that one time. He indicated that there may be a condition of RSD involved. (T. 73)

She continued under the care of Dr. Kirincic at Hinsdale Orthopedics and in September 2009, Dr. Kirincic ordered an EMG, which was administered on September 2, 2009. (T. 74) On September 8, 2009, she began treatment at the Rehab Institute of Chicago, which Dr. Kirincic recommended. (T. 75) While at RIC, Dr. Rader interviewed her. Based on his initial assessment, RIC allowed her in an in-patient program there for 1 month. This program included

physical therapy, occupational therapy, psychiatry, mind/body training, and other modalities to handle the pain without medication. (T. 76) She found that the program was beneficial in that they taught her how to pace herself with her pain by using relaxation techniques and therapies. However, the program did not make her condition go away. (T. 77)

About that time, she was also seen by Dr. Citow, the employer's Section 12 physician. (T. 78)

Around this time, she also moved her residence from Brookfield, Illinois to Indiana. She moved because she had a 5-story house with lots of stairs with no bathroom or bedroom on the first floor, so it was exhausting to go up and down the stairs and to keep up a household. (T. 79) In Indiana, she moved to a single-level apartment. (T. 79) The distance from the apartment to the Academy for Learning was 15 minutes. (T. 80) Based on Dr. Citow's January 14, 2010 report, she was advised to return to work full duty. She made a good faith attempt to return to work at that point. (T. 80) However, the pain was just increasing, and every day just seemed harder and harder to get up and go to work. By the end of the day, she was physically exhausted, and the pain was unbearable. On January 21, 2010, she returned to Dr. Kirincic, at which point the doctor recommended a reduced-hour return to work: 4 hours per day. (T. 81) She also referred her to Dr. Gruft, a pain psychologist, and Dr. Tumlin.

On January 21, 2010, Petitioner returned to work. Respondent allowed her to work 4 hours a day as a Special Education Teacher. (T. 83) She had a 15-minute drive to school but sometimes her Aide, Judy Daniels, would pick her up. (T. 83) The accommodations given to her by Respondent included not having a first period and going home for lunch. She could teach everything within those 4 hours. Respondent also set her up at u-shaped desk, so she was always on one side of the desk and her students were on the other side. She was also allowed to sit on

the floor with pillows and teach the class. (T. 84) While she was teaching, she was also paid a differential for the hours that she was losing. (T. 84)

On January 22, 2010, she saw Dr. Tumlin on one occasion. Between February 3 – March 2010, she was seen by Dr. Gruft on about 5 occasions. Dr. Gruft was trying to rule out celiac disease. (T. 85) She was referred to Dr. Demeo at Rush in March 2010 to determine whether celiac disease was a cause of her complaints. A biopsy was taken that ruled out celiac disease. (T. 85)

Petitioner testified that she noticed, upon returning to work for 4 hours/day in the beginning of 2010, that the pain she experienced on Monday was just as bad as it was on Friday. She was also having pain from sitting while driving to and from work. (T. 86-87) However, she kept working through May 31, 2010, which was the end of the school year. (T. 88)

In August 2010, she returned to work with a limited 4-hour schedule. (T. 90) Dr. Kirincic referred her to Dr. Lubenow at Rush Pain Center. The parties agreed to such referral. (T. 90)

On October 14, 2010, Petitioner saw Dr. Lubenow for her initial evaluation. He took a detailed history and conducted a physical examination of her as well as a visual examination of her entire body. (T. 91) During the course of care with Dr. Lubenow, he measured temperature differences in various parts of her body mechanically. Dr. Lubenow also referred her to his pain psychologist, Dr. Patricia Merriman. (T. 92)

On October 27, 2010, she saw Dr. Lubenow again and also saw Dr. Merriman. (T. 92) Dr. Lubenow performed a full examination of her body, made notations of her temperature differentials, and took her off work completely. Eventually, her TTD weekly benefits were restarted. (T. 93)

On December 6, 2010, Dr. Lubenow prescribed a 5-day infusion of medication to be administered at Rush Medical Center. Such infusion was to be followed by an aggressive physical therapy program. Petitioner recalled receiving very little benefit from the 5-day infusion of medication. Each time Dr. Lubenow saw Petitioner, he would conduct a physical examination.

On January 12, 2011, Dr. Lubenow prescribed a trial of a spinal cord stimulator. Dr. Lubenow was treating her with oral medication, which, Petitioner testified, was helping the pain or decreasing, maybe, some of it - - but she was not very functional at that time. (T. 95-96)

On April 18, 2011, a trial spine cord stimulator was implanted while she was at Rush. Petitioner testified that it definitely benefited her in that she was able to walk longer distances but the stimulation up her back was painful. Her legs seemed more functional, but the stimulator was hindering her back. (T. 96-97) During that period, they would try to change the settings on the stimulator to see if she would get any additional benefit. She also saw either Dr. Lubenow or one of his associates, Dr. Jaycox.

By May 5, 2011, Dr. Lubenow suggested the trial of an intrathecal pump because she was not getting sufficient benefit from the trial of a spinal cord stimulator. (T. 97) An intrathecal pump is a pump that delivers medication internally into her spine. (T. 98) Petitioner testified she felt she was getting a benefit from the intrathecal pump since it delivers medication to the spine rather than enduring the side effects of the oral medication that goes through her liver. (T. 98)

On June 7, 2011, Petitioner testified, she received a letter from Debra Hooks at Echo Joint Agreement. The letter advised her that they would need a physician's statement for her to return to work that school year and required a full-duty release without any restrictions. (T. 100)

On July 7, 2011, she was sent for another examination, this time by Dr. Noren, Respondent's Section 12 examining physician.

On July 21, 2011, Dr. Lubenow prescribed a motorized scooter for her. Petitioner, not Respondent, paid for that scooter. She finds it helps her get to the store, follow her children in the mall, and save her strength for walking. (T. 102) By the end of 2011, she was only able to walk a quarter of a block and would notice that the pain would go from a 3-4 and spike up immediately as soon as she walked a certain distance. (T. 103) Also at that time, she was unable to drive so she needed someone else to drive her places. (T. 104)

Petitioner received a letter, dated August 3, 2011, from Debra Hooks. (See Px. 28) Ms. Hooks wrote that they wanted her back for a full contractual day. Petitioner testified that, to her understanding, that meant her employment was terminated. (T. 105) Although she could not return to work, she continued to receive her weekly workers' compensation benefits from Respondent. (T. 105)

Around February 27, 2012, following a "Utilization Review for Authorization of Placement of the Intrathecal Pump," she had the permanent pump installed. (T. 106) However, she initially had an adverse reaction to the pump that included severe headaches and a puncture of the sac around her spine. She lost spinal fluid as a result. (T. 107) Petitioner testified that the permanent intrathecal pump definitely benefits her. Prior to the pump, the pain was out of control and she felt pain greater than an 8 out of 10. But now, she can control the pain between 4 and 7. She also uses a device called a bolus, which allows her to receive a little more medicine 4 times a day. She can use the bolus whenever she chooses, but after 4 times in 1 day, she is blocked from using it. (T. 108)

After she had the pump installed, she continued under the care of Dr. Lubenow and his associates at Rush. She returned to them every few weeks for titration of the medications. During those visits, for a majority of the time, the Rush staff increased the medication. (T. 108-109) During those visits, when Dr. Lubenow would increase her medication, she would notice a corresponding decrease in her pain. She also continued to receive workers' compensation benefits during that time.

On May 23, 2012, Petitioner was sent to Dr. Konowitz, one of Respondent's Section 12 physicians. (T. 110)

On August 1, 2012, at Dr. Lubenow's request, Petitioner underwent an initial Functional Capacity Evaluation ("FCE") at ATI. After the FCE, she remembers having a hard time getting up and out of the ATI facility. Petitioner testified that she feels that it was just too much and that the pain was really severe in her back and her legs. (T. 111)

On August 16, 2012, she returned to Dr. Lubenow and advised him of her increased pain after the FCE. At that time, he discussed taking a driving exam. Petitioner testified that she wanted to drive. Dr. Lubenow also referred her to Dr. Merriman for another psychological evaluation. (T. 112)

In August and September 2012, Petitioner was seen by Dr. Obolsky, one of the Respondent's Section 12 physicians, for a psychological evaluation. (T. 113-114) Dr. Obolsky saw her for 2 days - - first for a written test and then for an interview that he conducted. (T. 114)

In May 2013, she was seen at Marianjoy for a specialized driving evaluation. (T. 114) It involved her getting into a car and driving. When she was evaluated, the evaluator never asked her to proceed with further testing or training and did not say that she needed the use of hand controls or alternate vehicle controls. (T. 115)

On July 25, 2013, Petitioner saw Dr. Lubenow. He recommended an update of her FCE. Her FCE was updated on October 17, 2013 at ATI. (T. 116)

While under the care of Dr. Lubenow, the parties agreed that she would undergo vocational rehabilitation, which was based on the doctor's plan of having her attempt a return to work. Petitioner chose Steven Blumenthal as a vocational counselor, but Respondent would not authorize it. Respondent indicated that they would only pay for Vocamotive, Inc., to be Petitioner's vocational counselor. (T. 117-118)

On April 28, 2014, she was evaluated by Vocamotive. The initial evaluation took a couple of hours. After that evaluation, there were no further requests that she return for any training or job placement. Petitioner received a report that indicated she had lost access to any viable labor market with her condition. (T. 118)

On May 2, 2014, she saw Dr. Lubenow, and he provided her with various permanent restrictions that included working a 3-4-hour work day, driving for no more than 15 minutes, sitting 30 to 40 minutes and then changing positions, standing only 10 to 15 minutes at a time, using a scooter for local transport, and using a cane to walk short distances. All this was in addition to a 20-lb. lifting restriction. (T. 119) The staff at Vocamotive, never asked her to return there or to conduct a job search. She continued to receive her workers' compensation benefits as she was off work and was having her medications titrated by Dr. Lubenow. (T. 120)

Respondent then chose to have Petitioner evaluated by a forensic rehabilitation specialist named "EVR, Inc." Petitioner initially objected to undergoing an additional vocational evaluation but agreed to sit for the first meeting. Such meeting took approximately 40 – 45 minutes. After the meeting, no one from EVR or any other vocational facility asked her to perform a job search. (T. 120-121)

On October 10, 2014, she was examined again by Dr. Konowitz, who was one of Respondent's Section 12 physicians. This was his second examination of her. (T. 122)

By 2015, Petitioner continued to receive workers' compensation benefits and continued under the care of Dr. Lubenow. Regarding her intrathecal pump, they arranged to use an outside source to come to her home and fill the pump. The pump must be refilled with opioids every 6-7 weeks. Meanwhile, she would see Dr. Lubenow every 6-9 months. (T. 123) During this period of time, her condition remained stable. (T. 124) What she noticed about herself is that she always had to decide what she would do that day. If she extended herself, she would be "out of it" the next day. Petitioner testified she is in bed for a lot of the day because of the pain and has only so many boluses to use throughout the day. So, she has to plan what she is going to wear. She usually wears light flannel pajamas because she cannot wear elastic. She doesn't wear a bra, and showering is no longer a necessity. (T. 124-125) Showering was difficult because she can't have the water touch her back. So, washing her hair is difficult and showering is exhausting. As for cleaning the house, if she cleaned the bathroom, she wouldn't be able to do anything the next day. She cannot do the floors or vacuum as it is too painful and increases the pain. (T. 126)

On March 26, 2015, she went back to Dr. Konowitz, Respondent's Section 12 physician, for another examination.

The EVR report suggested that Petitioner may benefit from a second driving evaluation, which she underwent on June 30, 2015. (T. 127) She was at Marianjoy for an hour or so and was in the vehicle for 20 minutes. She thinks she did 10 minutes with her feet and then 10 minutes with her hands using the hand controls on the vehicle. The use of hand controls did not extend the length of time she was able to drive, and the evaluator never recommended full-time use of

the hand controls. The evaluator only continued to recommend local driving. He did not recommend any further sessions of driving instruction after that. (T. 128)

Petitioner testified about a December 16, 2015 letter she received from Bonnie Jordan of Echo Joint Agreement. (Px. 29, T. 131-132) In that letter, Ms. Jordan directed her to come back to work at sedentary duty, which would include sitting, standing and walking, for 8 hours a day. Ms. Jordan offered her 1 of 2 positions: a PAEC School Teacher or an AFL Instructional Assistant. (T. 133) In other words, 1 job offer was that of a Special Education Teacher at the elementary school and the other job offer was that of an Aide at the Academy for Learning.

Based upon the letter, Petitioner met with Ms. Jordan, Carlida Goodley, and her boyfriend, William Izzo. During the meeting, the AFL aide's job was offered to her, but the teacher's position was not offered to her. (T. 134) The restrictions listed in the letter did not come from Dr. Lubenow. Dr. Lubenow, her treater, continued to restrict her to a 3-4 hour work day with 15 minutes of driving, 30 – 45 minutes of sitting at a time, 10 to 15 minutes of standing at a time, use of her scooter for local transport and use of her cane for walking short distances. However, none of these restrictions were listed in the letter. (T. 135)

Petitioner testified that she returned to work with restrictions. (T. 138) On the first day, it took her 1 hour and 15 minutes to drive to the school because she needed to stop since she was unable to sit that long. She had pain from pushing the pedal. (T. 139) Her attempt to return to work lasted approximately 5 weeks during which she was able to drive to work 8-10 times. (T. 140) It would always take her in excess of an hour to get to the school. When she would drive home, it would take her 1 hour and 15 minutes and sometimes over 2 hours due to traffic stops and her own stops. (T. 141) On the dates she needed to get to school and get home without driving, she would ask either her sister Beth, who works at AFL, to drive her there, or one of her

kids, or her boyfriend. Once at the facility, she used a wheelchair or her cane or received assistance from an Aide. The type of assistance she used depended on how far around the building she needed to go. Her sister, Beth, would also help her during the day as she also worked at AFL. (T. 142)

On January 11, 2016, she had a meeting with Wayne Dendler, the principal of the Academy for Learning. (T. 144) Mr. Dendler had direct supervision over her and told her that she would be assigned as an Aide's position in the art room of Hugh Cannon, the Art Teacher. (T. 144) Mr. Dendler restricted her in that he didn't want her in the hallway with the children and did not want her to have any contact with the students whatsoever. In the art room, she was positioned in the back of the classroom with a desk surrounded by boxes that were higher than the desk and between her and the students. (T. 145)

Petitioner was shown Petitioner's Exhibit 30, which is a job description for an "Instructional Paraprofessional". (T. 146) The restrictions of an Instructional Paraprofessional included lifting the students and participating in the physical restraints of students. She was also required to stay there from the beginning of the first period to the final period of the day. (T. 153) During the second period, she would often put up her feet in a reclining type chair that they gave her or else go to the nurse's office where there was a bed that she was able to use. She needed to get the weight off her feet in order to control some of her pain. (T. 154) While assigned to Hugh Cannon's classroom, she was told by Mr. Cannon that he didn't want her doing anything but sitting behind her desk and having conversations with her students in the classroom. She could tell them that they were doing a nice job and ask them to get off their phones. (T. 156-157) She had actual physical contact with 4 students and she came from behind her desk and would help them with their projects. This was 1 period 5 times a week. (T. 158) She noticed

that her pain was increasing and that she was having a harder time sitting and standing. She was also having a hard time getting her pain to decrease from the 7-8 level. (T. 159) For Mr. Cannon, she probably wrote up 2-3 behavior reports based on student's misbehavior during the class. (T. 159) She also worked with the laminating machine and a copier, which involved reading the manual and teaching Mr. Cannon. During the first week, she was able to work 4 out of the 5 days but by Friday, she had to take off work because she could not get out of bed. (T. 160) She was unable to get out of bed due to the pain and the fact that she could not sleep during the night.

On January 13, 2016, Petitioner testified, her sister's nose was broken during a fight in the hallway with a student. (T. 162) Petitioner testified that she was in tears and upset because of the appearance of her sister and her broken nose. She was physically feeling pain "off the charts" because she was upset. Around 11:00 that morning, she saw Bonnie Jordan for approximately 3 to 4 minutes in her classroom. (T. 166 – 167) During that time, her emotional state was that she was upset although she was not crying anymore. (T. 167) Ms. Jordan made a comment about how great she looked and how well she was doing in the classroom.

During the second week of her return to work, Martin Luther King Day was celebrated on the Monday. She was only able to work 2 out of the 4 remaining days that week due to pain and her inability to get out of bed. (T. 168) At that time, she was unable to get the pain under control like she usually could on a regular day.

In the third week, she worked the entire week, 5 days. (T. 169-170) During this final week, her condition changed in that she started to get headaches and started getting sick to her stomach. When she got home from work, she went directly to bed to prepare herself for the next day at work. (T. 170) Also, during the final week, she was not sleeping more than 1-2 hours a

night and was vomiting. She could not bring her pain down, even to a 5. The pain escalated all the time - - even on weekends. (T. 171)

Mr. Dendler had an opportunity to see her on a daily basis while she was at the school. (T. 172)

On February 12, 2016, she saw Dr. Lubenow and described to him her condition during her attempt to return to work. Dr. Lubenow opined that she was permanently and totally disabled. Petitioner provided the report of that visit to her employer. Since February 12, 2016, Petitioner has not returned to work in any capacity and has not received any pay from workers' compensation or from ECHO. (T. 173-174)

In a letter dated April 4, 2016, from Bonnie Jordan at ECHO to her, she was notified that her position was terminated based on Dr. Lubenow's opinions. (Px. 32, T. 174)

Since she was terminated from her employment with Respondent, she has been maintaining her regimen of using the intrathecal pump and getting it filled by an outside facility that comes to her home. She testified that she returns to Dr. Lubenow in 9 months ... or sees him every 6 months to a year. (T. 175) Dr. Lubenow gives her oral medications and gives her prescriptions for the in-home pump refill. (T. 175) She gets refills every 6-7 weeks. Around December 28, 2016, she had an unfortunate incident: the pump shut down, which caused her to go into withdrawal and required her to have the pump replaced by Dr. Lubenow at Rush. (T. 177) Since that time, her regimen of intrathecal pump use has continued. She continues to this day to be on the same schedule. The benefit she receives from the intrathecal pump is that she is more functional with it, although it does not take away her pain. The pump gives her 2-5 hours in the day to maintain her pain and keeps her from going to an 8/10 on the pain scale. (T. 178)

Petitioner testified that she notices that everything is a chore. She must limit her activities and if she does something one day, she cannot do it the next day. She has a hard time sleeping, sitting, and standing and does a lot of TV watching. Her social life is gone. With regard to the pain in her body, she notices that the backside of both of her legs are constantly burning, and that the more she does, the greater the burning, to the point that it feels like the area is on fire. (T. 179) In her sit bones, she feels like she is sitting on concrete all the time and that she can actually feel the bones rubbing on the concrete if she sits for 5 minutes. Therefore, she brings cushions with her wherever she goes. As for her lower back, she notices that the pain goes straight across the lower back and is constant. (T. 180) The constant pain feels like stabbing and sometimes like electrical pain. She feels sensitivity from her shoulder blades down to her lower back so that if someone comes from behind and touches her, her nerves just scream and will make her cry because of the severe shock of pain she feels. (T. 181) Likewise, putting on clothing is painful. It is not worth the pain to put on a bra. The last time she drove a car was in 2016. Instead, her daughter, her boyfriend, her sister or her mom drives her where she needs to go. If the drive is within a local area, for example to Walmart, she can do it but if it is for longer than a 10-minute period, she notices that the pain increases, and she eventually loses her concentration. (T. 183) With regard to her ability to walk, she finds that it depends on the day. Now, she forces herself to walk 3 times a week with her usual trip going to, and walking through, Aldi's. She walks through the aisles and walks with a cane. If she needs to go farther distances, she uses her scooter. She typically uses the scooter on a weekly basis. (T. 184-185)

For sitting, she can sit 15-20 minutes before she starts to shift and then she has less and less time to sit during the rest of the day because the pain slowly increases. Her pain is in her sit bones and in the lower back. With regard to standing, she can stand for 10-15 minutes. The pain

slowly increases when she is standing; she can start feeling the pain after probably 5 minutes of standing.

With regard to her sleep, she wakes up because of the pain and needs to continue repositioning herself. (T. 186)

She and her boyfriend, William Izzo, have not had sexual intercourse for 3-4 years. Before March 2009, they were able to have sexual intercourse and be physical with each other. (T. 187) Today, they cannot touch or hug or lay on each other because the pain is too great; that pain has stayed the same to the present time. (T. 187)

According to Respondent's union contract, which is in effect, Petitioner would be earning $66,626.00, as a Special Education Teacher. (T. 190) As a Teaching Assistant, (an "Aide",) she would be earning $23,727.00. (T. 192, Px. 35)

On cross-examination, Petitioner agreed that after her March 23, 2009 accident, she was able to get up from the pallet jack without any help. (T. 196) She did not start to feel something in her body until she got on the bus and rode back to school. (T. 197)

Since the 2009 accident, the pain, which started in her back and went down to her legs, has been the same. With the use of the intrathecal pump, she notices that the intensity of the pain is different because the pain now ranges between a 4 and a 7. (T. 202)

When Dr. Konowitz, Respondent's Section 12 physician, initially examined her, he had her walk a straight line. He also examined her hands. Dr. Konowitz examined her 2 or 3 times. He personally examined her for about 10 minutes each time. (T. 204)

When she saw Dr. Obolsky, she had a 2-day exam. She reiterated that on the first day, there was a written test, and the second day, Dr. Obolsky interviewed her for approximately 1 hour. (T. 206)

When she returned to work in January - February of 2016, she had a conference with Principal Dendler about the restrictions she had been given. (Px. 31) In fact, the School District honored those restrictions and did not go beyond any of the restrictions stated in Px. 31. (T. 212) Those restrictions included using cushions when seated, using a cane when walking, as needed, using a wheelchair for long distances, using an electric scooter, taking breaks, as needed, laying down in the nurses office, as needed during the plan period or duty-free lunch period, staying out of the hallways when the students are present, not physically managing the students, and not performing any heavy lifting. (T. 212)

While she worked with Mr. Cannon in the Art Room, she, in fact, performed work for him that included speaking with students. (T. 213)

With regard to the modified-duty job given to her in February 2016, she does not think she could handle that job, even with the restrictions, today. She cannot handle the modified-duty job because of the number of hours she must work and the drive to and from work. (T. 214)

The pain from driving comes from using her leg to continuously push down the pedal and sitting. The pain from driving is in her back, her bottom, and her legs, but not in her arms or her shoulders. (T. 216) As a passenger in a car, she can ride for a few hours depending on the day. (T. 217)

Petitioner testified that Dr. Lubenow has never discussed the idea of weaning her off the medicine in her intrathecal pump. (T. 219 – 220) They have discussed lowering some of her oral medications although those medications do not do the same thing as the medicine in the pump, as they work in 2 different ways. (T. 220)

On redirect examination, after reviewing Px. 27, a letter to her from Respondent that was dated June 7, 2011, Petitioner testified that it was her understanding Respondent terminated her

employment and would not allow her to return to work with any restrictions. (T. 220-221) She did not continue to receive benefits from Respondent. The letter indicates that if she did wish to return to work for Respondent, she would have to reapply for employment and was not guaranteed a position. (T. 222) Petitioner further testified that given the accommodations made by Mr. Dendler (Px. 36, Dep. Ex. 2, or Px. 31), she was unable to continue working for Respondent after 5 weeks. (T. 222-223) Petitioner further testified that she underwent 2 driving tests and after using the hand controls on at least 1 test, found that she was not able to drive any farther with the use of hand controls. After the instructor tested her with the hand controls, he did not recommend that she use hand controls to continue to drive and did not say she needed to return for further testing or training. (T. 223-224)

On recross examination, Petitioner testified that she was unable to continue working after 5 weeks in the modified position due to the pain. Before that 5-week period, she had not worked 8 hours a day and had not driven. Petitioner testified that the pain she experienced during the 5-week period was getting worse. She was experiencing headaches. By the last week of the 5 weeks, Petitioner testified, she was vomiting and was having a hard time eating. So, there were other symptoms beyond the pain. (T. 225-227)

Testimony of Elizabeth Piersialla

Elizabeth Piersialla, a Special Education Teacher at ECHO Joint Agreement and Petitioner's sister, testified on Petitioner's behalf. (T. 230 – 231) Ms. Piersialla testified that in the 5 years leading up to Petitioner's accident in 2009, Petitioner was active in high school. She played on the softball team in college, continued to play softball, and regularly played volleyball in a weekly league. (T. 232) Ms. Piersialla found Petitioner to be mentally fit and sharp prior to

March 2009. (T. 232) Ms. Piersialla noticed that from the time of the accident to the beginning of 2016, she noticed that Petitioner seems to tire much more quickly and is always in pain if anyone touches her. (T. 232) There have been occasions when someone who hasn't seen her goes up to give her a hug and she will yell for quite a while afterwards. She appears to be in a lot of pain from the hug. (T. 233)

Ms. Piersialla was present for Petitioner's attempted return to work for 5 weeks in early 2016. Specifically, Ms. Piersialla recalled an incident on January 13, 2016 where she herself was struck by a student in the hallway. The student broke Piersialla's nose. While Piersialla waited to go to the hospital, she was visited by Petitioner. Ms. Piersialla testified that Petitioner appeared to be very frantic and emotionally upset at that time. (T.235)

On February 12, 2016, Ms. Piersialla drove Petitioner to her appointment with Dr. Lubenow due to increasing pain. Since that appointment to the present time, she has never known Petitioner to be able to drive herself. Either Bill, Petitioner's boyfriend, or Ms. Piersialla drives Petitioner around. (T. 239)

Ms. Piersialla notes that Petitioner is better able to control her pain since the insertion of the intrathecal pump. (T.240) She further testified that with the benefit of her intrathecal pump, Petitioner can sit in a chair for 3-4 hours with the family and she will be okay, she will tolerate the pain. (T. 240) Ms. Piersialla testified that Petitioner's mental acuity is not as good as it was before the accident and that a lot of the time, the medication does not help. (T.240) As a passenger in a car, Petitioner is able to ride along with her for 30 – 45 minutes. (T. 242)

On redirect, Ms. Piersialla testified that Petitioner must move positions a lot, which would include going from sitting to standing. (T.244)

Testimony of William Izzo

William Izzo, a police officer for the Village of Lyons, also testified on behalf of Petitioner. Mr. Izzo testified that for almost 12 years, he has been Petitioner's boyfriend. (T. 245-246) Up until March 2009, he would see her almost every day, although they were not living together. (T. 246) During the time he saw her, up until March 2009, the two of them would do everything from boating, motorcycling, laying patio blocks, painting, scraping fences, painting inside rooms, and walking with the kids and her friends. He had a hard time keeping up with her. (T. 247) Also prior to March 2009, they had a sexual relationship. (T. 247) Since her second injury, their sexual activity has gotten less and less until there is none. (T. 253-254) From March 2009 to January 2016, her condition progressively deteriorated. From her first injury, she had pains in her chest and from her second injury, she had pains in her back going down into her buttocks. (T. 248) Since the second injury, he believed, they could not do anything sexually, she couldn't go on the motorcycle, she couldn't go boating, she couldn't walk or do all the physical activities she used to do. (T. 248) When they tried to do physical activities together, she would say that it was painful. (T. 248-249) She was frustrated, both emotionally and physically, because she never really bounced back after the injury. (T. 249)

During the 5 weeks she went back to work, she was reaching for the bolus all the time while laying down. He was forced to get up at a certain time and had a lot of trouble getting her ready for work. When she came home, she had a breakdown. He could tell that she was "spent" and had nothing left in her. (T. 251)

Since being home from work, Petitioner is able to get out of bed, although she does not do so until 10:00 or 11:00. Now she can avoid overstressing or overworking. She can control her pain a lot better now and she can take a break if she needs to lay down. She is able to cook

and clean a little bit. (T. 252) Depending on the day, she can use a light little vacuum on the floor for 10-15 minutes. (T. 261) If she does too much, she pays for it later. (T. 261-262) Mr. Izzo noticed that since Petitioner attempted to return to work in 2016, he has not known her to drive herself anywhere. (T. 252)

Mr. Izzo testified that he takes her to the grocery store and to do errands. When he drives her, he often brings her scooter with him. When she is walking, she needs to have her cane. (T. 253) There are times that she walks with her cane rather than ride her scooter, such as when she is in the grocery store. (T. 258) They have been out of state with each other to Benton Harbor, which was about a 1½ hour drive. (T. 256-257) When he drives her, there are times that he must stop to let her get out and walk. (T. 259-260) They would have to stop 2-3 times so that she could get out and walk. As long as she can stop and take breaks and lay down, they can drive 1-2 hours together.

Deposition Testimony of Marie Kirincic, M.D.

Dr. Kirincic is a physician who is board-certified in physical medicine and rehabilitation, as well as in pain management. (Px. 23, Dep. Ex. 1) Dr. Kirincic completed her Pain Fellowship at the Rehabilitation Institute of Chicago Chronic Pain Care Center. Dr. Kirincic began treating Petitioner on April 9, 2009, within weeks of her March 23, 2009 injury. She continued to treat Petitioner through the time that Dr. Lubenow took over Petitioner's care.

Dr. Kirincic ordered an EMG of her lower extremities, and interpreted the findings as follows:

"The needling part was abnormal on her bilateral and paraspinal. So, it was suggestive of S1, the sciatica. The true sciatica of S1 bilateral, lateral and then right at least inflamed nerve or some irritation to the nerve. (Px. 23, p. 61)

Dr. Kirincic testified that Petitioner was not able to return to work in a full-duty capacity in 2009. (Px. 23, p. 41) Further, Petitioner was not at MMI, and required additional pain management treatment. (Px. 23, p. 89) Dr. Kirincic diagnosed Petitioner as suffering from atypical CRPS that was causally related to the March 23, 2009 injury. (Px. 23, pp.76, 103) She opined that Petitioner had degenerative changes at L5-S1 and a probable disc injury and that the discogenic component of her pain started a couple of months post injury. The EMG was positive for some irritation from the sciatic nerve on both sides. (Px. 23, p. 106) Dr. Kirincic testified that CRPS can affect a patient's torso (Px. 23, p. 52) and that Petitioner's condition is causally related to the March 23, 2009 incident, blunt trauma being the most common cause of CRPS. (Px. 23, pp. 37-38) During her examinations, Petitioner complained of allodynia, hyperpathia, burning pain and radiating pain. Dr. Kirincic documented weakness (Px. 23, p. 14), multiple trigger points (Px. 23, p. 72), limited lumbar range of motion (Px. 23, p. 60), hyperhidrosis/abnormal sweating (Px. 23, p. 76) and temperature dysregulation. (Px. 23, p. 76)

Dr. Kirincic further testified that the treatment performed by Hinsdale Orthopaedic Associates, Dr. Gelband, Dr. Tumlin, Dr. Gruft and RIC was reasonable and necessary. (Px. 23, p. 90)

On cross-examination, Dr. Kirincic testified that the staff at RIC thought there was a temperature difference, but never really documented it. She testified that an EMG is not a test for CRPS, but for a nerve injury. She testified that a trigger point injection can serve as an

objective test. Dr. Kirincic testified that Petitioner has CRPS in the torso. Lastly, Dr. Kirincic testified that Petitioner is still able to work at least part time. (Px. 23, pp. 91-115) On redirect examination, Dr. Kirincic testified that Petitioner favors the RIC treatment regimen versus the Rush Pain Center regimen. (Px. 23, pp. 120-121)

Deposition Testimony of Timothy R. Lubenow, M.D.

Dr. Lubenow is board-certified in anesthesiology as well as pain management. (Px. 24, p. 5, Px. 24, Dep. Ex. 1) He has been working in a private practice and in a teaching capacity at Rush University Medical Center. (Px. 24, p. 12) He is a Full Professor of anesthesiology at Rush Medical College. (Px. 24, Dep. Ex. 1) He is trained in the use of opioid medication and medication delivery systems. (Px. 24, p. 14) Dr. Lubenow's 28-page curriculum vitae is extensive and includes research on CRPS and lectures on the management of RDD/CRPS. Dr. Lubenow testified that CRPS is diagnosed by utilizing criteria of the patient showing 3 symptoms and having 2 physical findings on exam. (Px. 24, p. 11) Dr. Lubenow testified that CRPS is a neurological pain disorder that is characterized by the presence of such things as complaints of hypersensitivity, complaints of swelling, complaints of discoloration, limited range of motion, difference in hair and nail growth and asymmetrical temperature findings. (Px. 24, p. 20)

Dr. Lubenow testified that he has worked over 30 years at the Rush Pain Center. (Px. 24, p. 12) He testified that he has treated tens of thousands of patients with chronic pain conditions. He has treated 1000 to 2000 patients with the use of an intrathecal pump. He further testified that he currently has approximately 250 patients that he treats with use of an intrathecal drug delivery system. (Px. 24, p. 16)

Dr. Lubenow has been Petitioner's treating pain specialist since October 2010. (Px. 24, p. 17) Dr. Lubenow was the physician agreed upon by Petitioner and Respondent after Respondent denied the referral to Mayo Clinic. During his physical examinations of Petitioner, he noted she had significant diffuse allodynia (hypersensitivity) from her lumbar to lower cervical spine, significant allodynia of her lower lumbar vertebral region, and sensitivity to the posterior aspect of her thighs. (Px. 24, pp. 18, 25) He also noted abnormal hair growth on Petitioner's thighs as well as mechanically measured temperature differences of 1.5°C to 1.8°C. (p. 26) Dr. Lubenow testified that this did meet the criteria for CRPS. (Px. 24, pp. 74, 100) Dr. Lubenow testified that allodynia was a constant finding and that the others were not always present at all examinations. Therefore, he has always referred to Petitioner's diagnosis as atypical CRPS. (Px. 24, p. 104)

Petitioner also had positive findings of S1 radiculopathy in her low back. Dr. Lubenow testified that Petitioner was vulnerable to this type of nerve injury from the March 23, 2009 accident. (Px. 24, p. 19) Dr. Lubenow testified:

> Her current condition of ill-being is atypical complex regional pain syndrome, or alternatively one may refer to it as a neuropathic pain condition of the low back lumbar spine and legs bilaterally, she has a secondary diagnosis of bilateral S-1 radiculopathy. (Px. 24, p. 72)

Dr. Lubenow noted that the EMG was objective evidence of a neuropathic pain due to the S-1 Radiculopathy. (Px. 24, p. 72)

On February 27, 2012, Dr. Lubenow implanted a permanent intrathecal pain pump in Petitioner, which was authorized by Respondent after utilization review. (Px. 24, pp. 38-40) The intrathecal pump allows opioid medication to bypass Petitioner's GI system and

cardiovascular system. (Px. 24, p. 42) Thereafter, he and his associates continued to titrate Petitioner's medications to achieve the best pain control. (Px. 24, p. 59)

In August 2012, Dr. Lubenow referred Petitioner for an FCE that was found to be valid. The FCE evaluator limited Petitioner to 4 hours of work per day and limited her to light-duty work. (Px. 24, p. 45) He ordered a driving evaluation at Marianjoy. The tester concluded that Petitioner could only safely drive for periods of 20 minutes locally due to sitting tolerances without the use of adaptive gear or additional training. (Px. 24, p. 51) A subsequent FCE, though conditionally valid, demonstrated the same general restrictions. Based on these results, Dr. Lubenow advised vocational rehabilitation. (Px. 24, p. 51) He recommended a strict 3-hour work day limitation and 15-minute local driving limitation. (Px. 24, p. 60) Petitioner was allowed to use a cane for short distances and a scooter for longer distance. (Px. 24, p. 57) During that period Dr. Lubenow allowed refills of the pump to be done in Petitioner's home via various providers. (Px. 24, p. 58)

On February 12, 2016, Petitioner returned to Dr. Lubenow after having attempted a return to work for the previous five weeks. (Px. 24, p. 64) Dr. Lubenow noted Petitioner complained of increasing pain in her back and legs with new pain in her mid-thoracic area and burning in her buttocks. (Px. 24, p. 64) Her pain was increasing and was no longer under control. Dr. Lubenow noted that Respondent's examining physician, Dr. Konowitz, had removed any driving restrictions and work hour restrictions even though Dr. Konowitz had previously agreed with such restrictions. Dr. Lubenow disagreed with the removal of those restrictions and discussed with Petitioner her attempted return to work. He noted that Petitioner was having difficulty controlling her pain while driving beyond the restrictions he imposed. Petitioner was to be allowed to lay down at work for over an hour per day. At work she had no contact with students

and performed little to no actual work. (Px. 24, p. 65) During his examination of her, Dr. Lubenow noted limping, slow gait, increased allodynia on Petitioner's low to mid back and sacral area. (Px. 24, p. 65) He noted increased sensation to the application of an alcohol pad on Petitioner's legs, which he found to be confirmation of nerve dysfunction. (Px. 24, p. 66) Dr. Lubenow found Petitioner's condition to be consistent with chronic atypical CRPS, worse since her return to work. (Px. 24, p. 66) He offered a secondary diagnosis of bilateral S-1 radiculopathy. Based upon his course of care, Dr. Lubenow found Petitioner to be permanently and totally disabled. (Px. 24, p. 67)

Dr. Lubenow testified that Petitioner does not have opioid induced hyperesthesia. (Px. 24, pp. 66, 81) He bases his conclusion on the small dose of opioid Petitioner is receiving (Px. 24, p. 66), the fact that he has specifically tested Petitioner for this condition (Px. 24, pp. 82, 97), and his experience treating patients with opioid induced hyperesthesia numerous times in his career (Px. 24, p. 80). Dr. Lubenow found that Petitioner is at MMI (Px. 24, p. 86), that she is unable to return to gainful employment (Px. 24, p. 86), that she will require continuing treatment with use of the intrathecal pump and oral medications (Px. 24, p. 87), that the continued use of opioids in the intrathecal pump is within the guidelines of evidence-based medicine (Px. 24, p. 79), and that Petitioner's condition is causally related to the March 23, 2009 work accident. (Px. 24, p. 75)

On cross-examination, Dr. Lubenow testified that he could alternatively diagnose Petitioner with neuropathic pain syndrome. (Px. 24, p. 90) Dr. Lubenow testified that as of January 2011, the objective sign for Petitioner was an abnormal EMG. (Px. 24, p. 91) He also testified that the first time he evaluated Petitioner, he found that she did not meet the Budapest criteria for CRPS. At some later visits, however, he found that she did have sufficient physical exam findings to have met the Budapest criteria. (Px. 24, p. 100) On redirect examination, Dr.

Lubenow testified that from the time he implanted the intrathecal pump in Petitioner, he has given her small doses of the opioid. (Px. 24, p. 105) With regard to the issue of opioid-induced hyperalgesia, during that time frame, Dr. Lubenow reduced some of the medications. (Px. 24, p. 90)

Report of Patricia Merriman, Ph.D.

In a report dated March 23, 2016, Petitioner offered the response of Dr. Patricia Merriman, Petitioner's treating pain psychologist. (Px. 22) Dr. Merriman first notes that the testing procedure documented by Dr. Obolsky is inappropriate to rely upon in reaching his final conclusions. (Px. 22, p. 2) Likewise, many of the tests used are inappropriate to apply to Petitioner. Many of the other conclusions are incorrectly interpreted given the facts surrounding Petitioner's medical history. For example, there is no indication in her history that Petitioner was experiencing psychological problems prior to her injury. Petitioner had not sought treatment, she was working in a demanding job, and her relationships with family and friends appear to have been good. Petitioner has stated that her life at the time of the injury was good. She would like to return to that life, but the pain interferes. Dr. Obolsky's report purports to test for malingering which, according to Dr. Merriman, is not possible to test for because it is not a diagnosis. Somatoform disorders can play a role in legitimate pain conditions. Dr. Merriman also opined that Petitioner has been diagnosed as having a legitimate medical condition that causes severe pain, which is not psychogenic, but that this type of pain, more than most, can be affected by stress. Dr. Merriman found that Petitioner's report of distress has been congruent with her situation. (Px. 22)

Report by Vocational Rehabilitation Counselor at Vocamotive, Inc.

At the request of Respondent's TPA, on April 28, 2014, Petitioner presented to vocational rehabilitation counselor Lisa Helma, CRC, at Vocamotive, Inc., for vocational rehabilitation and possible placement services. (Px. 21, p. 13) Ms. Helma stated that she reviewed numerous medical records but will only discuss in her report those records that pertain to the employability Petitioner. (Px. 21, p. 17) She reviewed the May 2, 2014 restrictions by Dr. Lubenow, the February 26, 2014 medical note from Dr. Lubenow, the October 17, 2013 FCE, which was considered to be a "conditionally valid" representation of Petitioner's physical capabilities, and the March 2, 2011 psychological evaluation by Dr. Patricia A. Merriman. (Px. 21, pp. 17-18) The Arbitrator notes that Ms. Helma made no mention of, *inter alia*, the opinions of Dr. Alexander E. Obolsky, Dr. Mary L. Moran, Dr. Richard L. Noren, and Dr. Howard S. Konowitz. In addition to considering Petitioner's employability based on her physical capabilities, she considered Petitioner's age, educational status, vocational history, and socioeconomic status. (Px. 21, pp. 19-21) Ms. Helma found that given Petitioner's driving restrictions, and without transportation assistance, she would be limited to searching for employment in a small radius around her home. Ms. Helma concluded that Petitioner has lost access to her usual and customary line of occupation of Special Education Teacher. She further concluded that given the medical documentation available, Petitioner has lost access to any viable labor market and thus, found that her disability is total. (Px. 21, pp. 24-25)

Deposition Testimony of Former Principal Wayne Dendler

Petitioner offers the testimony of Wayne Dendler. (Px. 36) Mr. Dendler was in the employ of Respondent as the Principal at AFL from July 1, 2006 through June 30, 2017. (Px. 36,

p. 5) During his tenure, he had the opportunity to observe Petitioner performing her job duties on a daily basis. He described Petitioner as a competent and active Special Education Teacher with no limitations prior to her 2009 accidents. (Px. 36, pp. 7-8) Mr. Dendler testified that when Petitioner attempted to initial return to work as a Special Education Teacher in 2010, she had little energy, used a wheelchair to get around and had limited capacity to teach her students and engage in activities. Mr. Dendler described the students at AFL as having severe emotional and control issues, which teachers at regular schools could not control. Violence by students was a common occurrence. (Px. 36, pp. 10-11)

Mr. Dendler testified that he first learned that Petitioner was coming back to AFL in 2016 from Bonnie Jordan, Respondent's Assistant Director and Leanne Frost, Respondent's Director. He was advised that Petitioner was still being paid by ECHO and, therefore, they were to find a way to bring her back to work. Mr. Dendler testified that he objected to Petitioner's return because AFL was not appropriate due to safety concerns. (Px. 36, p. 16) Mr. Dendler identified the necessary duties of an Aide to include the lifting of a student, but more importantly, the active participation in physical restraint of a student. (Px. 36, p. 14) Further, an Aide is expected to continually interact with students even if they are violent. (Px. 36, p. 15)

Mr. Dendler observed Petitioner on January 11, 2016, the day she returned to AFL as an Aide. He described her as weak, tired and worn out. (Px. 36, p. 18) Petitioner was assigned to the art classroom and placed at a desk behind the students and advised to avoid any interaction with the students. (Px. 36, p. 18) Petitioner had no contact with the students of the classroom. Petitioner was not performing the duties of an Aide. (Px. 36, p. 20) He is aware of the January 13, 2016 incident when Petitioner's sister, Elizabeth Piersialla, was struck in the face by a student and sustained a broken nose. (Px. 36, p. 21) Mr. Dendler testified that he was directed by

Bonnie Jordan and Leanne Frost to deliver the list of accommodations to Petitioner. (Px. 31) Regardless of the accommodations, Mr. Dendler testified, Petitioner's physical condition deteriorated over the 5 weeks she attempted to return to work. He noted that during his tenure as Principal of AFL, no other employee was provided such significant accommodations and still was allowed to work as a Teacher or an Aide. When he was eventually advised that Petitioner was unable to continue working at AFL, Mr. Dendler testified, he was not surprised as he felt she did not belong in that environment due to her health. (Px. 36, p. 25)

On cross-examination, Mr. Dendler testified that although Respondent never put anything in writing similar to what they did with Petitioner, they have taken people back to work with job accommodations. Mr. Dendler testified that Petitioner provided minimal help to the art teacher. He knew that Petitioner had pain due to her injury and he was not sure if she had a pain pump in her or not. Mr. Dendler did not think Petitioner could come back to work with her restrictions because of the nature of the students in Respondent's building. It does not matter where you are because the students don't care - - or, they could get in a physical altercation. He also thought Petitioner could not perform the duties of a Paraprofessional such as circulating a classroom, supervising a hallway, or supervising the bus areas. (Px. 36, pp. 25-28)

On redirect examination, Mr. Dendler testified that the minimal paperwork Petitioner performed in the art classroom consisted of taking attendance and maybe recording assignments in the computer. (Px. 36, p. 29)

Deposition Testimony of Julie M. Wehner, M.D.

Respondent offered the evidence deposition of Dr. Wehner. (Rx. 3) Dr. Wehner is a board-certified orthopaedic surgeon who concentrates on spine surgery. (Rx. 3, p. 7) Dr. Wehner

noted that Petitioner had no prior history of chronic pain. (Rx. 3, p. 11) Dr. Wehner examined Petitioner on June 1, 2009, which was less than 3 months after the March 23, 2009 incident. (Rx. 3, p. 9) Dr. Wehner found mild pain with light palpation at the right paraspinal area at approximately T12 and pain underneath the bra area of her chest. (Rx. 3, pp. 11-12) She noted that Petitioner self-limited her range of motion. (Rx. 3, p. 12) Petitioner complained of a diffuse pattern of pain in her thoracic, lumbar, chest and upper abdominal areas. (Rx. 3, pp. 13-14) Dr. Wehner's impression was that Petitioner had soft tissue contusions and sprains that would be related to the accident, but continued complaints of pain that were not explained by the accident. (Rx. 3, p. 14) Dr. Wehner noted the MRI report indicated disc desiccation at L5-S1 that was mostly an anatomic variant or a normal aging process, but not pathologic or clinically significant (Rx. 3, p. 15) Based upon her examination of Petitioner, as well as a review of limited records, Dr. Wehner opined Petitioner could return to full-duty work. (Rx. 3, p. 18) Dr. Wehner advised ceasing chiropractic and acupuncture treatments, (Rx. 3, p. 19) and recommended she should perform home exercises.

On cross-examination, Dr. Wehner testified that she conducts §12 examinations 100% of the time for Respondents. (Rx. 3, p. 26) Dr. Wehner testified that, as of June 1, 2009, Petitioner's condition of ill-being did appear to be causally related to the March 23, 2009 work injury. (Rx. 3, p. 28) Dr. Wehner testified to reviewing records that were for another patient. (Rx. 3, p. 28) She reviewed no treating records other than those submitted at the initial examination 11 months prior to her deposition. (Rx. 3, p. 29) Dr. Wehner felt that Petitioner did receive some benefit from chiropractic treatment, that 6-12 visits would be reasonable for patients with soft tissue injuries, but that 4-6 weeks would be reasonable for patients with a chronic, underlying condition. (Rx. 3, p. 36) Dr. Wehner did not find that Petitioner deliberately misrepresented her

symptoms. (Rx. 3, p. 36) Dr. Wehner knew that Petitioner treated with the staff at RIC, whom she finds to be qualified and competent. (Rx. 3, pp. 41, 31) Dr. Wehner was unaware of the specific treatment at RIC, including any FCE results. (Rx. 3, pp. 41, 31)

On redirect examination, Dr. Wehner testified that in formulating her opinions, she did not rely on the few documents that were for another patient. Such records were sent to her by ATI. (Rx. 3, pp. 44-45) On June 1, 2009, when Petitioner presented to her, she did not have chronic pain. (Rx. 3, p. 45)

On recross examination, Dr. Wehner testified that soft tissue injuries can turn into chronic pain. (Rx. 3, pp. 46-47) Dr. Wehner testified that as of June 1, 2009, she did not think that Petitioner was a candidate for the RIC program. (Rx. 3, p. 47) However, Dr. Wehner has no treating records or test results for anything that occurred after June 1, 2009 (Rx. 3, p. 47). For a condition to be chronic, Dr. Wehner testified, the pain has to last at least 6 months. (Rx. 3, p. 48) At the time she examined Petitioner, Petitioner was 3 months post-accident. (Rx. 3, p. 48)

On redirect examination, Dr. Wehner testified that a person can complain of pain for 6 months and have nothing wrong with him. (Rx. 3, p. 51) She testified that Petitioner's injury was not like a crushing injury or something that would lead you to believe she had such soft tissue injuries that she would end up with chronic pain. She was knocked down. There was no bruising and she had a full range of motion. (Rx. 3, pp. 51-52)

On redirect examination, Dr. Wehner testified that Petitioner sustained a trauma on March 23, 2009, but it was not enough to cause a chronic pain syndrome. (Rx. 3, p. 54)

Deposition Testimony of Richard L. Noren, M.D.

Dr. Noren is board-certified in pain management and anesthesiology (Rx. 9, pp. 5-7) He was Professor in the Department of Anesthesiology between 1992 – 1993 at Emory University School of Medicine. Currently, Dr. Noren is in private practice at Pain Care Consultants from 1995 to the present. (Rx. 9, p. 6)

On July 7, 2011, Dr. Noren testified that he saw the Petitioner for the first time for a physical examination. She was 47 years old, left-hand dominant, weighed 136 lbs., and reported that in March 2009, a student pushed her over a forklift while at a grocery store, so she hit the back of the forklift. She fell so she was sitting on the forklift between the bars. She reported treatment that included a 5-day epidural infusion at Rush Presbyterian Hospital. She was unable to get of the bed for the first 2 days and did not complete any physical therapy. She was also scheduled for a trial of an intrathecal pump. She personally denied any upper or lower extremity nail changes, though she reported sweating from her knees to her thighs and at times, her whole body sweated. She denied any color changes. She states that her thighs were swollen, and they had gone up a pants size. (Rx. 9, pp. 10-12) Regarding her activities, she testified that she was limited to walking for 5 to 15 minutes. When sitting, she frequently needed to change positions, and was not able to drive due to medications and intermittent confusion with the medications. She said that she last drove in the fall on 2010. (Rx. 9, p. 12) She reported that she uses a wheelchair when going grocery shopping and has severe body aches with prolonged distances of walking. Her current medications are Gabapentin, Cymbalta, Hydrocodone, 3 to 6 tablets per day, Tramadol, 2 to 4 tablets per day, Amitza, Synthroid and Trazodone. (Rx. 9, p. 13)

During his physical examination, Dr. Noren testified, her gait was normal. She had difficulty standing on her toes and reported pain over the lateral portion of her hips, over the

trochanteric region when standing on her toes. There was no allodynia in the upper extremities and the lower extremities with repeated testing. Her back had severe allodynia in the thoracic and lumbar region to slight touch. No color changes or swelling was noted. (Rx. 9, pp. 14-15) On the motor exam, she had normal motor strength in both upper and lower extremities, symmetric reflexes, and negative straight leg raising. There were equal temperatures in the upper and lower extremities. There was no swelling in the upper or lower extremities and no nail changes. Her legs appeared to be shaved. She had normal pulses. There was an equal vein pattern in both of her feet. And specific measurements of the upper and lower extremities showed no measurable edema. (Rx. 9, p. 15) At the end of her physical examination, he reached the conclusion that he was unclear what her diagnosis was. He recommended that she see a rheumatologist for further evaluation as a source of explanation for pain syndromes. (Rx. 9, p. 16) The subjective complaints she made, including the allodynia, were all related to her fall on March 23, 2009. (Rx. 9, p. 17)

Dr. Noren also had the opinion that there were no objective findings of complex regional pain syndrome during his examination of the Petitioner on July 7, 2011. (Rx. 9, p. 17) Dr. Noren testified that of the Budapest criteria to diagnosis CRPS, she had the subjective finding of allodynia, but there were missing signs such as no temperature changes, edema, and no vasomotor or sudomotor changes. Her complaints of allodynia in and of itself could be any disease, but to draw the conclusion that it is CRPS or atypical CRPS is merely conjecture. (Rx. 9, p. 18) Regarding work, Dr. Noren testified that it was his opinion that she was able to meet her job description based upon the exam findings he had received. (Rx. 9, pp. 20-21)

Dr. Noren also provided opinions following a medical records review of all of Dr. Lubenow's notes, dated October 14, 2010 through August 4, 2016, both FCEs dated August 1,

2012 and August 17, 2013 and the IME report of Dr. Alexander Obolsky, dated June 7, 2013. (Rx. 9, pp. 21-22) Dr. Noren disagreed with Dr. Lubenow's diagnoses of either atypical CRPS or neuropathic pain condition with an S1 radiculopathy. When Dr. Noren saw her on July 7, 2011, he found that she had no exam findings of an S1 radiculopathy. (Rx. 9, pp. 22-23)

Dr. Noren also addressed Dr. Lubenow's diagnosis of "atypical CRPS", which Dr. Noren believed is just an opinion based on Dr. Lubenow's own choice to use this term. However, there is no such clinically acceptable diagnosis as atypical complex regional pain syndrome and that the pain management community in its text books, its journals, and its clinical practice does not, in any place, recognize a diagnosis of atypical CRPS. (Rx. 9, p. 24)

As to whether the intrathecal pump therapy is currently necessary and causally related to her March 23, 2009 accident, Dr. Noren believed that it was not. She had undergone a surgical procedure for no specific diagnosis, an interventional invasive treatment into her spinal canal for no specific pathology. He did not believe the records showed that it resulted in any functional improvement. (Rx. 9, p. 25) It also made no anatomic or physiologic sense that a doctor would conduct a surgery, with an incision and dissection down to the ligaments along her spine, in the same region as her neuropathic pain. It is contraindicated due to her description of allodynia over her entire back. So, performing surgery in the same region as the complained pain would be contraindicated because it would likely exacerbate or worsen the syndrome. However, that would be for someone who actually has CRPS. (Rx. 9, pp. 25-26)

Currently, he found Ms. Jacobs to be at maximum medical improvement. He based that opinion on having multiple medications, some of which she has responded to. She had a spinal cord stimulation trial and she has had an unnecessary intrathecal pump, which has not improved her condition. (Rx. 9, p. 28) Petitioner also was likely functioning at a light physical demand

level following the August 2012 functional capacity evaluation, and Dr. Noren did not see anything in the records to suggest she was capable of a higher level of function. (Rx. 9, p. 30) Based on the FCEs, it was Dr. Noren's opinion that she was able to return to work as a Teacher at ECHO Joint Agreement. (Rx. 9, p. 33)

On cross-examination, Dr. Noren testified that he has conducted 20-50 examinations for MES Solutions, for whom he conducted an examination in this case. (Rx. 9, p. 40) He testified that he no longer has the records he reviewed before he examined Petitioner on July 7, 2011. (Rx. 9, p. 41) He testified that he performs about 2 legal-medical exams per week, and almost all of them are done on behalf of the employer. (Rx. 9, pp. 43-44) He charges $1,500.00 per examination. (Rx. 9, p. 44) Dr. Noren testified that he last published in 1994; none of his 3 publications deal directly with the treatment of CRPS/RSD. (Rx. 9, p. 47) CRPS is a diagnosis of exclusion. (Rx. 9, p. 49) Dr. Noren did not agree that an opinion from someone who is qualified to make a CRPS diagnosis holds more value and more weight if that person has a long-term relationship, i.e., spends more time with the patient over a longer period of time. Rather, he would say that on that specific visit, the patient might have met the criteria. (Rx. 9, p. 50) Dr. Noren testified that the Budapest criteria is the best criteria we have at the current time for an undiagnosable, non-specific disease. (Rx. 9, p. 51) Dr. Noren then identified some of the symptoms and signs of CRPS. (Rx. 9, pp. 51-52) Additional records would help him in determining if, on a specific date, she had findings that met the Budapest criteria. (Rx. 9, pp. 57-58) Upon examination, Dr. Noren found severe allodynia in her thoracic and lumbar region to the slight touch. Petitioner would report extreme pain and withdraw when the doctor touched her lower lumbar area. She also reacted with a slight pilomotor change, i.e., goosebumps, with light touching to her back. This is considered a possible indicator of CRPS. (Rx. 9, pp. 60-61) Dr.

Noren tested, by touch, her upper extremities and her lower extremities for any temperature differential, but he found none. (Rx. 9, p. 61) He testified that he did not recall that Dr. Lubenow documented changes in temperature. (Rx. 9, p. 62) Dr. Noren testified that he wrote: "Catherine Jacobs provides a history and subjective exam findings consistent with neuropathic pain," that "this is an extremely unusual presentation for a complex regional pain syndrome," and that "this appears to be causally related to her injury of March 23rd of 2009." (Rx. 9, pp. 63-64) Dr. Noren testified that he reviewed records that indicated or confirmed that Petitioner consistently complained of chronic pain since March 23rd of 2009 and that he wrote that Catherine Jacobs has an atypical presentation of the syndrome, i.e., CRPS. (Rx. 9, pp. 64-65) He referred Petitioner to a rheumatologist and assumed the rheumatologist's findings were negative. (Rx. 9, p. 65) Dr. Noren has implanted 20-30 intrathecal pumps over the course of his career. (Rx. 9, p. 67) Respondent did not contact Dr. Noren after they received the results of the utilization review; he had no discussion with them between 2011 and 2017. He also mentioned he wanted an FCE. (Rx. 9, p. 68) At that time, Dr. Noren was provided with a job description but he was never informed that Petitioner's job duties included the physical restraint of disabled children and young adults. (Rx. 9, p. 70) Dr. Noren found no evidence of S1 radiculopathy during his only examination of her on July 7, 2011 and he was never sent the results of an EMG study. (Rx. 9, pp. 72-73) If positive EMG results were sent to him, they would not have been significant because they did not match his exam findings. (Rx. 9, p. 74) A diagnosis of CRPS is a well-recognized, non-fictitious medical diagnosis and is a clinical diagnosis. Dr. Noren found Petitioner to be at MMI and believed her work restrictions to be consistent with the 2 prior FCEs. (Rx. 9, pp. 75-76) Dr. Noren agreed that he is not a psychologist and that there is no finding in any record that Petitioner is malingering. (Rx. 9, pp. 78, 81) In Dr. Noren's experience, many

people who have a chronic pain condition do show issues of somatization. (Rx. 9, p. 82) He felt that Petitioner can work light-duty work for a normal workday. Such light duties would not include physically restraining the students. Dr. Noren did not know if Petitioner has any documented driving restrictions. (Rx. 9, pp. 82-84)

On redirect examination, Dr. Noren testified as part of his retention policy, he holds onto physical records for less than a year. (Rx. 9, pp. 86-87) Dr. Noren testified that his private practice is orthopedic-related, with a lot of people having spinal issues. Probably 3% to 5% of his current patients have a diagnosis of CRPS. (Rx. 9, p. 87) Early in his practice, through 2011, he personally performed insertion of intrathecal pumps and he still manages his patients with pumps and has replaced pumps in patients who have pumps implanted in them. (Rx. 9, p. 88) For at least 15 years, he was putting pumps into his patients. (Rx. 9, p. 88) He also testified that his examination of Petitioner was consistent with Dr. Lubenow's exam of Petitioner. Other than in his review of the medical records, Dr. Noren has not seen documented physical findings that would meet the criteria for CRPS. Dr. Noren reviewed 6 years of Dr. Lubenow's records from 2010-2016. (Rx. 9, p. 89) Dr. Noren testified that it was unusual for Petitioner to have had acupuncture and to have undergone an EMG since this is a woman who complains of severe allodynia, who states that it is extremely painful for wind to blow on her back. Most people with CRPS cannot tolerate needles being stuck in them. (Rx. 9, pp. 89-90) Dr. Noren testified that when he saw Petitioner, he did not specifically diagnose Petitioner with CRPS and that when he wrote "this is an extremely unusual presentation for complex regional pain syndrome," he would have been commenting on what Dr. Lubenow had opined. (Rx. 9, pp. 89-90) Dr. Noren testified that there is not a body of medical literature that discusses atypical complex regional pain syndrome. (Rx. 9, p. 92)

On recross examination, Dr. Noren testified that one either meets the criteria for the diagnosis of CRPS, or one does not. (Rx. 9, p. 93)

Deposition Testimony of Howard S. Konowitz, M.D.

Dr. Konowitz, one of Respondent's Section 12 physicians, is board-certified in anesthesiology and pain management. (Rx. 8, p. 5, Rx. 8, Dep. Ex. 1) Between 2010 and 2015, Dr. Konowitz served as the clinical Assistant Professor for the Department of Anesthesiology at Loyola University Medical Center. (Rx. 8, p. 6, Dep. Ex. 1) Dr. Konowitz has maintained his own practice in Glenview, Illinois since 2001. (Rx. 8, p. 7)

Dr. Konowitz examined the Petitioner on three different occasions, producing a total of eight IME reports or addendum reports. (Rx. 8, p. 10) His first appointment with Petitioner on May 23, 2012. His examination included having the Petitioner fill out a 6-page pain questionnaire as well as three Scantron questionnaires. These questionnaires provide a screening test among other screening tools, in order to determine treatment and proper medication prescriptions. (Rx. 8, p. 12)

Dr. Konowitz reported Petitioner's active medications including Gabapentin, Cymbalta, Tylenol, Levothyroxine, Colace, Fleet enema, Amitiza, Flovent, and multivitamins. (Rx. 8, p. 13) Dr. Konowitz also performed a physical examination of her. When assessing for complex regional pain syndrome, there was hyperalgesia, (an increase in pain to a noxious stimuli). However, she had no color changes, no temperature changes, no edema, no trophic or nail changes. (Rx. 8, p. 15) These are all signs and symptoms in the Budapest criteria for complex regional pain syndrome ("CRPS") In her case, one criterion, hyperalgesia, was not sufficient to meet the Budpest criteria, which requires meeting 3 out of 4 symptoms.

The Budapest criteria, which were published around 2006, were developed by 30 physicians. The condition has had many names over the years. Complex regional pain syndrome used to be reflex sympathetic dystrophy, which used to be causalgia. There is renaming of the condition which goes back to the 1800s. There were also earlier criteria for this disease, which is called a syndrome because there is no specific blood test, such as with diabetes or hypertension, in which blood can be drawn to prove the condition. With complex regional pain syndrome, you must meet the Budapest criteria because there is no specific test that confirms the diagnosis. (Rx. 8, p. 17)

The Budapest criteria include the following four symptom categories: (1) reports of hyperalgesia or allodynia; (2) reports of vasomotor changes, i.e., temperature asymmetry or skin color; (3) reports of sudomotor changes, i.e., sweating changes or edema on exam; and finally (4) reports of motor/trophic changes, i.e., any loss of hair, increased hair, changes in the nails and see changes to the skin along with specific temperature changes in areas. (Rx. 8, p. 18, Rx. 8, Dep. Ex. 12: "Complex Regional Pain Syndrome: Treatment Guidelines, June 2006, published by Reflex Sympathetic Dystrophy Syndrome Association, containing the "Revised CRPS criteria proposed by the Budapest Consensus Group") Here, in Petitioner's situation, Dr. Konowitz testified, he only found 1 of the Budapest criteria, that being the subjective complaints of mechanical allodynia. However, in order to render a diagnosis of CRPS, one needs to have at least 1 symptom in 3 of the 4 categories, and at least 1 sign in 2 or more of the categories. (Rx. 8, Dep. Ex. 12, Rx. 8, p. 20) The sign categories are the same as the symptom categories except there must be confirmation via objective test at the time of evaluation. (Rx. 8, Dep. Ex. 12) Additionally, the criteria are based on what is examined on the patient on the day they had the complaints and symptoms. So, either the patient has full Budapest signs or symptoms on that

day, or not. It cannot be a piecemeal diagnosis with signs from one day to the next. (Rx. 8, p. 21) Dr. Konowitz formed an opinion that Ms. Jacobs suffered from subjective pain complaints, but beyond that, she did not meet the criteria of complex regional pain syndrome. He therefore requested additional records including an independent psychiatric exam and an FCE. (Rx. 8, p. 22)

Unlike Dr. Lubenow, who had diagnosed Ms. Jacobs with "atypical CRPS", Dr. Konowitz testified that there is no such diagnosis of "atypical CRPS". Either you meet the criteria and have CRPS, which is the Budapest consensus, or not. There are no criteria saying that you have a diagnosis of atypical CRPS. (Rx. 8, p. 24)

Dr. Konowitz testified that after reviewing Dr. Obolsky's report, he learned that there were psychiatric and secondary pain factors that could affect the severity and main physical exam symptoms and her pain complaints so that her subjective pain complaints could not be used to validate any underlying pain severity. (Rx. 8, p. 31) On August 20, 2013, Dr. Konowitz also reviewed the Petitioner's job description and believed that she could perform all parts of the job description except for contact with physical restraint of students. (Rx. 8, p. 32)

Regarding her intrathecal pain pump, by January 17, 2014, Dr. Konowitz opined that weaning and discontinuing the pain pump would be recommended because you need to have a physical diagnosis and have met the psychological criteria to clear someone to have an intrathecal pump. In neither case was this met. (Rx. 8, p. 33) Here, the Petitioner did not have a diagnosis. Weaning her off the pump normally takes over 6 months. (Rx. 8, p. 34) The only 2 medications necessary for her treatment, as of January 17, 2014, were Gabapentin and Cymbalta and those were the only two medications related to this accident. (Rx. 8, p. 37) Additionally, at

that point, her activity restrictions were light-duty, which was based on the U.S. Department of Labor criteria, that one can lift up to 20 lbs. (Rx. 8, p. 37)

On October 10, 2014, Dr. Konowitz conducted another physical examination of Petitioner. Regarding CRPS, the only Budapest finding was hyperalgesia present in the extremities. He was not allowed to touch the upper part of her back as she would not let him examine her with the pin prick. (Rx. 8, p. 39) He did not see criteria such as edema, sweating, nail changes, hair growth changes, or temperature changes, which are things required by the Budapest criteria. (Rx. 8, p. 40) Based on his physical examination and the Budapest criteria, there was no diagnosis of CRPS. (Rx. 8, pp. 40-41) According to Dr. Konowitz, the treatment protocol provided at Rush-Presbyterian-St. Luke's through Dr. Lubenow is a very different protocol than the rest of the world. (Rx. 8, p. 43) The issue here gets down to a diagnosis. Dr. Lubenow has a CRPS treatment plan without a CRPS diagnosis. (Rx. 8, p. 44) Dr. Konowitz testified that he trained with Dr. Lubenow years ago. (Rx. 8, p. 45) During his examination of the Petitioner, Dr. Konowitz noted that there were no objective findings and so she did not meet the criteria for CRPS. (Rx. 8, p. 46) Current medications for her included Clonidine, Dilaudid, which is specifically in the pump, and the pump cannot be stopped. She also took Wellbutrin, Celebrex, Gabapentin, Cymbalta, which are all psychological medications and for the nerves so that is reasonable treatment for her. (Rx. 8, p. 47)

On March 26, 2015, Dr. Konowitz conducted another physical examination of Petitioner. (Rx. 8, Dep. Ex. 7) During his physical examination of Petitioner on March 26, 2015, from the CRPS standpoint, there was no temperature asymmetry, no edema, and no color changes found, all of which are criteria for the Budapest consensus group to make the diagnosis of complex regional pain syndrome. (Rx. 8, p. 50) Dr. Konowitz also reviewed the Marianjoy driving

evaluation, dated May 14, 2013. (MES/Marianjoy may have provided the report with a typo date of May 14, 2015, when in fact the report should be dated May 14, 2013.) (Rx. 8, p. 54) He came to the opinion that, based upon the Marianjoy report, a discussion with the patient, and her examination, that she could drive for 20 – 30 minutes at a time, get out of the car and stretch, and go back for another 20 – 30 minutes of driving. (Rx. 8, p. 52) According to Dr. Konowitz, the driving restrictions would only include being able to stretch every 20 – 30 minutes, and that she may have permanent adaptive controls available if needed. (Rx. 8, p. 58)

In his final report of November 5, 2015, his diagnosis was "mechanical allodynia". With the Petitioner, there is no other diagnosis that justifies her subjective complaints. It wasn't that there were other diagnoses that fit her, he just had her at allodynia. Allodynia is defined as a subjective experience to a non-painful experience. For example, when putting on clothing causes pain or, in her case, when rolling a pin wheel on her feels like a knife cutting her skin, those signs don't fit or justify a diagnosis. (Rx. 8, p. 59) Dr. Konowitz, while reading his answer to question 1 in his November 5, 2015 addendum report, noted that "mechanical allodynia … can be caused by intrathecal opoids, which have been medically prescribed for her pain state. This is opoid-induced hyperalgesia, which has been reported with chronic intrathecal use of opoids, but to date, frequency is intermittent. Alternatively, there is no diagnosis that justifies the subjective complaints." (Rx. 8, Dep. Ex. 10, p. 1) Here, there was no reason to install an intrathecal pump as it is not placed for subjective complaints. A diagnosis of mechanical allodynia is not a sufficient diagnosis for a pain pump. Instead, you need to have either a malignant pain state or a non-malignant pain state. In the non-malignant pain state group, you must have a definitive diagnosis. In her group, there is no definitive diagnosis. Here, we have subjective pain complaints, which do not correlate with all the lists given before about intrathecal pain pumps,

such as needing it for CRPS, mechanical back pain, or post-laminectomy pain syndrome, for example. (Rx. 8, p. 64) Here, Dr. Konowitz recommends that Ms. Jacobs can perform sedentary-duty work that includes sitting, standing, and walking for an 8-hour period.

Regarding her psychiatric examination with Dr. Obolsky on June 7, 2013, Dr. Konowitz confirmed that the Petitioner exhibited psychiatric and secondary gain factors affecting the severity and maintenance of her physical symptoms and pain. She presented with multiple psychiatric factors such as dependent personality traits and somatic reactions under stress. Somatic reactivity under stress results in functional impairment and disability in this patient; this would account for all her pain on a daily basis in addition to her potential hyperalgesia. (Rx. 8, p. 67)

On cross-examination, Dr. Konowitz testified that MES Solutions hired him to examine Petitioner and to write the reports and addendums. He charged $1,500.00-$2,000.00 per examination, and $1,250.00/hour for his deposition testimony. He further testified that he conducts approximately 2 IMEs per week. MES Solutions provided all the medical records for his review. With regard to his curriculum vitae, Dr. Konowitz testified that the last time he published was in 1999, which was during his residency. Each time he met with Ms. Jacobs, he remembers spending 1½ hours with her. So, in her case, he spent approximately 4½ hours total during his 3 exams of her. (Rx. 8, pp. 69-75) They discussed the EMG report and the Marianjoy report that includes the driving exam. (Rx. 8, p. 76) Dr. Konowitz found the results of Petitioner's Cage Questionnaire, which assesses the risk of long-term opioid use, to be negative. (Rx. 8, pp. 78-79) He also noted that Petitioner did not report pre-existing complaints of pain that were similar to those she experienced following the incident. (Rx. 8, p. 84) Dr. Konowitz also testified that he truly believes that Petitioner feels the pain she described to him. In returning her

to sedentary duty work, Dr. Konowitz testified, he was giving her the lowest possible duty from her subjective complaints. He did not see that she was going to be any less than sedentary duty, but she could be greater than sedentary duty. (Rx. 8, p. 86) Dr. Konowitz testified that he does not know the workings of Dr. Obolsky's office and does not know whether he followed the appropriate protocol. (Rx. 8, p. 89) When he referred to secondary gain, that did not equate to intentional fraud. (Rx. 8, pp. 92-93) Dr. Konowitz testified that he does not agree with the placement of the pump because of the risks involved and because one must have a diagnosis that meets the criteria. Dr. Lubenow does not have that diagnosis. (Rx. 8, pp. 103-104) Dr. Konowitz testified that he boosted Petitioner from sedentary duty to light duty based on what she told him she could do at work with her own physical state. He believes that an FCE is just a jumping-off point for him. (Rx. 8, pp. 108, 147) Dr. Konowitz agreed that Petitioner did not sustain subsequent trauma following the accident. (Rx. 8, p. 108) Dr. Konowitz further testified that she told him she was able to drive an hour and that she would get in and out of the car. (Rx. 8, pp. 121-122) He suggested additional driving sessions with and without adaptive equipment. (Rx. 8, p. 123) Dr. Konowitz opined that Petitioner's hyperalgesia, or allodynia, might be opioid-induced as a result of chronic, intrathecal use of opioids. (Rx. 8, pp. 125-126) One way to test for this is to lessen the amount of the opioid in the intrathecal pump. (Rx. 8, p. 127) Dr. Konowitz continues to recommend that Petitioner be weaned from use of the intrathecal pump. (Rx. 8, p. 134) Even if Petitioner experiences subjective pain that limits her to driving no more than 20-30 minutes, Dr. Konowitz did not feel that a 30-minute limit of driving would be appropriate. (Rx. 8, pp. 136-137) Dr. Konowitz testified that Petitioner could perform sedentary-duty work for 8 hours a day, based on his examinations of her and the records and diagnostic test results he had been given. He felt she was at MMI. (Rx. 8, p. 137) Dr. Konowitz's final opinion was that

Petitioner's current condition consists of subjective symptoms without physiological abnormality and that she exhibits psychiatric and secondary gain factors that affect the severity and maintenance of her physical symptoms and pain complaints. (Rx. 8, pp. 137-138) He testified: "All patients' subjective pain I will believe is true" and "Pain is always what one experiences." Dr. Konowitz agrees that there is no evidence of any psychological issues before the accident. (Rx. 8, pp. 138-139) Dr. Konowitz opined that there was an underlying event, but no specific pain diagnosis since she does not meet the criteria. He equates objective findings with signs, symptoms, physical exam findings. (Rx. 8, pp. 139-140)

On redirect examination, Dr. Konowitz testified that during each of the 4 physical examinations that he conducted of her, he found that she never met the Budapest criteria for complex regional pain syndrome. (Rx. 8, p. 141) He testified, in answer to question 4 in the August 20, 2013 report, that only the psychiatric exam to date has been reasonable and necessary. (Rx. 8, pp. 142-143) Dr. Konowitz defined secondary gain factors as a whole list of events that benefits you from having a pain disorder, including monetary rewards. (Rx. 8, pp. 144-145) He believed that Dr. Lubenow was violating a standard of care by installing the intrathecal pump because he did not have a valid pain diagnosis. (Rx. 8, p. 145) Dr. Konowitz testified that in answering question 9 in the October 10, 2014 report, he is simply stating the medications she was on at that time but is not recommending such medications. (Rx. 8, p. 150) Petitioner did not tell him that she needed to stretch ever 20-30 minutes when she drives. (Rx. 8, pp. 152-153) He testified that 1.3-1.5 mg. of hydromorphone in a pain pump is considered a dosage that could lead to opioid-induced hyperalgesia. (Rx. 8, p. 153)

On recross examination, Dr. Konowitz agreed that in one of his answers, he listed a continuation of the pain pump medications, and that part of the explanation was that one cannot

discontinue these 2 medications without weaning her from the pump. Then Counsel asked him if, later on, he authored an report in which he leaves off the intrathecal pump medications when answering the same question. Dr. Konowitz responded that it depends on how they asked the question. If the doctor stated they should discontinue the pump and wean it, then the medications come off. Dr. Konowitz testified that in the report he stated she is to wean off the pump and discontinue it and so, he took the medications off the list. (Rx. 8, pp. 156-158)

Section 12 Report of Mary L. Moran, M.D.

Dr. Mary L. Moran is a licensed medical doctor, who is board-certified in internal medicine and rheumatology. (Rx. 4) Between 1991 – 1996, she was an Assistant Professor of Medicine at the University of Chicago. (Rx. 4) From 1999 to the present, she has been in private practice at the Center for Arthritis and Osteoporosis, Illinois Bone & Joint Institute. (Rx. 4) On January 4, 2012, for one hour, twenty minutes, she examined Petitioner and later prepared a report of her findings and opinions. (Rx. 5)

Dr. Moran's physical examination of Petitioner on January 4, 2012 revealed that she was alert, oriented and afebrile. She is sitting comfortably in the chair. Her weight is 138 lbs. Her skin appears entirely clear. Her neck shows full and normal range of motion without provocation of pain. There is no adenopathy or thyromegaly. Her extremities were normal in appearance. There was no swelling, warmth or erythema. The joint examination showed a full range of motion of the shoulders, elbows, wrists, metacarpophalangeal and proximal interphalangeal joints, knees, hips and ankles. There is no evidence of swelling, warmth, erythema or reproducible tenderness with direct palpation of any of her joints. The patient had very well-developed musculature in the upper and lower extremities both proximally and distally. There

was no evidence of atrophy. Deep tendon reflexes were 2+ and symmetric in both the upper and lower extremities. Motor examination demonstrated 5/5 strength in the upper and lower extremities both proximal and distal. Petitioner would not allow her to directly palpate her back. When touching her around the shoulders posteriorly and along the trochanteric regions, she complained and winced with pain. (Rx. 5)

Dr. Moran provided the following opinions: it is her assessment that an intrathecal pump for medication is not indicated, though she does not have first-hand experience with the such pumps. She notes Petitioner has subjective complaints of pain, but there are no objective findings to substantiate mechanical pain or injury. (Rx. 5)

With regard to a scooter that had been recommended, Dr. Moran did not believe that Petitioner needs a scooter as she is able to ambulate. (Rx. 5, p. 1) Dr. Moran thought it was unusual that the patient was able to sit comfortably in a chair in which she is clearly experiencing the pressure of the chair directly on the areas in which she is unable to be touched. (Rx. 5, p. 3)

Dr. Moran also gave opinions regarding Petitioner's treatment to date. She summarized by stating that extensive medical management has been done, including treatment with Gabapentin, Tramadol, Cymbalta, and daily narcotics – "none of which have really resulted in significant reduction in symptom relief". (Rx. 5, p. 4) Dr. Moran did not agree with Dr. Lubenow with respect to the placement of an intrathecal pump. Dr. Moran stated: "[i]t seems extremely unlikely that this patient would respond to treatment with intrathecal medication, given that she has had little or no response to all of the previously stated medications and the spinal cord stimulator." (Rx. 5, p. 4) Dr. Moran said it was difficult to say what the diagnosis is, only saying that the patient subjectively complains of constant severe pain and hypersensitivity in an area where there is entirely normal tissue. (Rx. 5, p. 4) Regarding Petitioner's prognosis,

although she has been given very aggressive therapies, not only in terms of medical management with medications but also with rehabilitation, she has had little or no response. It seems unlikely that her subjective complaints of pain will resolve. (Rx. 5, p. 4) Dr. Moran further testified that she does not believe that further treatment is needed with respect to the original injury. She has had all reasonable treatments. Unless there was clearly a significant subjective finding on nerve testing or diagnostic imaging pointing to a particular source of her pain, she does not feel that any additional treatment is recommended. Finally, Dr. Moran stated that she believes that the patient could return to work in a sedentary job, which would be a sitting job. Dr. Moran believed she has lived with this without signs of detectable debilitation. (Rx. 5, p. 5)

Section 12 Report of Jonathan S. Citow, M.D.

Dr. Citow conducted an examination of Petitioner and later wrote a Section 12 report with his findings and opinions. (Rx. 2) Dr. Citow is a board-certified neurosurgeon. (Rx. 1) His practice is currently at the American Center for Spine & Neurosurgery in Libertyville, Illinois. (Rx. 1) Dr. Citow performed a physical examination of Petitioner on November 4, 2009. (Rx. 2) His physical examination of Petitioner revealed that her back was non-tender with full range of motion, though there was a diffuse achiness around her buttock. Range of motion was intact. Straight leg raising was negative bilaterally. Motor strength was 5/5 and sensation was grossly intact. (Rx. 2, p. 2) Dr. Citow also reviewed medical records that included MRIs of the thoracic and lumbar spine from June 11, 2009, which were essentially normal. Dr. Citow's diagnosis of Petitioner's condition was non-anatomic dysthesisas, not likely related to the injury. (Rx. 2, p. 2) He found her prognosis to be excellent, that she had reached MMI and that she

should be able to return to work full-duty without restrictions. (Rx. 2, p. 2) Dr. Citow also authored an addendum. (Rx. 2, pp. 4-5)

"Independent Forensic Psychiatric Examination" by Alexander E. Obolsky, M.D.

Dr. Obolsky is a board-certified forensic psychiatrist, licensed to practice medicine in Illinois and board certified in psychiatry and neurology from 1994 – the present. (Rx. 6) From 1999 to the present he has been the medical director of Health & Law Resource, Inc., a corporate and legal psychiatric consultations and evaluations facility. Over the years, he has also been the director of several in-patient clinics and between 1995 – 1998, was the Director of the Division of Forensic Psychiatry at the Department of Psychiatry and Behavioral Sciences, Northwestern University Medical School. From 2003 to the present, he has been the Assistant Professor of Clinical Psychiatry and Behavioral Sciences at Northwestern University Medical School. (Rx. 6)

Dr. Obolsky performed a 4-day evaluation of Petitioner for her forensic psychiatric evaluation. (Rx. 7, p. 3) Ms. Jacobs also exhibited physical discomfort and pain behaviors that worsened with the length of time she spent in the evaluation. (Id.) Dr. Obolsky opined that Petitioner presents with multiple psychiatric factors reasonably expected to influence negatively her response to the continued prospective medical care. It was also his opinion, with a reasonable degree of medical psychiatric certainty, that Petitioner did not develop any condition of mental ill-being due to any work-related events. (Rx. 7, p. 1 of 6) In her written tests, Dr. Obolsky noted that there were serious inconsistencies among various sources of data relating to the potential presence of anxiety and depressive symptoms. Her inconsistent performance on validity indicators undermine the reliability of her self-reported symptoms of anxiety and depressive symptoms. (Rx. 7, p. 3 of 6) Dr. Obolsky also noted that Petitioner scored within

failing range on the Green Word Memory Test ("GWMT") and on the Structured Inventory of Malingered Symptomology ("SIMS"). Her performance on these two tests were consistent with symptom amplification. Petitioner's scoring patterns on measures of attention and executive function (Digit Forward Trails A&B, Wisconsin Cart Sort (WCST)) were below expectation based on her educational attainment. Her pain complaints do not explicate her performance on these tests. These tests were consistent with symptom exaggeration. (Rx. 7, p. 4 of 6) It was Dr. Obolsky's opinion that she exhibits psychiatric and secondary gain factors that affect the severity and maintenance of her physical symptoms and pain complaints. (Rx. 7, p. 5 of 6) When asked whether the pain pump or medicine delivered by the pump is necessary, Dr. Obolsky believed that the subjective pain and physical complaints, without identified pathology, are an unreliable foundation for invasive procedures, unless explicitly performed to change Petitioner's verbal behaviors, i.e., to cause a decrease a in her complaints of pain. (Rx. 7, p. 5 of 6)

Deposition Testimony of Assistant Director of Respondent, Bonnie Lee Jordan

Bonnie Lee Jordan testified that she was employed by Respondent from July 1, 2015 to June 30, 2017. ECHO Joint Agreement stands for Exceptional Children Have Opportunity and it is a special education cooperative that services school districts in southern Cook County. Bonnie Jordan served as the Assistant Director for Curriculum and Instruction. (Rx. 12, pp. 4-5) Ms. Jordan was not employed by Respondent during the 2009 work accidents. However, she was present when Petitioner returned to work in 2016. (Id., p. 6) Between January 11, 2016 and April 12, 2016, she was working as Assistant Director of ECHO. (Id.) She accommodated Petitioner's work restrictions in bringing her back to work. Her accommodations in January 2016 included returning to work for 8 hours with intermittent standing and sitting. She also

ordered Wayne Dendler and Jennifer Evanetti to review with Petitioner any accommodation she may need to do her duties. Ms. Jordan had been working with all of her Principals to have this happen, so she gave some suggestions for what things could be used, such as a scooter for building travel and also a cane for the classroom and for short distances, seat cushions, no heavy lifting and no physical management. (Id., pp. 7 - 8)

Petitioner was given the job of a Paraprofessional and was assigned to the room of the Art Teacher, Mr. Cannon. (Id., p. 9) Petitioner did not object to trying the restrictions and accommodations in her return to work. (Id., p. 10) While Petitioner went back to work in January 2016, it was Ms. Jordan's recollection that Principal Wayne Dendler was saying that she was having a hard time. (Id.) Her start date of January 11, 2016 was confirmed, and she would start as a Step 5, line 4, pursuant to the collective bargaining contract. (Id., p. 11)

However, they received a letter dated February 12, 2016, from Dr. Lubenow to Petitioner's attorney, David Kosin, saying that Dr. Lubenow found her to be totally and permanently disabled and recommends that she limit her driving restrictions to 20 minutes at a time. (Rx. 12, Dep. Ex. 3) Bonnie Jordan testified that based on Dr. Lubenow's report, she sent a letter to Ms. Jacobs on April 4, 2016 in which she recommended termination of her employment due to her inability to return to work. (Rx. 12, p. 12, Rx. 12, Dep. Ex. 3) That recommendation was confirmed in a vote of termination of employment at ECHO's regularly-scheduled board meeting and reduced to writing to Petitioner. (Px. 32) Her official date of termination was April 12, 2016. (Rx. 12, p. 13)

On cross-examination, Ms. Jordan testified that she was not an employee of Respondent at the time Petitioner sustained the accident and was not an employee there when Petitioner first returned to work in 2010. (Rx. 12, pp. 15-16) Regarding Petitioner's second return to work, Ms.

Jordan agreed that she received a letter from Respondent dated December 16, 2015 that stated, per documentation from York Risk Services, Petitioner was cleared to return to work for 8 hours a day at sedentary duty. (Rx. 12, pp. 15-16) Sedentary duty meant she could sit, stand, and walk for 8 hours. Only York Risk Services is mentioned in the letter, not the name of the doctor who released her. (Rx. 12, p. 17) Ms. Jordan testified that she felt that there was an independent examination upon which those restrictions were based. (Rx. 12, p. 17) Ms. Jordan testified that she did not know the restrictions that Petitioner's treating physician had imposed on her. (Rx. 12, p. 18) Ms. Jordan agreed that there is nothing in the December 16, 2015 letter from Respondent that says Petitioner should avoid restraining students. (Rx. 12, p. 21) Ms. Jordan testified that she did recall Principal Dendler saying that he was uncomfortable with Petitioner returning to the position of Paraprofessional at AFL. (Rx. 12, p. 22) Ms. Jordan testified that Petitioner's attempted return to work began on January 11, 2016 and lasted about a month. (Rx. 12, p. 23) She recalled seeing Petitioner once for 5-10 minutes during her return to work. Petitioner was in the Art Room when Ms. Jordan visited with her. (Rx. 12, p. 24) Ms. Jordan was aware that during Petitioner's return to work in 2016, Petitioner had cause to be off work on numerous occasions to see her doctors. (Rx. 12, p. 26) Ms. Jordan testified that Petitioner's termination was based on her inability to return to work. (Rx. 12, p. 30)

On redirect examination, she testified that Petitioner was not the first Paraprofessional to be given a job accommodation such as no physical management of the students. (Id., p. 36) For example, when they did CPI training, which is Crime Prevention Training, there were people who could not participate due to pregnancy, due to lifting restrictions, or due to back issues. Respondent made sure that it was noted that they could not participate in the physical management of students. (Id., p. 37) When Ms. Jordan saw Petitioner the one time during her

return to work in 2016, she remembers seeing her sitting in the back of classroom working on papers. They both said hello. Ms. Jordan said she would also stop and talk to the kids and be disruptive. Ms. Jordan further testified that Petitioner did not seem to be in any kind of distress at that time. (Id., p. 38)

On recross examination, Ms. Jordan testified that the only Paraprofessional who was given the restrictions Petitioner was given was Petitioner, Catherine Jacobs. (Rx. 12, pp. 38-39)

EVR Vocational Assessment, Transferable Skills Analysis and Labor Market Survey

Respondent offered into evidence the forensic EVR Vocational Assessment & Transferable Skills Analysis along with the EVR Labor Market Survey. (Rx. 10, Rx. 11) On August 19, 2014, Petitioner met with the vocational counselor for an interview at Petitioner's Counsel's office. (Rx. 10, p. 1) The medical records and reports that Kathleen M. Dytrych, CRC, reviewed included the following: the January 4, 2012 report by Dr. Mary L. Moran, the June 7, 2013 psychiatric exam report by Dr. Alexander E. Obolsky, the August 20, 2013 report by Dr. Howard S. Konowitz, the October 17, 2013 FCE report, the November 13, 2013 work release form by Dr. Timothy R. Lubenow, the January 17, 2014 report by Dr. Howard S. Konowitz, the February 26, 2014 report by Dr. Matthew Jaycox, the August 15, 2014 work release by Dr. Matthew Jaycox, the October 14, 2014 report by Dr. Howard S. Konowitz, and the Marianjoy Driving Evaluation records that included records from May 14, 2013 and May 25, 2013. (Rx. 10, pp. 6-14) Notably missing from the records reviewed are the results of Petitioner's August 1, 2012 FCE, which the evaluator found to be valid. (Px. 4, Dep. Ex. 4, Px. 4) The evaluator limited Petitioner to 4 hours of limited work per day. (Px. 4) Ms. Dytrych sought a new FCE, which was never authorized. She also suggested that Petitioner undergo another driving

assessment, which occurred on June 18, 2015. (Px. 15) Given that Ms. Dytrych created Rx. 10 and Rx. 11 before June 18, 2015, she did not consider the results of the new driving assessment. Ms. Dytrych concluded that Petitioner may or may not have lost access to her usual and customary employment as a Special Education Teacher, and that there were various full-time or part-time jobs available to the her, depending upon which physician's opinions applied to Petitioner. (Rx. 10, p. 19) No job readiness training or job placement was authorized by Respondent.

Ms. Dytrych compiled a Labor Market Survey. The Labor Market Survey lists over 100 jobs. It is divided into sedentary v. light-duty jobs, teaching-related v. career alternatives and jobs within 15 minutes of Petitioner's residence v. those in which no driving restriction is required. (Rx. 11, p. 1)

Missing from Ms. Dytrych's analysis are the following final restrictions by Dr. Lubenow, (Px. 18, p. 267), which is dated May 2, 2014:

1) 3-4 hours of work per day
2) 15 minutes of local driving per day
3) Sitting 30-45 minutes then rest/position change
4) Standing 10-15 minutes then position change
5) Maximum lifting of 15 pounds
6) Use of scooter for local transport
7) Use of cane for short walks

As noted above, Ms. Dytrych failed to consider the valid FCE of August 1, 2012. Ms. Dytrych's analysis is also based upon Dr. Konowitz' October 14, 2015 return to light-duty work. However, Ms. Dytrych is unaware that Dr. Konowitz agreed that Petitioner could return to only sedentary-duty work at best. (Rx. 7, p. 137) Petitioner notes that the Labor Market Survey was submitted without testimony. The school districts are varying distances from Petitioner's home. None of them document the time necessary to travel to each school given traffic speed and congestion. None of the part-time positions noted on the list of school districts delineate whether they are part-time per week or part-time per day. Of all the positions listed by Ms. Dytrych, only one is "primarily sedentary" though it does require lifting. The heaviest lifting requirement would be a "box of records" at most. (Rx. 11, p. 16) However, that job is full- time and is 19 miles away. Some of the listed job opportunities fall outside of Petitioner's stated restrictions, as indicated by Ms. Dytrych. (Rx. 11, pp. 21-24)

II. Conclusions of Law

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

The Arbitrator finds Petitioner's current condition of ill-being, as diagnosed by Dr. Lubenow, to be causally related to her work injury of March 23, 2009.

Based on the clinically required Budapest criteria, neither Dr. Noren nor Dr. Konowitz was able to diagnosis Petitioner with CRPS. The Budapest criteria are recognized as the current standard upon which Petitioner's treating physician, Dr. Lubenow, would render a diagnosis. (Px. 24, pp. 8-11) Dr. Noren and Dr. Konowitz testified that Dr. Lubenow's opinion that Petitioner had atypical CRPS is not a recognized medical diagnosis.

Dr. Noren examined Petitioner on a single occasion approximately 6-1/2 years prior to trial. Dr. Noren testified that when he examined Petitioner, she exhibited severe allodynia in the thoracic and lumbar region to slight touch. Upon touching her lower lumbar region, he testified, he would remove his hand because she reported extreme pain. Dr. Noren also found that there was a slight pilomotor change with lightly touching her back. He did not note any color changes or swelling. (Rx. 9, pp. 14-15) He stated that his diagnosis of her was indeterminate and referred her to a rheumatologist. (Rx. 9, p. 16)

Dr. Noren testified that he wrote, in his initial report, the following: "as noted by Dr. Lubenow, this is an extremely unusual presentation for a complex regional pain syndrome," and that based on the history that she provided, "this appears to be causally related to her injury" of March 23, 2009. (Rx. 9, pp. 63-64) Dr. Noren diagnosed Petitioner as suffering from atypical CRPS. Dr. Noren later attempted to deny that he made these statements.

Dr. Noren found no clinical evidence of S1 radiculopathy.

The opinions of Dr. Konowitz are suspect since they rest upon an incomplete review of all the relevant medical records. Dr. Konowitz did not review the RIC records that document abnormal sweat patterns. Dr. Lubenow documented temperature variances along with abnormal hair growth, yet Dr. Konowitz never scientifically tested for temperature differences.

During his examinations, Dr. Konowitz did not find color changes, edema or temperature asymmetry.

Neither Dr. Noren nor Dr. Konowitz noted or explained the positive S1 radiculopathy documented on Petitioner's EMG because they were not given the EMG results.

Neither Dr. Noren nor Dr. Konowitz acknowledged the objective findings of CRPS as documented by Dr. Lubenow, in the RIC records, or in the treating records of Petitioner's other physicians.

The Arbitrator notes that Dr. Lubenow testified inconsistently about his findings that met the Budapest criteria. He testified in one part of his deposition that in the very beginning of her presentation to him, she had some temperature asymmetry and an increase in her hair distribution in her thighs or her legs. These signs would have provided sufficient diagnostic criteria to diagnose CRPS. (Px. 24, p. 74) Later in the deposition, Dr. Lubenow testified that at his very first evaluation of her, he found that she did not meet the Budapest criteria, but at some later point he found that she did have sufficient exam findings to meet the Budapest criteria. Those criteria were seen during only *one* exam. However, such signs and symptoms were not all there on the first day he saw her in 2010. (Px. 24, p. 100)

Notwithstanding this inconsistency in his testimony, the Arbitrator finds Dr. Lubenow to be the most qualified to render this diagnosis when considering the opinions offered by all of the physicians in this case. Dr. Lubenow's curriculum vitae reveals his expertise in the study and treatment of CRPS. Moreover, Dr. Lubenow has been Petitioner's treating physician for approximately 7 years. Doctors Kirincic, Louis and Gruft concur with Dr. Lubenow's diagnosis.

Even if one of the medical witnesses was equivocal on the question of causation, it is for the Commission to decide which medical view is to be accepted, and it may attach greater weight to the opinion of the treating physician. *International Vermiculite v. Indus. Comm'n*, 394 N.E.2d 1166, 31 Ill. Dec. 789 (1979)

Based on the foregoing, the Arbitrator finds that he agrees with the following diagnosis of Petitioner's condition of ill-being, which Dr. Lubenow offered:

> Her current condition of ill-being is atypical complex regional pain syndrome, or alternatively one may refer to it as a neuropathic pain condition of the low back lumbar spine and legs bilaterally, she has a secondary diagnosis of bilateral S-1 radiculopathy." (Px. 24, pp. 71-72)

Dr. Lubenow testified that he believed the cause of these conditions was the work injury that was described in March of 2009. (Px. 24, pp. 24-25)

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

The Arbitrator finds the medical services rendered to Petitioner from March 23, 2009 through the date of the closing of proofs, February 22, 2018, to be reasonable and necessary. The Arbitrator bases this finding on the records and opinions of Petitioner's treating physicians, as well as on Petitioner's testimony.

On behalf of Respondent, Dr. Noren testified that the medications prescribed to Petitioner, such as Gabapentin, were appropriate and reasonable. Dr. Konowitz testified that he would have prescribed Gabapentin and Cymbalta but does not agree with the placement of the pump.

On February 24, 2012, Dr. Lubenow implanted a permanent intrathecal pain pump in Petitioner. (Px. 24, Dep. Ex. 2)

In his August 20, 2013 report (Rx. 8, Dep. Ex. 4), Dr. Konowitz testified, he indicated that the treatment to date has been reasonable and customary. He testified, unconvincingly, that the treatment to which he was referring was the independent psychiatric exam that he had ordered. (Rx. 8, pp. 27-28)

The Arbitrator does not consider a psychiatric exam that was ordered by a Section 12 physician to be treatment.

Petitioner testified that the intrathecal pump alleviates her pain.

Petitioner objected to the admission of Deposition Exhibits 3-10 of Respondent's Exhibit 8 on the basis of hearsay but allowed the Arbitrator to review such reports for the sole purpose of determining whether or not the doctor has appropriately rendered opinions pursuant to *Ghere* in the appropriate time frame. (Rx. 8, pp. 154-155)

The Arbitrator's award here includes all the treatment documented in Petitioner's treating medical records as well as the total unpaid medical charges for such treatment, $321,368.95 (Px. 25), pursuant to Section 8(a) and subject to Section 8.2 of the Act.

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

The Arbitrator finds, based on Petitioner's testimony, the medical records, and the opinions of Petitioner's treating physicians, that Petitioner is entitled to the periods of temporary benefits as outlined below:

It is undisputed that Petitioner remained off work from March 24, 2009, the day after her accident, through January 13, 2010. Petitioner testified that around July 13, 2009, her benefits were terminated based on Dr. Wehner's reports. However, it was eventually worked out that her back benefits would be paid, and she continued with her treatment. On January 14, 2010,

Petitioner attempted to return to full-duty work based on the opinions of Dr. Citow. (Rx. 2) Petitioner was unable to perform her full duties, and on January 21, 2010, she began to work limited hours per day and was paid TPD.

Petitioner worked on restricted hours through the end of the school year. On June 1, 2010, summer break began with Petitioner still on restrictions. Therefore, she was entitled to TTD through August 23, 2010, after which she returned for the new school year and was paid TPD once again. Petitioner received TPD through October 27, 2010. On October 28, 2010, Dr. Lubenow took Petitioner off work completely. Petitioner was entitled to TTD through the date of June 17, 2014, which is the date on which Vocamotive determined Petitioner lost access to any viable labor market, thus concluding that her disability was total.

After June 17, 2014, Petitioner continued to receive temporary benefits. Respondent claims those represent TTD benefits. Petitioner claims that as of this date, Petitioner was entitled to maintenance benefits while she cooperated with Respondent's forensic vocational counselor, EVR.

From January 11, 2016 through January 31, 2016, Petitioner testified (3 weeks), she made a good-faith attempt to return to work in the accommodated position of Paraprofessional. Although she worked 8 hours a day, she was being paid as a Paraprofessional, not as a Special Education Teacher. Therefore, she earned TPD for this 3-week period.

From February 1, 2016 through February 12, 2016, Petitioner earned maintenance benefits after her failed attempt to return to work at that greatly accommodated position.

On February 12, 2016, Dr. Lubenow found Petitioner to be permanently and totally disabled.

Based upon the above, Petitioner is entitled to receive 244-1/7 weeks of TTD benefits at $717.97/week. The parties agree that Respondent paid TTD benefits in the amount of $217,550.50. (Rx. 2A, Section 9)

Petitioner is also entitled to 28 weeks of TPD benefits, for the period from August 24, 2010 through October 27, 2010, at a rate of $464.06/week, as well as 3 weeks of TPD benefits, for the period January 11, 2016 through January 31, 2016 when she worked as a Paraprofessional, at a rate of $549.99. Respondent is entitled to a credit in the amount of $12,993.64 for TPD paid. (Rx. 2A, Section 9)

Petitioner is also entitled to maintenance benefits from June 18, 2014 through January 10, 2016 and February 1, 2016 through February 12, 2016, a total of 83-3/7 weeks. Respond claims they have paid no maintenance benefits. Respondent shall have a credit for any overpayment of TTD as payment for maintenance.

Respondent offered into evidence Rx. 14, which is entitled "York Risk Services Individual Claim Report showing payments of TTD, TPD, and PPD, dated October 31, 2017".

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

The Arbitrator has found the opinions of Dr. Lubenow to be more persuasive than those of Doctors Noren and Konowitz.

On February 12, 2016, Dr. Lubenow examined Petitioner. He noted that she ambulates with a cane. She limps and favors the right leg. She has a slow, cautious gait. He further noted that there is allodynia in the lower back that extends up to the mid-thoracic back, as well as in the sacral area. Motor strength is 5/5 in both legs, and deep tendon reflexes are symmetric at 2+. He

found she has a decreased sensation to the cool application of an alcohol pad on the legs, and to a greater extent, on the low back and mid back to approximately the T8 dermatomal region. He noted that she has an intraspinal drug delivery system implanted, which is refilled by Stellar Home Health. (Px. 24, Dep. Ex. 8)

Dr. Lubenow opined Petitioner has chronic, persistent atypical CRPS of the lower extremities and lumbar region that is worse since her return to work. Dr. Lubenow was concerned that Petitioner was driving above her previously-stated safe driving restrictions and noted that, in reality, Petitioner was really not working at her current place of employment. He limited her driving to 20 minutes at a time. Dr. Lubenow found Petitioner to be totally and permanently disabled. (Px. 24, Dep. Ex. 8)

Based upon the opinions of Dr. Lubenow, the Arbitrator finds that commencing on February 13, 2016, Petitioner became medically permanently and totally disabled. Therefore, the Arbitrator orders Respondent to pay Petitioner permanent and total disability benefits of $717.97/week for life, which commenced on February 13, 2016, as provided in Section 8(f) of the Act.

O. Evidentiary Ruling: the *Ghere* objection

During the depositions of Doctors Wehner, Noren and Konowitz, Petitioner raised *Ghere* objections based on the Court's ruling in *Ghere v. Indus. Comm'n*, 278 Ill. App. 3d 840 (4th Dist. 1996) and Section 12 of the Act. Section 12 requires, in pertinent part, Respondent to provide Petitioner with a copy of their examining physician's report no later than 48 hours before the case is set for hearing. The *Ghere* Court held that a purpose of Section 12 was to prevent surprise medical testimony at trial. In *Ghere*, Dr. Climaco, an emergency room physician who

had previously treated claimant, but not for his heart, testified live. He offered a causation opinion regarding claimant's heart condition. Respondent objected to the admission of such opinion. The arbitrator sustained the objection. The Court agreed with the ruling of the arbitrator and the Commission that such opinion was not furnished to the employer 48 hours before the arbitration hearing. The Court found that Dr. Climaco's testimony constituted surprise medical testimony. Accordingly, based on the facts in *Ghere*, the Court applied the 48-hour rule in Section 12 to treating physicians as well.

At the deposition of Dr. Konowitz, when Petitioner raised his first *Ghere* objection, he argued that Dr. Konowitz's opinion about Dr. Lubenow's treatment had not been disclosed until the commencement of the deposition. (Rx. 8, p. 23)

Respondent pointed out that in the Notice of Deposition (Rx. 8, Dep. Ex. 2), which he had previously sent to Petitioner and to Dr. Konowitz, he wrote the following:

> "Questions will be asked during the deposition of Dr. Konowitz about Dr. Lubenow's treatment of the Petitioner and his written remarks in narrative reports about Dr. Konowitz's opinions. We will ask for Dr. Konowitz's opinions about Dr. Lubenow's written remarks. There will be no audio-visual equipment." (Rx. 8, Dep. Ex. 2)

In response, Petitioner argued that merely pointing out an area in which the doctor may formulate an opinion during the time he is rendering his testimony in an evidence deposition does not meet with *Ghere*. Accordingly, he objected and moved that Dr. Konowitz's opinion be stricken. (Rx. 8, p. 24)

The Arbitrator overruled this objection.

Later in the deposition, Petitioner's attorney stated that he never received the Notice of Deposition and objected to the admission of such document. (Rx. 8, p. 154, Rx. 8, Dep. Ex. 2) The Arbitrator overruled such objection. The Notice of Deposition shows that it was sent to Petitioner's attorney at 134 N. LaSalle Street, Suite 1340, Chicago, IL 60602, which is the same address listed for Petitioner's attorney on Ax. 1 and Ax. 2A. There is a Certificate of Service with the Notice of Deposition that indicates it was sent via regular mail before 5:00 p.m. on December 14, 2016. (Rx. 8, Dep. Ex. 2)

In *Homebrite Ace Hardware v. Indus. Comm'n*, 351 Ill. App. 3d 333 (5th Dist. 2004), claimant was injured when lifting buckets. He experienced low back pain and treated for this condition. He was found to have a herniated disc. Claimant was released to return to work with restrictions. For 4-6 weeks post-accident, there was no mention of any neck problems. Claimant testified that he never had any neck problems before the accident, but later was referred to a neurosurgeon, who treated him for low back pain and cervical pain once it developed. Before an evidence deposition, the treating neurosurgeon did not provide either claimant's attorney or respondent's attorney with a report or an opinion as to a causal connection between the current condition of ill-being of his low back and neck, and the accidental injury. At the deposition, the neurosurgeon testified, over a *Ghere* objection, that there was a causal connection between claimant's low back and neck problems, and the accidental injury. The neurosurgeon further testified that claimant was in need of neck surgery, which had not been done because respondent did not authorize it. The arbitrator found that the neck and low back were causally related to the accident and ordered respondent to authorize the neck surgery. The Industrial Commission affirmed the arbitrator's decision and the circuit court confirmed the Commission decision.

The Appellate Court in *Homebrite* noted that *Ghere* did not set forth a bright-line rule that undisclosed opinion testimony constitutes surprise.

The *Homebrite* Court disagreed with the employer's contention that the Commission cannot arbitrarily determine when an opinion constitutes surprise testimony. The Court noted that the neurosurgeon's records contained details about treatment of claimant's neck condition and hence the employer was put on notice that the neurosurgeon might testify as to the causal connection between the neck condition and the accident. Therefore, the Court rejected the employer's argument that this testimony by the neurosurgeon should have been excluded.

At Dr. Konowitz's deposition on January 5, 2017, Petitioner's attorney stated that he understands that opposing counsel and Dr. Konowitz have been in possession of Dr. Lubenow's written remarks for years. (Rx. 8, p. 24)

Petitioner's attorney had no objection to the Arbitrator reviewing Deposition Exhibits 3-10 of Rx. 8 for the sole purpose of determining whether or not the doctor appropriately rendered opinions pursuant to *Ghere* in the appropriate time frame. (Rx. 8, pp. 154-155)

M. Should penalties or fees be imposed upon Respondent?

Petitioner filed a motion claiming she is entitled to Section 19(k) penalties of $138,857.80 (= 50% of [$321,368.95 in outstanding medical charges less a Section 8(j) credit of $43,653.35]) plus Section 19(l) penalties of $10,000.00 plus Section 16 attorneys' fees of $29,771.56 (= 20% of $138,857.80). (Px. 33)

Petitioner argues that when Dr. Kirincic referred Petitioner to Mayo Clinic, Respondent declined authorization for such referral but agreed to authorize Dr. Lubenow at Rush Medical Center to treat Petitioner. When Dr. Lubenow escalated Petitioner's care by seeking

authorization of an intrathecal pump, Respondent sought the opinion of Dr. Noren who advised against the pump. When Respondent's own utilization reviewer, Ann Nikolaou, R.N., authorized the insertion of the intrathecal pump, Respondent did so, but then sought the opinion of a pain specialist, Dr. Konowitz. Dr. Konowitz recommended removal of the pump. It appears that neither Dr. Noren nor Dr. Konowitz were provided with a complete set of treating records, including the EMG of the lower extremities, when they initially rendered their opinions.

Dr. Lubenow testified that the EMG indicated S1 sciatica that would explain some of her radiating pain that came from the disc. The Arbitrator notes, however, that Petitioner also complained of pain in her neck and upper extremities.

Petitioner points out that Respondent denied Petitioner's request to have Steven Blumenthal as her choice of vocational counselor. Instead, Respondent authorized Vocamotive, Inc., to carry out the vocational counseling. After Vocamotive, Inc., determined that Petitioner had lost access to any viable labor market, which would render her totally disabled, Respondent advised Vocamotive to close their file. Respondent then hired Ms. Dytrych of EVR to perform a forensic vocational analysis. Ms. Dytrych conducted a vocational interview of Petitioner in which Petitioner complained of pain that starts in her neck and travels down to her toes and affects her shoulder and arm, back, hands, feet, legs, and buttocks. Petitioner stated that "if [her] upper back is touched the pain goes up to 10/10." Ms. Dytrych initially performed her assessment and noted that there were 2 major issues that prevented Petitioner from returning to work: her driving limitation and her work hour limitation. Ms. Dytrych recommended an updated driving evaluation. Prior to Ms. Dytrych's compilation of the Labor Market Survey, Dr. Konowitz removed Petitioner's work hour restriction without acknowledging the limitations noted in the FCE and removed Petitioner's driving restrictions. Dr. Konowitz testified that he

boosted Petitioner from sedentary to light duty after he examined her based on what she told him she was able to do given her own physical state. He testified that the FCE is a jumping-off point for him. As noted above, Ms. Dytrych's Labor Market Survey relies on Dr. Konowitz's opinions to expand potential job opportunities and does not consider Dr. Lubenow's restrictions.

Petitioner returned to work as a Teacher's Aide (Paraprofessional) in January 2016. This was offered to Petitioner based on an ability to work an 8-hour day at a facility located over a 1-hour drive away. According to Petitioner's treating physician, neither requirement was within her capabilities. Respondent made numerous accommodations for Petitioner. Principal Dendler testified that he did not believe Petitioner should be working at this job given her condition because she could be struck by a student in class or in the hallway. Mr. Dendler further testified that Petitioner did not perform the duties of a Paraprofessional but then conceded that she did perform minimal paperwork during her 5-week attempt, such as taking attendance and recording assignments in the computer.

Petitioner points out that Respondent has denied payment of numerous medical bills that total $321,368.95, which includes bills for the implantation and maintenance of the intrathecal pump.

Respondent argues that Petitioner is not entitled to any penalties or fees as they have a good faith basis for non-payment of benefits: the findings and opinions on causation/future medical from examining physicians that include board-certified orthopedic surgeon Julie M. Wehner, M.D., board-certified neurosurgeon Jonathan S. Citow, M.D., board-certified rheumatologist Mary L. Moran, M.D., board-certified anesthesiologist and pain management

physician Richard L. Noren, M.D., and board-certified anesthesiologist and pain management physician Howard S. Konowitz, M.D.

The Arbitrator finds that Dr. Konowitz gave no opinion as the reasonableness or necessity of the intrathecal pump in his August 20, 2013 report. (Rx. 8, pp. 29, 142-143) Dr. Konowitz later testified during his deposition that Petitioner should be weaned from this pump and that the pump should be discontinued.

On August 27, 2012 and September 28, 2012, psychiatrist Alexander E. Obolsky, M.D., conducted an "Independent Forensic Psychiatric Examination" that included an interview and extensive testing of Petitioner. Dr. Obolsky opined, within a reasonable degree of medical psychiatric certainty, that Petitioner did not develop any condition of mental ill-being due to any work-related events. Dr. Obolsky stated that he does not possess the requisite expertise to offer opinions as to (1) whether Petitioner's physical symptoms and pain complaints are related to the work-related incidents, or (2) the appropriateness or necessity of the continuation of prospective pain management. Having said that, Dr. Obolsky concluded that his findings indicate that emotional and secondary gain factors play a significant role in the maintenance, severity, and exacerbation of her physical and pain complaints and that these factors also play a significant role in her perceived and reported functional impairments. His current evaluation indicated that Petitioner's subjective complaints are significantly driven by psychiatric factors and that these factors are unlikely to improve with surgeries. Dr. Obolsky opined that from a psychiatric perspective, Petitioner could benefit from conservative medical care that focused on improving physical functioning while putting into practice benign neglect of complaints that do not have an objective basis. (Rx. 7)

Bonnie Jordan testified that during Petitioner's 5-week attempt to return to work in 2016, she remembered stopping by the classroom once and saying hello to Petitioner. Ms. Jordan testified that she remembered seeing Petitioner at that time sitting in the back of the classroom working on papers in no apparent distress.

The Arbitrator notes that Respondent has paid Petitioner $217,550.50 in TTD benefits, $12,993.64 in TPD benefits, $8,272.45 in other benefits (permanency advance), and $0.00 in maintenance benefits.

Respondent has also paid $43,653.35 in medical benefits through their group carrier and is entitled to a Section 8(j) credit in this amount.

In *McMahan v. Indus. Comm'n*, 183 Ill. 2d 499, 702 N.E.2d 545 (1998), claimant sustained a May 20, 1992 slip-and-fall accident while working for respondent that resulted in a low back injury. Claimant had injured his back 11 years earlier while working for another employer and underwent back surgery at L5-S1 in August 1985. However, since March 1990, claimant experienced very little difficulty with his back while working as a laborer for respondent. Claimant admitted that he periodically experienced mild left leg pain and pain down his left foot. His work activities at respondent's grain elevator included climbing, shoveling, painting, and lifting.

On May 21, 1992, claimant informed his supervisor of the slip-and-fall accident. An accident report was not completed or forwarded to the insurance carrier at that time because it was respondent's policy to take care of small workers' compensation claims internally. In November 1992, when claimant's supervisor realized that claimant's low back condition was more serious than first believed (claimant had continued to work in pain and had voiced complaints), she completed an accident report and forwarded it to the insurance carrier. The

carrier informed the supervisor that there was a problem with coverage on the accident because respondent had not complied with its policy provisions. As a result, the carrier refused to pay any of claimant's medical bills. The supervisor was also told by respondent not to pay any more of claimant's bills internally. Claimant was left to deal with those bills on his own.

In January 1994, orthopedic surgeon Walter Baisier, M.D., performed a lumbar laminectomy and discectomy at L4-L5 on claimant. The Supreme Court's Decision states:

> "Dr. Baisier opined that surgery was necessary to relieve claimant of his symptoms and that claimant's condition was causally connected to his fall on May 20, 1992. No other physician gave a contrary opinion."

The Supreme Court considered the sole issue of whether claimant was entitled to penalties under Section 19(k) of the Act and attorney's fees under Section 16. The Court overruled precedent and held:

> "In any case, we do not read Section 19(k) as precluding the imposition of penalties for unreasonable and vexatious delay in paying medical expenses ... Under Section 8 the amount of 'compensation' ... is expressly defined to include not only compensation for lost wages ... but also payment for medical services."

The Court held that Petitioner was entitled to, *inter alia,* 19(k) penalties on unpaid medical bills that totaled $21,795.11.

The Arbitrator finds that Respondent's conduct in the case at bar does not rise to the level of the employer's conduct in *McMahan.* The employer in *McMahan* denied TTD and paid only some pre-surgical medical bills. Significantly, the employer had no medical opinion that denied causation. Moreover, the employer made an intentional decision not to honor their statutory obligation to claimant, and they did so simply because they had not complied with the requirements of their insurance policy and were unwilling to absorb the cost themselves.

In the case at bar, Dr. Lubenow's primary diagnosis was atypical CRPS, which did not meet the Budapest criteria for CRPS. Dr. Noren opined surgery or the insertion of needles in the region of the complex regional pain syndrome is really considered to be contraindicated because it is likely to exacerbate or worsen the syndrome. Dr. Konowitz did not diagnose CRPS and did not agree with placement of the intrathecal pump. In order to place the pump, Dr. Konowitz testified, one has to have a diagnosis that meets the criteria, and Dr. Lubenow did not have that. Dr. Konowitz suggested that diagnostic error can lead to treatment error. Furthermore, Dr. Konowitz believed that Petitioner's current pain may be due to opiate-induced hypersensitivity.

On February 24, 2012, following a "Utilization Review for Authorization of Placement of the Intrathecal Pump," Petitioner had the permanent intrathecal pump installed. (T. 106) After the pump was inserted and after it was shown to alleviate her pain to a moderate degree, Respondent sought to have the pump removed and denied all charges associated with the pump, as well as a number of other bills.

The Arbitrator recognizes that Respondent in the case at bar engaged in (examining) doctor shopping and vocational rehabilitation counselor shopping. The Arbitrator has found that Petitioner's treating physicians are more persuasive than Respondent's Section 12 examining physicians. The Arbitrator gives minimal weight to the opinions of Kathleen Dytrych, CRC.

Petitioner testified that she continues to have her pump refilled regularly and continues to see Dr. Lubenow every 6 to 9 months. So, despite the fact that Respondent has denied payment of a great number of medical bills, the medical providers have rendered, and continue to render, medical care to Petitioner for her accidental injuries.

Respondent has opinions regarding causation/future medical care from 5 examining physicians, as well as an opinion from 1 examining psychiatrist.

Respondent has paid $43,653.35 in medical benefits through their group carrier, $217,550.50 in TTD benefits, $12,993.64 in TPD benefits, and $8,272.45 in other benefits (permanency advance).

Based on the foregoing, the Arbitrator finds that penalties under Sections 19(k) and 19(l), as well as attorney's fees under Section 16, are not warranted.

Brian T. Cronin
Arbitrator

3-6-2019
Date

STATE OF ILLINOIS)

COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

James Smith,	)	
	)	
Petitioner,	)	
	)	
vs.	)	**Case No. 17 WC 5524**
	)	
City of Chicago/Dept. of Public Library,	)	**Consolidated case: 18 WC 2516**
	)	
Respondent.	)	
	)	

ORDER

This matter comes before the Commission on the request of the attorneys to correct a typographical error contained in the body of the Corrected Decision of Arbitrator Steven Fruth. The Corrected Decision, issued on October 23, 2019, corrected the accident date on page nine (9) and the heading on page fifteen (15), from September 1, 2016 to September 19, 2016, the actual date of the accident, so that the body of the Order comports with the date of accident listed on Illinois Workers' Compensation Commission Arbitration Decision Form and the proofs at trial. The Corrected Decision issued on October 23, 2019, failed to correct the same typographical error that occurred on page fifteen (15). Under the heading of Conclusions of Law 17 WC 5524 (DOI 9/19/2016) the first sentence under paragraph F still identifys the accident date as September 1, 2016 rather than September 19, 2016.

After reviewing the Orders, the e-mails and the requests of counsel, and having discussed the matter with counsel for both sides, the Commission finds as follows:

(1) the parties agree that the date of September 1, 2016 is an error and the correct date of September 19, 2016 should be listed;
(2) it is clear from the document that the date of injury was September 19, 2016 based upon the evidence presented and the heading of the paragraph where the error is found listing the date of injury "(DOI) as 9/19/2016", and other references to the date of accident or date of injury;
(3) the order should be corrected to reflect an accident date of September 19, 2016 as requested by the parties.

It is therefore ordered by the Commission that the Corrected Decision of the Arbitrator issued on October 23, 2019, a copy of which is attached, shall be and hereby is corrected to reflect on page fifteen (15) of the order that the date of accident/injury was September 19, 2016.

Deborah L. Simpson
Signature of Commissioner

June26, 2020
Date

JUN 30 2020

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

James Smith
Employee/Petitioner

Case # **17 WC 5524**

v.

Consolidated case: 18 WC 2516

City of Chicago/Department of Public Library
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Steven Fruth**, Arbitrator of the Commission, in the city of **Chicago**, on **August 22, 2018** and **August 28, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

N. ☐ Is Respondent due any credit?

O. ☐ Other _____

FINDINGS

On **September 19, 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 $**73,111.83**; the average weekly wage was $**1,406.00.**

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

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

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

Respondent shall be given a credit of $**34,013.51** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**34,013.51**.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$937.33/week** for **36 & 2/7 weeks**, commencing **October 4, 2016 through June 14, 2017**, as provided in§8(b) of the Act.

Respondent shall be given a credit of **$34,013.51** for temporary total disability benefits that have been paid.

Respondent shall pay $750.00 for reasonable and necessary medical services provided by Dr. James Schiappa, pursuant to §8(a) of the Act and adjusted in accord with the medical fee schedule provided by §8.2 of the Act.

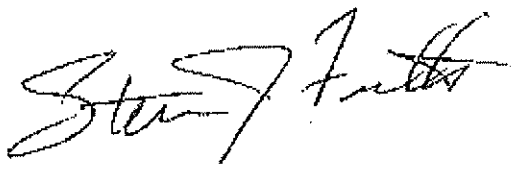
Respondent shall pay $424.25 for medical bills paid by the Illinois Department of Public Aid.

Respondent shall pay Petitioner permanent partial disability benefits of **$775.18/week** for **25 weeks**, because the shoulder injuries sustained caused a **5% loss of the person-as-a-whole**, as provided in §8(d) 2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of **$775.18/week** for **16.7 weeks**, because the left foot injuries sustained caused a **10% loss of the left foot**, as provided in §8(e) of the Act.

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

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



Signature of Arbitrator

October 18, 2019
Date

ArbDec p. 2

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

James Smith
Employee/Petitioner

v.

City of Chicago/Department of Public Library
Employer/Respondent

Case # **18 WC 2516**

Consolidated cases: 17 WC 5524

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Steven Fruth** , Arbitrator of the Commission, in the city of **Chicago**, on **August 22, 2018** and **August 28, 2018.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

B. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ 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 3, 2018**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**67,567.64**; the average weekly wage was $**1,299.39**.

On the date of accident, Petitioner was **54** years of age, ***married*** with **1** dependent children.

Respondent ***has*** paid all reasonable and necessary charges for all reasonable and necessary medical services for Petitioner's claimed lower back injury.

Respondent shall be given a credit of $**12,375.14** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**12,375.14**.

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

Petitioner failed to prove that he is entitled to recommended prospective medical care for his claimed left knee injury.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $866.26/week for **33 weeks**, commencing **January 4, 2018 through August 22, 2018**, as provided in §8(b) of the Act.

Respondent shall pay to Petitioner penalties of $**12,993.90**, as provided in §19(k) of the Act; $**4,680.00**, as provided in §19(l) of the Act; and attorney's fees of $**3,534.78**, as provided in §16 of the Act.

Petitioner's claim for recommended prospective medical care for his claimed left knee injury is denied.

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

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

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

before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

October 18, 2019
Date

ICArbDec19(b)

James Smith v. City of Chicago-Department of Public Library
17 WC 5524, consolidated 18 WC 2516
Corrected October 23, 2019

INTRODUCTION

These matters proceeded to hearing before Arbitrator Steven Fruth. The disputed issues were:

17 WC 5524 (DOI 9/19/2016): ***F:*** Is Petitioner's current condition of ill-being causally related to the accident?; ***J:*** Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?; ***L:*** What is the nature and extent of the injury?

18 WC 2516 (DOI 1/3/2018): ***F:*** Is Petitioner's current condition of ill-being causally related to the accident?; ***K:*** Is Petitioner entitled to prospective medical care?; ***L:*** What temporary benefits are in dispute? TTD; ***M:*** Should penalties be imposed upon Respondent?

FINDINGS OF FACT

Petitioner James Smith testified that in September 2016, he was employed by Respondent as an MTD (motor truck driver). His job duties included moving books and other items from one place to another. He drove a 35,000-ton U-Haul type truck.

On September 19, 2016, Petitioner testified he tripped over a loose piece of shelving while unloading his truck. He fell forward against the interior wall of the truck hitting his left shoulder and twisting his left ankle. He noticed tightness and soreness in his left shoulder and ankle.

Petitioner's supervisor sent him to MercyWorks on September 20, 2016 complaining of 10/10 pain in the left foot and left shoulder (PX. B). Petitioner was diagnosed with a left shoulder bursitis and left Achilles tendinitis. On September 20, 2016 he was advised to return to full duty work on September 21, 2016

On September 27, 2016, Petitioner returned to MercyWorks reporting that his shoulder was feeling better, but that his ankle felt stiff after sitting. Petitioner was referred to an orthopedic physician.

On October 4, 2016, Petitioner saw Dr. James Schiappa (PX. C). Petitioner complained of pain in his left AC joint. X-rays of the left shoulder revealed arthritis and swelling of the AC area. X-rays of the left foot and ankle revealed a minimally displaced fracture of the talus in the posterior, which required no treatment. Dr. Schiappa noted that Petitioner was still waiting for a total knee replacement which is to be done when approval is given. Dr. Schiappa recommended surgery to relieve the pain in the AC joint.

On October 18, 2016, Petitioner returned to Dr. Schiappa complaining of left shoulder and left foot pain. Petitioner's left shoulder was much better, but the left foot was still tender. Dr. Schiappa noted there was a chip on the posterior talus Petitioner was advised to return in 2weeks and remain off work.

Dr. Schiappa entered a supplemental note on November 1, 2016, in which he stated that an MRI is mandatory to determine if the ligaments of the shoulder are intact. This was an addendum to the original October 4 report. Dr. Schiappa noted that the total knee replacement has "nothing to do with this patient." He did believe that Petitioner needed surgery to his left shoulder. Dr. Schiappa stated that "this is a new dictation done on 11/1/16, to get the records straight for patient's name, James Smith."

Petitioner returned to Dr. Schiappa November 22, 2016, still complaining of discomfort in his left shoulder. He was not experiencing severe pain and had full range of motion. Petitioner was still complaining of tenderness of the Achilles tendon and was given a Medrol Dosepak along with Norco. Petitioner was authorized off work.

On December 2, 2016, Petitioner was seen by Dr. Julia Bruene of Midwest Orthopedics at RUSH (PX. D). Petitioner was complaining of pain in his left foot and ankle mostly over the posterior aspect in his Achilles region. He stated it was very tight and he has significant difficulty ambulating stairs, specifically descending stairs. He had pain with walking.

Petitioner reported less shoulder pain than before but still complaining of an achy pain when the shoulder was slightly elevated. Dr. Bruene diagnosed left posterior foot and ankle pain consistent with left sided Achilles tendinopathy and left sided shoulder pain consistent with left sided calcific rotator cuff tendinitis. Dr. Bruene recommended a hybrid night splint for the ankle, administered a cortisone injection in the left shoulder, recommended physical therapy and authorized Petitioner off work.

Petitioner testified he was seen at Athletico for his initial physical therapy evaluation on December 13, 2016 (PX. E). Therapy continued through February 20, 2017. Petitioner underwent 26 therapy sessions to his left shoulder and left ankle.

Petitioner returned to Dr. Bruene January 18, 2017, reporting that his shoulder improved significantly but that his ankle symptoms continued despite the physical therapy. On examination Dr. Bruene noted pitting edema around the Achilles and the posterior ankle. There was a pes planus deformity but the remainder of the exam of the ankle was within normal limits. On examination of the shoulder Petitioner had a positive Hawkins sign but Speed's was negative. There was no joint tenderness over the AC joint. Dr. Bruene recommended continued physical therapy for the shoulder and administered a cortisone injection to the left ankle. She authorized Petitioner off work pending significant improvement of symptoms.

On March 1, 2017, Petitioner returned to Dr. Bruene reporting that his shoulder was feeling much better and that his heel pain was only slightly improved. She recommended a left ankle MRI and referred Petitioner to her partner, Dr. Kamran Hamid. She continued Petitioner off work.

On March 7, 2017, Petitioner underwent a left ankle MRI at Rush Oak Park Hospital. The MRI revealed thickening and an increased signal of the Achilles tendon at its insertion, suggesting tendinosis, with evidence of retrocalcaneal bursitis. There was also evidence of mild tenosynovitis of the peroneal tendons and findings suggestive of prior sprain and/or tear of the deltoid ligament.

On March 20, 2017, Petitioner returned to Dr. Hamid who reviewed the MRI with Petitioner. He noted Petitioner's range of motion was limited and recommended continued non-operative treatment. He also recommended a home exercise program along with night splints and authorized Petitioner off work.

Petitioner returned to Dr. Hamid on May 1, 2017 advising he was doing well with Voltaren and the night splints. Dr. Hamid continued to keep Petitioner off work.

Petitioner last saw Dr. Hamid on June 15, 2017 with his symptoms improving. It was noted that when he wears tight shoes, he has pain and occasional pain when walking. He notices a tight pain when he goes up and down the stairs if his foot is not completely on the step. Petitioner used a dolly at work with bins weighing 75 to 100 pounds each, stacked 5 high.

Dr. Hamid's diagnosis was left insertional Achilles tendinopathy, greatly improved. Petitioner was returned to work without restrictions.

Petitioner testified he returned to work for the Respondent at his regular job earning the same rate of pay. He testified that when he returned to work, he noticed occasional soreness in his left shoulder. He referred to it as aches and pains. It does not

occur every day but noticed it when he lifts things. Petitioner testified when he returned to work, he noticed occasional stiffness and soreness when walking. He also testified he notices some pain in his left foot depending on how much weight he is lifting.

Petitioner still has complaints with his left shoulder and left foot.

Petitioner testified he was performing his regular job for Respondent until January 3, 2018, when he had another accident. He was moving books and other items on a smart cart. The front wheels of the smart cart swivel and got caught in a groove in a sidewalk. The cart started to tip over and Petitioner went to grab it to keep it from falling over so all of the books would not fall to the ground. As he did so, he felt pain in his low back.

Petitioner testified his supervisor took him to MercyWorks where he was examined for his back injury. He was authorized off work. Petitioner testified he returned to MercyWorks on January 5, 2018 and January 8, 2018 and was authorized off work at each visit.

Petitioner identified Petitioner's Exhibit #2 as being the 3 off work notes (City of Chicago work status report) he received from MercyWorks. Petitioner testified that he gave these documents his supervisor.

Petitioner further testified that MercyWorks referred him to Dr. Robert Strugala at Midland Orthopedics (PX #3). Petitioner initially saw Dr. Strugala on January 19, 2018. He reported pain in his low back which radiated into the left leg when standing. He did not receive any relief from a Medrol Dosepak. On exam Petitioner had decreased active lumbar extension and a positive straight-leg sign on the left. X-rays suggested straightening of lumbar lordosis. Dr. Strugala diagnosed low back and leg pain for 3 weeks consistent with left lumbar radiculopathy. Dr. Strugala recommended a lumbar MRI and took Petitioner off work.

On February 5, 2018, Petitioner underwent the lumbar MRI at MRI of River North (PX #3). The MRI revealed mild disc bulging at L1-2 and L2-3, and a left disc protrusion with facet arthrosis at L3-4 and moderate foraminal stenosis impinging the left L3 nerve root, an annular fissure with a small disc protrusion and mild bilateral foraminal stenosis at L4-5, and a small disc protrusion with bulging and facet arthrosis and foraminal stenosis at L5-S1.

On February 9, 2018, Petitioner returned to Dr. Strugala who reviewed the MRI with him. Dr. Strugala again diagnosed low back and leg pain consistent with left lumbar radiculopathy. He noted that the left foraminal disc protrusion was impinging

the L3 nerve root. Dr. Strugala recommended possible pain management and physical therapy. He again authorized Petitioner off work.

Petitioner began his physical therapy on February 14, 2018 at Shirley Ryan Ability Lab (PX #4). Petitioner gave a history of prior therapy for his left shoulder and left Achilles. He complained of left sided low back pain and left lower extremity pain to his knee which started January 3, 2018 while pushing a smart cart. He reported that an MRI revealed a herniated disc. Petitioner denied any significant medical history.

Petitioner returned to Dr. Strugala February 23, 2018 with some improvement noted. Dr. Strugala recommended continued physical therapy and continued off work. On March 9, 2018, Petitioner returned to Dr. Strugala reporting that the therapy was helpful. Slow but steady improvement was noted. Dr. Strugala recommended continued physical therapy and off work status but noted that a pain management consultation might not be necessary.

Petitioner testified that in early March 2018, he was noticing knee pain with physical therapy. He testified that he informed the therapist on March 14 that over the weekend, he had tested his back out by doing more walking and exercising. He testified this is what the therapist wanted him to do.

The therapist noted that Petitioner reported that he tested his back with increased weight-bearing, a trip to the store, and up on his feet for many hours. He reported that he woke up Sunday with intense 7/10 knee pain. Petitioner also reported that he had met with his referring physician who recommended continued therapy for his low back.

On March 23, 2018, Petitioner returned to Dr. Strugala advising he was making good progress with therapy. He also advised that as the therapy has advanced he noticed an increase in his symptoms. He testified that a more demanding therapy session that introduced squatting activities which caused significant pain in the medial aspect of his left knee. He stated that he did not fall. The record notes Petitioner reported that he was struggling with left knee symptoms "this past week" and unable to attend therapy.

The Arbitrator notes that the progress notes from Shirley Ryan Ability Lab for March 3, March 7, and March 9 do not document any therapy modality that incorporated squatting.

On examination March 23 there was no effusion in the knee. There was medial pain with full extension and flexion and with McMurray's. There was no pain with varus or valgus stress. Dr. Strugala continued with the diagnosis of low back pain with lumbar

radiculopathy. He "feared" that Petitioner may have injured his left knee in physical therapy and suffered a mensical tear. He stated that these symptoms were now interfering with Petitioner's lower back rehab and recommended a left knee MRI. He also advised Petitioner to hold off on his physical therapy for his back.

The left knee MRI at MRI of River North on April 2, 2018 revealed a tear of the posterior horn of the medial meniscus, an MCL sprain, a sprain of the lateral patellar retinacula, and mild thinning of the articular cartilage in the lateral compartment (PX #3).

Petitioner returned to Dr. Strugala on April 6, 2018. Dr. Strugala reviewed the MRI and noted that the knee was injured after performing squatting activities in physical therapy. Petitioner still had a positive McMurray's sign. He referred Petitioner to his partner, Dr. Maday. Dr. Strugala further opined that Petitioner's low back symptoms had improved but had not resolved. He recommended continuing with a home exercise program until further notice.

On April 11, 2018, Petitioner saw Dr. Michael Maday. Petitioner testified that he informed Dr. Maday what happened to his left knee. He denied any history of prior knee problems.

Dr. Maday noted that Petitioner reported injuring his left knee in therapy March 6, 2018 while doing instructed squatting exercises. He reported that he twisted his knee while holding onto a table. On examination Dr. Maday noted effusion in the knee. There was full motion and strength. McMurray's was positive. Lachman's, anterior drawer, and posterior drawer were negative. Dr. Maday noted that the MRI was consistent with 2 tears of the medial meniscus.

Dr. Maday diagnosed a left knee acute onset of medial meniscal tear following a twisting injury that occurred in therapy. He noted that the twisting injury "appeared to be the direct cause of the symptoms." Dr. Maday recommended arthroscopic surgery. Because there were no significant degenerative changes he did not believe a corticosteroid injection would help. He further opined that Petitioner should not undergo any treatment to his back because it would aggravate his knee. Dr. Maday authorized Petitioner off work.

Petitioner testified his last visit with Dr. Strugala was on June 7, 2018 at which time he continued to struggle with left knee and low back pain. Dr. Strugala again opined that Petitioner injured his left knee in therapy. He further opined that the knee issue will hinder management of Petitioner's low back and his ability to perform work conditioning. He continued to authorize Petitioner off work.

Petitioner testified that he wants to have the surgery recommended by Dr. Maday. Petitioner also testified that his back and left knee are sore. As for his low back, Petitioner testified when he sits as he was doing when testifying, the back is not as sore as when he is moving around.

On cross-examination, Petitioner testified he had a prior back injury about 4 or 5 years ago when he picked up some newspapers at work. He testified he had back spasms. He also testified he is 6'1" and 350 lbs.

CONCLUSIONS OF LAW

17 WC 5524 (DOI 9/19/2016):

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

There was no genuine dispute that Petitioner injured his left shoulder and left foot and ankle in the September 1, 2016 work accident.

Petitioner had immediate onset of shoulder and foot and ankle symptoms. He sought medical care the day after his accident at the clinic Respondent sent him to. Petitioner's treating physicians opined that these injuries were causally related. No evidence was offered to rebut Petitioner's claim that his condition of ill-being in his left shoulder and left foot and ankle were causally related to the September 1, 2016 work accident.

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

Petitioner's Exhibit F is a medical bill from Dr. James Schiappa in the amount of $750.00. The charges were incurred for visits Petitioner had with Dr. Schiappa on October 4, 2016 and November 22, 2016. Respondent presented no rebuttal evidence on this bill.

The Arbitrator awards the bill of Dr. Schiappa to Petitioner pursuant to §8(a) of the Act and adjusted in accord with the medical fee schedule provide by §8.2 of the Act.

Petitioner's Exhibit G is a printout from the Illinois Department of Public Aid reflecting their lien of $424.25. The printout reflects payments for a visit to Oak Park Hospital on March 7, 2017 where Petitioner underwent the left ankle MRI.

There were also payments made for visits to Dr. Julia Bruene on January 18, 2017 and March 1, 2017. There was also a payment to Dr. Kaitlyn Weidenbach for March 7, 2017. That visit reflects a radiology diagnosis for the MRI that was performed on that date. There was also a payment to Dr. Hamid for the March 20, 2017 office visit.

The charges paid by the Illinois Department of Public Aid were all for treatment that was reasonable, necessary and causally related to this accident. The charges are also obviously much less than the fee schedule amount would have been.

The Arbitrator awards the Illinois Department of Public Aid lien of $424.25 to Petitioner who is responsible for reimbursing IDPA.

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

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

i) No AMA Impairment rating was offered in evidence. The Arbitrator cannot give any weight to this factor.

ii) Petitioner was a Motor Truck Driver for Respondent. He was able to return to full duty work in that capacity. The Arbitrator gives great weight to this factor.

iii) Petitioner was 53 years old at the time of his accident. He had a statistical life expectancy of 27 years. Petitioner has continuing complaints that did not prevent his return to full duty work. The Arbitrator gives moderate weight to this factor.

iv) Petitioner was able to return to work at his previous of higher wage. There was no evidence that his future earning capacity was affected by his injuries. The Arbitrator give great weight to this factor.

v) Petitioner sustained injuries to his left shoulder and left ankle which required medical intervention. Petitioner received physical therapy and medication for his shoulder. Dr. Schiappa recommended surgery for Petitioner's shoulder but a later treating physician, Dr. Bruene, made no such recommendation. X-rays of Petitioner's left ankle revealed a minimally displaced fracture of the talus. Treatment for the ankle involve 2 cortisone injections, splints, physical therapy, and medication. At the end of his medical Petitioner was released for full duty work without restrictions. The Arbitrator gives great weight to this factor.

Based on the evidence, including above 5 factors, the Arbitrator finds that Petitioner's left shoulder injury caused a permanent partial disability of 5% of a person-as-a-whole, 25 weeks, and that Petitioner's left foot and ankle injury caused a permanent partial disability of 10% loss of the left foot, 16.7 weeks.

18 WC 2516 (DOI 1/3/2018):

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

There was no dispute that Petitioner had an accidental injury to his low back January 3, 2018. There is a dispute of whether Petitioner's condition of ill-being in his left knee is causally related to the work accident on January 3, 2018.

On January 19, 2018, Dr. Strugala noted Petitioner's complaints of pain across his lower back which radiated into his left leg. The pain extended down to the knee. The provisional diagnosis was low back pain with left lumbar radiculopathy. On February 9, 2018, Dr. Strugala, after reviewing the lumbar MRI which demonstrated disc bulges and protrusions with L3 nerve root impingement, continued with his diagnosis of low back pain with radiculopathy.

The extensive nature of the lumbar MRI findings suggest that the disc bulges and protrusions were present before the January 3, 2018 work accident. Petitioner did admit to a prior back injury 4 or 5 years before but had been working without significant problems or restrictions before this accident. The circumstantial chain-of-events evidence of accident and immediate onset of symptoms is sufficient to prove that Petitioner's condition of ill-being in his low back is causally related to the January 3 accident.

An employee may sustain a compensable injury that occurs during treatment or therapy for an otherwise unrelated but compensable injury. However, the Arbitrator finds that Petitioner failed to prove that the condition in his left knee is causally related to the January 3, 2018 work accident. The Arbitrator did not find Petitioner credible in describing his claimed knee injury.

The evidence is clear that Petitioner did not initially injure his knee in the January 3, 2018 accident. Petitioner claims that his knee was injured during rehabilitative physical therapy prescribed for his back injury. Petitioner testified at trial that he was doing squatting exercises in therapy in March 2018 when he twisted his knee.

The Arbitrator found no documentation in the physical therapy records of Shirley Ryan Ability Lab (PX #4) that such an event occurred. The Arbitrator found no documentation that squatting was a part of any therapy modality at any time.

In the March 14, 2018 physical therapy note, Petitioner reported that he was testing his back out and increasing his weight bearing over the weekend. He was on his feet for many hours and then woke up on Sunday with intense knee pain. Petitioner testified this is what the therapist wanted him to do while doing home exercises which had been prescribed to him by the therapist.

The Arbitrator found no documentation in the physical therapy records of Shirley Ryan Ability Lab (PX #4) that Petitioner had been advised by his therapist to engage in squatting as part of his home exercise program or that he "test" his back by spending many hours on his feet, a well-documented trigger of his low back pain.

Petitioner gave the history of injuring his knee in a squatting exercise in therapy to Drs. Strugala and Maday. Correspondingly, it was this history they relied on when they opined that the squatting activity in therapy caused the diagnosed meniscus tears.

As stated before, there is no documentation that Petitioner engaged in squatting activities as part of his therapy for his back injury. There is no documentation that Petitioner complained of knee pain during any therapy session before March 14. The Arbitrator notes that Petitioner was diagnosed with 2 tears of his medial meniscus, an injury when traumatically caused tends to be extremely painful. There was no documented complaint of such pain in any therapy note.

Petitioner testified, and reported to his physical therapist, that he had engaged in extensive walking and time on his feet the weekend before the march 14 therapy visit. The Arbitrator does not believe that this was the sort of home exercise recommended by the therapists at Shirley Ryan Ability Lab. The therapy notes Petitioner's documented complaints of low back pain with far less strenuous activities in supervised therapy.

Due to Petitioner's lack of credibility in describing the onset of his left knee injury, the Arbitrator finds that Petitioner failed to prove that his claimed left knee injury is causally related to his work accident on January 3, 2018.

K: Is Petitioner entitled to prospective medical care?

In light of the Arbitrator's finding above that Petitioner failed to prove that his claimed left knee injury was causally related to his work accident, the Arbitrator finds that Petitioner failed to prove that he is entitled to the recommended prospective medical care for the knee.

Petitioner would be entitled to prospective medical care if the claimed injury was causally related to a work accident. Here, Petitioner was not credible in the history he gave describing events that were not substantiated in his treatment records.

L: What temporary benefits are in dispute? TTD

The parties stipulated that Petitioner's average weekly wage was $1,299.39 (ArbX #2).

Petitioner testified he was off work from January 4, 2018 through August 22, 2018. The medical records offered into evidence support this period of lost time. Further, the medical records do not show that Petitioner was at MMI for his lower back injury.

The Arbitrator further notes that based on Respondent's Exhibit #2, a payment listing of all payments made on this case, temporary total disability benefits were paid through April 13, 2018 and not April 24, 2018 as stated in Respondent's Exhibit #1.

The Arbitrator, therefore, finds that Petitioner was temporarily totally disabled from his lower back injury from January 4, 2018 through August 22, 2018.

M: Should penalties be imposed upon Respondent?

Petitioner placed into evidence 2 Petitions for Penalties and Attorney's Fees. The first one was filed May 31, 2018 and is directed to Respondent's failure to pay temporary total disability benefits at the correct rate. The Petition for Penalties and Attorney's fees alleges that multiple requests were made upon Respondent to correct the TTD rate, yet Respondent failed to do so (PX #5).

In support of the Petition for Penalties and Attorney's fees, Petitioner's attorney placed into evidence e-mails that he sent to attorney Kevin Reid from Respondent City of Chicago. The e-mails cover the period from February 21 through April 23, 2018. There is a trail of e-mails from Petitioner's attorney in an attempt to get Respondent to correct the TTD rate. Responses from Respondent's attorney indicate he was reviewing the matter, but it was not until April 4, 2018 Respondent agreed the average weekly wage should be $1,299.32 and not $820.93 (PX #7).

Petitioner also placed into evidence copies of the TTD checks and the payment transaction voucher which matches up to each TTD check. For this injury, it appears from the payment transaction voucher that TTD from January 4, 2018 through February 2, 2018 was not issued until February 2, 2018, 30 days post-accident. This is a period of

4 & 2/7 weeks and at $866.26/week, the amount paid should have been $3,712.79. The amount sent by Respondent was $2,345.61, which is $1,367.18 short (PX #8).

The TTD check covering the period February 3 through February 16, 2018 was issued on February 13, 2018 in the amount of $1,094.62. The TTD amount for this two-week period should have been $1,732.52 at the correct rate, yet Respondent paid only $1,094.62, which is $637.90 short (PX #8).

On February 27, 2018, Respondent issued another two-week check covering the period February 17 through March 2, 2018. This check was also in the amount of $1,094.62, which was also $637.90 short (PX #8).

On March 12, 2018, Respondent issued another TTD check in the amount of $1,094.62, covering the period March 3 through March 16, 2018. Again, the TTD check was short by $637.90.

Despite repeated e-mails Respondent did not correct the TTD underpayment until March 28, 2018, when it issued a check for $5,013.15 which included the TTD underpayment and the correct amount of TTD for the period March 17 through March 30, 2018 (PX #8).

Then on April 10, 2018, Respondent issued another TTD check in the incorrect amount of $1,094.62 covering the period of March 31 through April 13, 2018. Again, the TTD check was short by $637.90. This underpayment was made up by Respondent on a check issued on April 24, 2018.

The check stubs and payment transaction vouchers reflect it was 30 days before Respondent issued its first TTD check. Respondent did not offer any evidence to explain this delay in payment. Under §19(l), where the employer shall without good and just cause fail, neglect, refuse or unreasonably delay the payment of benefits under §8(a) or §8(b), the Arbitrator shall allow the employee additional compensation in the sum of $30.00 per day for each day that the benefits under said Section have been so withheld or refused. A delay in payment of 14 days or more shall create a rebuttable presumption of unreasonable delay.

In the instant case, Respondent offered no evidence to justify non-payment of full TTD to Petitioner for 30 days. Accordingly, the Arbitrator awards §19(l) penalties in the amount of $900.00 (30 days x $30.00 per day=$900.00).

Regarding the §19(k) penalties, Petitioner alleges that as of May 31, 2018, the date the penalty petition was filed, Respondent was paying temporary total disability benefits although at an incorrect rate. Petitioner's attorney made multiple demands to

Respondent to correct the TTD rate, yet Respondent failed to do so, thereby resulting in an underpayment of benefits to Petitioner.

In support of the penalty petition, Petitioner placed into evidence Petitioner's Exhibit #7, which is a group exhibit consisting of e-mails between Petitioner's attorney and the attorney for Respondent, Kevin Reid. The e-mails began February 21, 2018 and continued through April 23, 2018. Several of the e-mails are directly related to the incorrect TTD. Petitioner's attorney was specific in how he determined that the TTD rate was incorrect, yet Respondent's attorney either did not respond to the e-mails or responded by saying he was looking into the situation.

According to Petitioner's check stub dated March 28, 2018, the TTD rate was not corrected until then when Respondent issued a check in the amount of $5,013.15. The underpayment was included on that check along with the regular TTD payment of $1,732.52 for the period March 17 through March 30, 2018.

The next TTD check reverted to the incorrect TTD rate as the amount paid for the period March 31 through April 13, 2018 was $1,094.62. As a result of an April 23, 2018 e-mail from Petitioner's attorney to Respondent's attorney, the underpayment of $637.90 was made up on April 24, 2018.

The Arbitrator finds that Respondent's actions in paying temporary total disability benefits at the incorrect rate were unreasonable and vexatious, causing an unreasonable financial burden to Petitioner while he was off work.

The Arbitrator awards penalties to Petitioner pursuant to §19(k) in the amount of $5,197.56 (TTD from January 4 through March 28, 2018 =$10,395.12 x 50%=$5,197.56).

The Arbitrator also awards attorney's fees pursuant to §16 in the amount of $1,219.51 ($900.00 + $5,197.56=$6,097.56 x 20%).

With respect to the Petition for Penalties and Attorney's Fees filed August 16, 2018, Respondent terminated TTD benefits as of April 25, 2018. The basis for the suspension was treatment for a non-related injury based on the April 25 letter to Petitioner by Janet Galvin, Director, Workers' Compensation Division of the City of Chicago (RX #1).

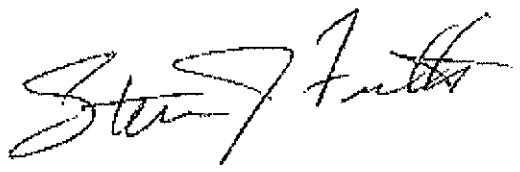
Respondent apparently terminated Petitioner's benefits because it disputed the claimed causal connection of Petitioner's knee injury to the January 3, 2018 work accident. As noted above, the Arbitrator agreed with Respondent's position with regard

to the knee injury's relation to the work accident. However, at the time of the claimed knee injury Petitioner was not at MMI with his lower back injury. Inasmuch as Petitioner had not reached MMI with his lower back, he was still entitled to TTD benefits. Accordingly, the Arbitrator finds that that Respondent's termination of Petitioner's TTD benefits on April 25, 2018 was unreasonable as contemplated by §19(k) and §19(l) of the Act.

The Arbitrator awards additional penalties pursuant to §19(k) in the amount of $7,796.34 (April 25 through August 28, 2018 = 18 weeks x $866.26 per week = $15,592.68 x 50%=$7,796.34).

The Arbitrator awards additional §19(l) penalties in the amount of $3,780.00 (April 25 through August 28, 2018 = 126 days x $30.00 per day=$3,780.00).

The Arbitrator also awards attorney's fees pursuant to §16 in the amount of $2,315.27 ($7,796.34 + $3,780.00= $11,576.34 x 20% = $2,315.27).



October 23, 2019

Steven J. Fruth, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Darian Alvarez,

Petitioner,

vs. NO. 18 WC 15664

LTI Services, LLC.,

Respondent.

20IWCC0374

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 8, 2019 is hereby affirmed and adopted.

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

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

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

DATED: JUN 29 2020
SJM/sj
o-6/17/2020
44

Stephen J. Mathis

L. Elizabeth Coppoletti

20 IWCC0374

DISSENT

I respectfully dissent from the Majority as I believe the evidence establishes that Petitioner's current condition of ill-being is causally related to his undisputed, work-related accident on May 8, 2018.

Petitioner was working without issue when he sustained an undisputed accident on May 8, 2018 when a rack holding over 1,000 pounds of meat ran over his left foot. Despite his pain, Petitioner continued to work. He reported the incident the following day and was sent to Concentra Medical Center where an x-ray revealed a fracture of the 5th metatarsal. Dr. Garelick reviewed the x-ray and noted that it appeared to be an old injury. He stated, however, that the incident could have aggravated the injury. Petitioner was returned to work with a boot. Petitioner next sought treatment with Dr. Kane. Dr. Kane performed another x-ray and noted that it revealed a displaced Jones fracture. Dr. Kane opined that the injury appeared to be related to the work injury. Dr. Kane subsequently performed an open reduction and internal fixation with a plate and 4 screws on June 14, 2018.

Petitioner subsequently underwent a Section 12 examination with Dr. Anand Vora. Dr. Vora initially opined that the Jones fracture was likely pre-existing but that it was plausible the injury may have exacerbated a pre-existing condition. However, Dr. Vora issues an addendum report following his review of the initial x-ray. Dr. Vora now believed that the fracture was pre-existing and that there was no evidence of an acute injury. He was of the opinion that Petitioner sustained a contusion as a result of the accident and that a direct trauma would not exacerbate or cause a Jones fracture. Therefore, Petitioner's condition was not related to the accident.

It is well established that employers take their employees as they find them. *O'Fallen School District No. 90 v. Industrial Comm'n*, 313 Ill. App. 3d 413, 417, 729 N.E.2d 523, 246 Ill. Dec. 150 (2000). To result in compensation under the Act, a claimant's employment need only be a causative factor in his condition of ill-being; it need not be the sole cause or even the primary cause. *Sisbro Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 205, 797 N.E.2d 665, 278 Ill. Dec. 70 (2003). "[A] preexisting condition does not prevent recovery under the Act if that condition was aggravated or accelerated by the claimant's employment." *Caterpillar Tractor Co. v. Industrial Comm'n*, 92 Ill. 2d 30, 36, 440 N.E.2d 861, 65 Ill. Dec. 6 (1982). Further, a chain of events which demonstrates a previous condition of good health, an accident, and a subsequent injury resulting in disability may be sufficient circumstantial evidence to prove a causal nexus between the accident and the employee's injury. *Int'l Harvester v. Indus. Comm'n*, 93 Ill. 2d 59, 63-64 (1982).

While Petitioner had a pre-existing condition, the evidence establishes that he was working without issue when he sustained an undisputed accident. It was not until after the accident that Petitioner sought medical care and surgery was recommended and performed. I would find that Petitioner established causal connection under the chain of events analysis. I would also adopt the opinions of Dr. Garelick and Dr. Kane. I find that their opinions relative to causal connection are supported by the evidence and further establish that Petitioner's accident was a causative factor in his condition of ill-being.

Based upon my finding of causal connection, I would award all reasonable and necessary medical expenses and TTD benefits from June 5, 2018 through September 5, 2018.

I further would award Petitioner 15% loss of use of the left foot. I would assign no weight to subsection (i) as an impairment report was not offered into evidence. I would assign little weight to subsection (ii) as Petitioner was able to return to work and currently works on his feet for 8 hours per day. I would assign moderate weight to subsection (iii) as Petitioner is 40-years old and has a long work career ahead of him in which he can experience the effects of his injury. I would assign little weight to subsection (iv) as there is little evidence of an impairment of earnings. I would assign greater weight to subsection (v) as Petitioner sustained a Jones fracture and underwent surgery requiring a plate and screws. He now experiences some good days and some bad days.

Based upon the above, I respectfully dissent from the Majority in this matter.

D Douglas McCarthy

Douglas D. McCarthy

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ALVAREZ, DARIAN
Employee/Petitioner

Case# **18WC015664**

LTI SERVICES LLC
Employer/Respondent

20IWCC0374

On 3/8/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.46% 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
JOSHUA E RUDOLFI
10 N DEARBORN ST SUITE 500
CHICAGO, IL 60602

5001 GAIDO & FINTZEN
GAIL BEMBNISTER
30 N LASALLE ST SUITE 3010
CHICAGO, IL 60602

20 IWCC0374

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

Darian Alvarez
Employee/Petitioner

v.

LTI Services, LLC
Employer/Respondent

Case # **18** WC **15664**

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 **Brian T. Cronin**, Arbitrator of the Commission, in the city of **Chicago**, on **January 17, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **May 8, 2018**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**31,616.00**; the average weekly wage was $**608.00**.

On the date of accident, Petitioner was **40** years of age, ***single*** with **0** dependent children.

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

Respondent shall be given a credit of $**0.00** 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

Petitioner failed to prove that the current condition of ill-being of his left foot is causally related to the May 8, 2018 accident.

Pursuant to Section 8(a) and subject to Section 8.2 of the Act, Respondent shall pay Petitioner the amount of the medical bills from Concentra for the dates of service May 9, 11, and 18, 2018, but not to exceed $787.10.

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

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

Signature of Arbitrator

3/7/2019
Date

MAR 8 - 2019

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

20IWCC0374

ILLINOIS WORKERS' COMPENSATION COMMISSION

ARBITRATION DECISION

Darian Alvarez,
Employee/Petitioner,

v. Case # 18 WC 015664

LTI Services LLC
Employer/Respondent.

FINDINGS OF FACT:

Petitioner, Darian Alvarez, testified that on May 8, 2018, he was working for Respondent, LTI Services, LLC, as a machine operator at a meat factory. He worked there for four months. On May 8, 2018, Petitioner testified, he was moving a rack of meat weighing over 1,000 pounds. One of the wheels on the rack did not work and a wheel on the rack "smashed" his left foot. Petitioner testified that he finished working that day and reported the injury the next day and "they" sent him to Concentra Medical Center.

Petitioner first visited Concentra on May 9, 2018 [PX 2] Afiz Taiwo, M.D. recorded the following: "He was moving a rack, as moving it, it rolled over the left foot last night. Pain is better. Notes swelling and mild pain with walking." During the review of the musculoskeletal system, Petitioner reported he has "muscle pain and limping." Upon examining Petitioner's left foot/toes, Dr. Taiwo wrote:

> "Appearance is normal. Tenderness in the lateral midfoot.
>
> Palpates normal. Full range of motion. Strength is normal
>
> bilaterally. Normal tone. Neurovascular function intact."

Upon examining Petitioner's musculoskeletal system, Dr. Taiwo found the following: "Normal gait. No tenderness or swelling of the extremities. Range of motion is within normal limits. Normal muscle strength and tone." Dr. Taiwo diagnosed Petitioner with a contusion of the left

foot and a closed nondisplaced fracture of the fifth metatarsal bone of the left foot. He recommended a walker boot, hot and cold compresses, Naproxen sodium, and x-rays. He released Petitioner to modified-duty work. [PX 2]

Petitioner returned to Dr. Taiwo on May 11, 2018 with complaints of numbness and tenderness in his left foot and slight pain. The x-rays were reviewed. No medication was prescribed or dispensed. He released Petitioner to modified-duty work. Under "Treatment Status," Dr. Taiwo wrote "Specialist Referral – Assume Care." [PX 2]

On May 18, 2018, Petitioner returned to Concentra at which time he saw a general orthopedic surgeon, David Garelick, M.D. Petitioner reported that he sustained blunt trauma to his left foot. Petitioner "does not remember a previous injury." Dr. Garelick reviewed the x-rays and opined there is an old injury at the base of the fifth metatarsal. There was degeneration at the cuboid fifth metatarsal joint that certainly looked old, possibly an old infection. He diagnosed Petitioner with a chronic left foot injury. Dr. Garelick explained that the rack hitting his foot could have aggravated his condition, but from his standpoint, he finds that Petitioner can wear a regular shoe. Dr. Garelick allowed Petitioner to return to regular-duty work as of May 21, 2018. He advised Petitioner to follow up with him next week just to confirm that his return to work has been uneventful. Dr. Garelick did not recommend additional treatment. [RX 2]

On June 5, 2018, Petitioner sought treatment with John F. Kane, D.P.M., at "Dr. John F. Kane, Inc." He reported to Dr. Kane that he was moving a heavy cart that was full of meat that weighed over 1000 pounds when the wheel of the cart "slammed into his left foot." Dr. Kane opined Petitioner's fifth metatarsal fracture was directly related to the work incident on May 8, 2018. Dr. Kane did not provide an opinion with regard to the age of the fracture based on the x-rays. Dr. Kane restricted Petitioner from work. On June 14, 2018, which was nine days after he first saw Petitioner, Dr. Kane performed an open reduction and internal fixation with hardware on Petitioner's left foot. [PX 3]

Following the surgery, Petitioner underwent a course of immobilization and therapy, including whirlpool therapy. The loose hardware was removed on August 22, 2018. On September 4, 2018, Dr. Kane noted Petitioner was symptom-free. Petitioner was able to return to a regular shoe and was released from care at maximum medical improvement with no restrictions. [PX 3]

On August 17, 2018, Petitioner presented for a Section 12 evaluation with Anand M. Vora, M.D. Dr. Vora is a board-certified orthopedic surgeon. Dr. Vora is in a full-time clinical practice and is a fellow of the American Academy of Orthopaedic Surgeons. [RX 1]

Dr. Vora examined Petitioner and reviewed medical records; however, Dr. Vora opined he would need to review the May 18, 2018 x-rays of the left foot to determine if the work injury either directly caused or aggravated Petitioner's foot condition. [RX 1]

Dr. Vora opined, regardless of causation, that the need for whirlpool and electrical stimulation therapy is not indicated as there is no scientific evidence to support these treatments. [RX 1]

Petitioner reported to Dr. Vora that he feels much better, has no pain, and feels he can return to work. Dr. Vora opined Petitioner could work full duty. [RX 1]

On September 20, 2018, Dr. Vora issued an addendum report. Dr. Vora reviewed the x-rays from May 18, 2018, three views of the left foot, non-weightbearing. The films showed evidence of chronic sclerotic Torg type 3 Jones fracture at the metaphyseal-diaphyseal junction of the fifth metatarsal shaft, chronic in nature. There were no acute findings. There was significant sclerosis and canal narrowing and bony resorption consistent with that of chronic changes of the fifth metatarsal. No acute fracture or abnormality was noted. [RX 2]

After reviewing the x-rays, Dr. Vora provided a diagnosis of the left foot as it related to the work injury was a contusion of the left foot. The findings of the fifth metatarsal zone 2 metaphyseal-diaphyseal Jones fracture, Torg type 3 were pre-existing and have no relationship to the work-related condition, and further, the severe sclerosis and changes suggest a condition that would not have been accelerated by any work-related condition. Dr. Vora opined a blunt trauma would not be mechanism that would exacerbate or cause a Jones fracture that required subsequent surgical treatment. The work-related condition would cause a contusion of the foot and the Jones fracture that was present that required surgical intervention was pre-existing and has no work-related basis and no work-related aggravation basis. Any treatment rendered for the fifth metatarsal Jones fracture would be considered unrelated to any work-related condition. The x-rays dated May 18, 2018, showed a chronic appearing non-fused fracture of the little toe proximal metatarsal, with no evidence of acute fracture or abnormality. The remaining opinions rendered from the original Section 12 evaluation remained unchanged.

Petitioner testified he now works for a recycling company, through a temp agency. He spends most of the time on his feet, earns $12.00 hour, and works 40 hours a week. He works occasional overtime. Petitioner reported he has "on and off" pain to the left foot and takes Tylenol. He has not received medical treatment since September 4, 2018.

CONCLUSIONS OF LAW:

In support of his decision with regard to issue (F) "Is Petitioner's current condition of ill-being causally related to the injury?", the Arbitrator concludes as follows:

It is well established that a Petitioner carries the burden of proving his case by a preponderance of the evidence. "Preponderance of the evidence is evidence which is of greater weight or more convincing than the evidence offered in opposition to it; it is evidence which as a whole shows that the fact to be proved is more probable than not." *Central Rug & Carpet v. Indus. Comm'n*, 838 N.E.2d 39 (1st Dist. 2005).

The Arbitrator concludes Petitioner has failed to prove by a preponderance of the evidence that his current condition of ill-being is causally related to the injury.

Based on the following three points, the Arbitrator finds that Petitioner is not credible:

1. Petitioner would have the Arbitrator believe that the wheel on 1000-pound cart "smashed" or "slammed into" or "rolled over" his left foot on May 8, 2018. Yet, when Dr. Taiwo examined his left foot the next day, he found that the appearance of the foot was normal. Although Petitioner complained of tenderness, the doctor made no finding of edema, erythema, or ecchymosis.

2. Petitioner reported to Dr. Taiwo during the May 9, 2018 review of the musculoskeletal system that he has "muscle pain and limping." Yet, when Dr. Taiwo examined Petitioner's musculoskeletal system, he found the following: "Normal gait. No tenderness or swelling of extremities. Range of motion is within normal limits. Normal muscle strength and tone."

3. Petitioner "did not remember a previous injury" to his left foot, despite Dr. Garelick's finding of an old fracture at the base of his fifth metatarsal and his diagnosis of chronic left foot injury. Dr. Vora found that Petitioner had a pre-existing Jones fracture and no evidence of an acute fracture. He told Dr. Vora he had no pain prior to this injury.

The Arbitrator notes that the opinions of the finest practitioners are no better than the history upon which they are based. Here, the history and information provided to the treating physicians is significantly flawed and vitiates the persuasiveness of those opinions. The Arbitrator concludes Petitioner did not provide any persuasive medical opinions establishing causation.

Essentially, there is no dispute that the wheel on the meat rack hit Petitioner's left foot. There is, however, an issue regarding whether the incident caused the fracture. In this regard, the Arbitrator finds the opinion of Dr. Vora persuasive.

Dr. Kane opined the fifth metatarsal fracture is directly related to the work injury. This opinion is not persuasive. Dr. Kane failed to address the age of the fracture. In fact, there is no evidence that Dr. Kane reviewed the x-rays from May 18, 2018. He ordered new x-rays. Dr. Kane performed surgery on Petitioner nine days after he first saw him. Both Dr. Vora and Dr. Garelick opined the fracture is pre-existing and chronic. Therefore, the fracture cannot be directly related to the work injury.

Dr. Garelick opined the findings on the x-rays of the left foot were old and chronic. Dr. Garelick only stated Petitioner could have aggravated his condition, Dr. Garelick did not provide a definitive opinion nor did he opine as to the extent of any possible aggravation. Additionally, Dr. Garelick opined Petitioner would be able to return to work full duty and to use a regular shoe. Furthermore, Petitioner did not return to Dr. Garelick. Dr. Garelick did not provide an opinion as to whether the surgery was reasonable, necessary or causally related to the work injury. The Arbitrator, therefore, does not find Dr. Garelick's opinions helpful as to whether Petitioner's current condition and surgery is related to the work injury.

The only opinion that includes a thorough explanation of the x-rays of the left foot and how that relates to the accident was Dr. Vora's opinion. He specifically stated the findings of the fifth metatarsal zone 2 metaphyseal-diaphyseal Jones fracture, Torg type 3 were pre-existing and have no relationship to the work-related condition, and further, the severe sclerosis and changes suggest a condition that would not have been accelerated by any work-related condition. Dr. Vora opined a blunt trauma would not be a mechanism that would exacerbate or cause a Jones fracture that required subsequent surgical treatment.

Considering all the evidence, as well as Petitioner's lack of credibility, the Arbitrator finds Petitioner failed to meet his burden by a preponderance of the evidence that his current condition of ill-being of his left foot is causally related to the accidental injury. The Arbitrator finds the work accident caused a left foot contusion but reached a point of maximum medical improvement on May 21, 2018, which was the effective date of Petitioner's full-duty return to work, per Dr. Garelick. Moreover, the causal connection was severed by further treatment with Dr. Kane as the Arbitrator finds the work injury did not necessitate surgery. The necessity of the surgery was not caused, directly or indirectly, by the work accident.

In support of his decision with regard to issue (J) "Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?", the Arbitrator concludes as follows:

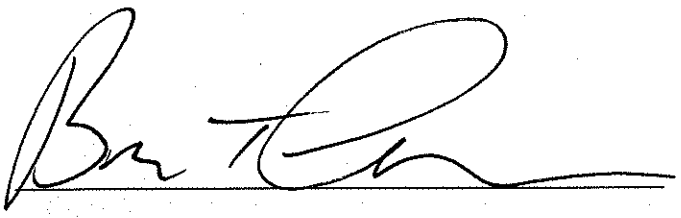
Pursuant to Section 8(a) and subject to Section 8.2 of the Act, Respondent shall pay Petitioner the amount of the medical bills from Concentra for the dates of service May 9, 11, and 18, 2018, but not to exceed $787.10.

In support of his decision with regard to issue (K) "What temporary benefits are in dispute? TTD," the Arbitrator concludes as follows:

Arbitrator's Exhibit #1 indicates Petitioner is seeking TTD benefits from June 5, 2018 through September 5, 2018. On June 5, 2018, Dr. Kane took Petitioner off work. However, Dr. Kane treated Petitioner for a condition unrelated to the accident, and the Arbitrator has found that Petitioner reached MMI for his left foot contusion on May 21, 2018. Therefore, the Arbitrator finds that Petitioner is not entitled to any temporary total disability benefits.

In support of his decision with regard to issue (L) "What is the nature and extent of the injury?", the Arbitrator concludes as follows:

Given the Arbitrator's findings on causation, he further finds Petitioner is not entitled to PPD benefits.



3-7-2019

Brian T. Cronin

Arbitrator

Date

STATE OF ILLINOIS)

COUNTY OF COOK) SS:

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

OSCAR COLORADO-VASQUEZ,	)	
Petitioner,	)	
vs.	)	No. 18 WC 000128
THE UNDERGROUND,	)	
Respondent.	)	

20IWCC0376

Decision and Opinion

On October 15, 2018 a 19(b) hearing was conducted by Arbitrator Huebsch. The Arbitrator's decision was filed on January 28, 2019 denying Petitioner's claim for prospective medical care on the basis that Petitioner failed to prove that his current condition of ill-being regarding his right knee was causally connected to the work accident of September 23, 2017.

A timely Petition for Review was filed by Petitioner's counsel, Arturo Juarequi on February 26, 2019. On March 5, 2019 Petitioner's attorney filed a Motion to Withdraw as counsel citing to irreconcilable differences and representing that he had informed Petitioner that the Petition for Review had been filed only for the purpose of preserving the right to appeal and to afford Petitioner the opportunity to retain new counsel.

The Motion to Withdraw was granted on March 13, 2019. The return date on Review (the date upon which an authenticated Transcript of Arbitration was due) was set for June 14, 2019. No Transcript of Arbitration was filed.

On July 2, 2019 the Commission issued notice of motion for a Rule to Show Cause why the petition for review should not be dismissed for failure to timely file an authenticated transcript. Notice was sent to Petitioner, Mr. Juarequi, and Respondent's counsel. Hearing was set for July 18, 2019. Petitioner failed to appear either personally or through counsel. The Commission continued the hearing on the Rule to Show Cause to August 29, 2019 and directed Respondent's counsel to send notice to Petitioner advising him of his need to appear on

20 IWCC0376

that date. Respondent's counsel sent a series of letters to Petitioner via regular and certified mail advising him of the subsequent continued hearing dates of August 29, 2019, September 12, 2019, November 14, 2019 and December 19, 2019.

Respondent's counsel represented that prior to the December 19, 2019 hearing Respondent counsel's office had a telephone conversation with Petitioner and at that time Petitioner informed Respondent's counsel that he had a new attorney. The Commission subsequently sent an email directly to Petitioner advising him that the matter had again been continued for hearing to January 16, 2020.

Hearing was conducted on January 16, 2020 and again there was no appearance by Petitioner personally or through counsel. The Commission finds based upon the evidence submitted at hearing and the record in its entirety that Petitioner has received notice of the pendency of the Rule to Show Cause and that multiple continuances of hearing have been entered in an attempt to ensure that Petitioner's right to due process has been protected. The Commission dismisses Petitioner's Petition for Review for failure to perfect in that an authenticated Transcript for Arbitration which was due on June 14, 2019, was never filed.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's Petition for Review is hereby dismissed for failure to perfect review, in that an authenticated Transcript of Arbitration was never filed.

DATED: JUN 2 9 2020

SJM/msb

D: 6/23/20

44

Stephen J. Mathis

Douglas McCarthy

L. Elizabeth Coppoletti

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Brandon Patton,

Petitioner,

vs.

NO: 19 WC 10831

20IWCC0377

D B Schenker,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, and temporary total disability ("TTD") benefits, and being advised of the facts and law, reverses the Decision of the Arbitrator for the reasons stated below. The Commission finds Petitioner sustained injuries that arose out of and in the course of his employment on March 3-4, 2019. The Commission also finds that Petitioner's current condition of ill-being regarding his lumbar spine is causally related to the work accident. As such, the Commission awards appropriate TTD benefits relating to Petitioner's work injury. 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

On the date of accident, March 3-4, 2019, Petitioner had worked as a warehouse worker for Respondent for approximately five months. Mr. Wilson, the general manager of the facility that employed Petitioner, testified that Respondent is a third-party logistics company that helps provide and manage labor to help companies transport products. Respondent does not sell the products. Instead, the company manages the removal of customers' freight from trucks into storage, and from storage into the trailers that deliver the freight to various stores. The facility where Petitioner works handles the logistics for certain dog food brands.

The facility is approximately 521,000 square feet large and no products are sold at the facility. There is a guard station on the road leading to the facility. Mr. Wilson testified that the guard station is located where one pulls off of the main road, Gateway Commerce. Just beyond the

20IWCC0377

guard station the road forks into three directions. Two of the roads are used for semitrucks transporting goods to and from the facility. The third road leads to the parking lot. The guards stationed in the station are present to make sure the truck drivers are picking up or delivering valid loads. However, the guards are not employed by Respondent. Between 80-100 trucks visit the facility each day. The guards check the paperwork and seals of each truck to make sure no one tampered with the shipments. They then direct the trucks to the proper location. There are approximately 120 trailer locations on the property for the semitrucks.

Mr. Wilson testified that Respondent does not own or control the facility. He further testified that Respondent does not own or control the parking lot. He testified that Respondent does not contract for nor provide any snow or ice removal from the parking lot or any other parking lot maintenance. Mr. Wilson testified that Respondent is unable to request snow and ice removal services for the property. Both parties agree that the parking lot is used by both employees and any visitors to the facility. The entire property, including the parking lot, is enclosed by a fence. Mr. Wilson testified that there is no reason for anyone to be in the parking lot unless they are a visitor, employee, or otherwise doing business with the company. Petitioner testified his supervisor told him to park in the parking lot and all the other employees also park in the lot. Mr. Wilson denied supervisors told employees to park in the parking lot. There are no reserved parking spaces other than those designated as handicapped accessible spaces.

On March 3, 2019, Petitioner was scheduled to work the 6 p.m. – 6 a.m. shift. Although there is a breakroom available for employees' use, Petitioner testified that he usually ate lunch in his car. That night, Petitioner went outside a few minutes before midnight to warm up his car before his lunch break. Petitioner testified that he regularly would quickly walk out to warm up his car before clocking out for his lunch break. Petitioner testified that he and other employees engaged in this practice because no one wanted to spend part of their lunch break warming up a car. Petitioner wanted his car to already be warm when he ate his lunch. Petitioner testified he regularly left his work station approximately 15 minutes before his scheduled lunch break in order to warm up his car. He testified that his supervisor gave him permission to do so.

Petitioner testified that on the date of accident the parking lot was partially plowed; however, there was still some ice on the ground. Petitioner testified that at approximately 11:55 p.m. on March 3, 2019, while hurrying to his car to warm the vehicle prior to the start of his lunch break, he slipped on ice and fell. Petitioner testified that he felt immediate pain in his lower back. After Petitioner fell, he returned to the building and clocked out at 12:01 a.m. on March 4, 2019, for his lunch break. Following his lunch break, Petitioner was taken via ambulance to the hospital. Under cross-examination, Petitioner agreed that the temperature was bitterly cold that night when he arrived at work. Petitioner parked in one of the parking spaces closest to the entrance to the building. He did not notice any snow or ice on the ground when he arrived at work. While it was getting dark when he arrived, Petitioner testified that the parking lot is well-lit.

In his written accident report, Petitioner wrote, "Walking to my car wasn't aware of the ice while walking was walking fast so fell hard. Feel like I injured left hip and left side of my back middle area." (RX 2). Petitioner testified that no one ever told him he was not allowed to leave his work station a few minutes early to warm up his car prior to clocking out for lunch. Petitioner testified that he always went out before the official start of his lunch break to warm up his car and

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was never reprimanded or disciplined for doing so. He testified that he personally witnessed other workers engaging in the same behavior and he believed the practice was very common and well-known. However, Petitioner admitted he did not have any personal knowledge regarding whether any employees had been disciplined or reprimanded for leaving the building without clocking out prior to his work accident. Under cross-examination, he testified that he hurried out to his car because he wanted to avoid receiving attendance points if he did not clock out for lunch during the designated time period.

Mr. Wilson testified that he was present during Petitioner's employee orientation in late November or early December 2018. During the orientation, human resources reviews information regarding attendance policies, tardiness polices, and employee breaks. He testified that the company builds in three minutes of transit time for any worker to get from their work station to the time clock in order to clock out for or in from lunch. The orientation covered the policies for clocking in and out for lunch. Mr. Wilson testified that five employees were disciplined on February 28, 2019, for not clocking out when they left for lunch and clocking in afterward in an attempt to extend their lunch breaks. He is unaware of any disciplinary action taken against Petitioner before the work accident and believes he's a good employee. Petitioner has never been disciplined or warned, to Wilson's knowledge, about leaving the building without clocking out. Mr. Wilson testified that he does not anticipate any disciplinary action against Petitioner relating to this work accident because under the circumstances, everyone was more concerned about Petitioner's condition after his fall.

Mr. Wilson identified RX 5 as a picture of the parking lot outside the warehouse facility. He testified that the picture was taken shortly after Petitioner's fall and shows Petitioner's car and the site of Petitioner's fall. He identified RX 6 as an aerial picture of the parking lot. After reviewing the pictures, Mr. Wilson agreed that while the handicapped accessible parking space was approximately 85% cleared of snow and ice, the area where Petitioner slipped and fell was not completely clear of snow and/or ice.

Petitioner was taken to the ER a few hours after his fall. (PX 1). He complained of left low back pain after a slip and fall on ice as well as left hip pain. The doctor diagnosed an acute lumbar myofascial strain. Petitioner underwent chiropractic treatment from Dr. Eavenson primarily as well as physical therapy multiple times a week. (PX 2). Dr. Eavenson first examined Petitioner on April 2, 2019. Petitioner complained of low back pain that was worse when lying down or moving. He complained of difficulty sleeping and described the pain as sharp as well as pins and needles. Dr. Eavenson diagnosed protrusion of lumbar intervertebral disc. The April 3, 2019, lumbar MRI had the following impression: 1) a central annular tear at the apex of a right paracentral broad-based protrusion at L5-S1 measuring up to 6mm in thickness resulting in dural displacement but no central canal stenosis or foraminal stenosis; and 2) bilateral foraminal hyperintense zones at L4-L5 and left foraminal hyperintense zone at L3-L4 suspicious for annular tears. (PX 4). On April 4, 2019, Dr. Eavenson referred Petitioner to Dr. Gornet.

Dr. Gornet first examined Petitioner on April 17, 2019. (PX 3). Petitioner primarily complained of central bilateral low back pain and intermittent shooting pain and paresthesias in his left leg from the anterolateral calf to his foot. Petitioner reported having no prior significant back complaints and denied any right leg symptoms. After reviewing the recent MRI, Dr. Gornet

believed Petitioner sustained a disc injury at L5-S1 and possibly at L3-L4 and L4-L5. He recommended conservative treatment including additional physical therapy, medication, and an injection at L5-S1 centrally. On June 4, 2019, Dr. Blake performed a L5-S1 ILESI with fluoroscopy. (PX 5). On June 17, 2019, Petitioner reported improvement in his condition to Dr. Eavenson from the recent lumbar injection. The chiropractor noted that active lumbar motion had improved in all planes. Dr. Eavenson noted a positive straight leg raise at 80 degrees with some sensory loss noted in the right lower extremity. Petitioner was to continue attending physical therapy.

Petitioner testified that Respondent was unable to accommodate any work restrictions. He has remained completely off work since the March 3-4, 2019, accident.

Conclusions of Law

Petitioner bears the burden of proving each element of his claim by a preponderance of the evidence. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 203 (2003). Petitioner must show by a preponderance of the evidence that he sustained 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 his injuries arose out of and in the course of his employment.

This case requires the Commission to carefully consider two questions. The first is whether the parking lot where Petitioner and other employees parked is part of Respondent's premises. The second is whether Petitioner's violation of the Respondent's policies regarding clocking in and out for lunch breaks sufficiently took Petitioner out of the course of his employment. Respondent does not dispute that Petitioner fell in the parking lot. Additionally, Mr. Wilson, Respondent's witness, testified the pictures in evidence showed the area where Petitioner fell was not completely clear of snow and/or ice.

Petitioner's injuries are only compensable if they occurred on Respondent's premises; thus, Petitioner must prove that the parking lot used by the employees and visitors to Respondent's facility is part of the company's premises. "Injuries sustained on an employer's premises, or at a place where the claimant might reasonably have been while performing his duties, and while a claimant is at work, or within a reasonable time before and after work are generally deemed to have been received in the course of the employment." *Suter v. Ill. Workers' Comp. Comm'n*, 2013 IL App (4th) 130049WC, ¶18. Likewise, the "fact that the employer leases space and the area where the injury occurs is used by other tenants or the public does not necessarily mean it is not the employer's premises." *Suter*, 2013 IL App (4th) 130049WC at ¶34 (quoting *County of Cook v. Indus. Comm'n*, 165 Ill. App. 3d 1005, 1009 (1988)). Instead, the proper inquiry is whether the employer maintains and provides the lot for its employees' use. *Mores-Harvey v. Indus. Comm'n*, 345 Ill. App. 3d 1034, 1040 (2004). If so, then the parking lot constitutes part of the employer's premises. *Suter*, 2013 IL App (4th) 130049WC at ¶30.

The Illinois Appellate Court has identified three factors used to determine whether an

employer provided a parking lot for the use of its employees: 1) whether the parking lot is owned by the employer; 2) whether the employer exercises control or dominion over the parking lot; and 3) whether the parking lot is a route required by the employer. *See, Walker Bros., Inc. v. Ill. Workers' Comp. Comm'n*, 2019 IL App (1st) 181519WC at ¶23. In this present case, Petitioner did not offer any evidence regarding whether Respondent owned or exercised any control over the parking lot, whereas Mr. Wilson testified that Respondent neither owns nor controls the parking lot. Mr. Wilson further testified that Respondent did not have the ability to even request maintenance or snow removal for the parking lot. However, the totality of the evidence proves the parking lot is a "route required by the employer."

Respondent's entire facility is enclosed by a fence. It is undisputed that the only people on the property are connected to Respondent's business, whether as employees, delivery drivers, or other visitors. While approximately 80-100 semitrucks visit the property each day to either deliver or pick up loads, these trucks are directed to the 120 trailer locations. However, a separate road leads directly to the parking lot and the main entrance to the facility. From the totality of the evidence, it appears the only way to reach the main entrance to the building is via the parking lot. Furthermore, there is no evidence that there are alternative places where employees can park. Simply put, the evidence shows that employees were required to navigate the parking lot in order to enter the building and begin working each day. Therefore, while Respondent may not own or control the parking lot, there is no question that the parking lot is a "route required by the employer." As such, the Commission finds Respondent provided the parking lot for the use of its employees and the lot is part of Respondent's premises.

To determine whether Petitioner's injury arose out of his employment, the Commission must consider the type of risk to which Petitioner was exposed. In Illinois, there are three categories of risk to which an employee may be exposed: 1) risks distinctly associated with one's employment, 2) risks that are personal to the employee, and, 3) neutral risks that have no particular employment or personal characteristics, such as those to which the general public is commonly exposed. *Dukich v. Ill. Workers' Comp. Comm'n*, 2017 IL App (2d) 160351WC, ¶31. However, Illinois courts have consistently reasoned that a risk analysis in unnecessary when the injury is the direct result of a hazardous condition on an employer's premises. Instead, courts have deemed injuries resulting from a hazardous condition or defect such as ice on the employer's premises to be "risks distinctly associated with the employment." *See, Dukich*, 2017 IL App (2d) 160351WC at ¶40. Based on Petitioner's credible and unrefuted testimony, the Commission finds his injuries are the direct result of a hazardous condition on Respondent's premises and therefore arose out of Petitioner's employment. For the foregoing reasons, the Commission reverses the Decision of the Arbitrator and finds Petitioner met his burden of proving she sustained a compensable injury arising out of and in the course of her employment.

In reaching the conclusion that Petitioner sustained a compensable injury arising out of and in the course of his employment, the Commission finds Petitioner did not sufficiently deviate from his work duties when he failed to clock out before going outside to warm up his car to remove himself from the scope of his employment. The Commission generally finds Petitioner's testimony that his supervisors knew and approved employees leaving work before clocking out in order to warm up his car prior to his official lunch less than credible. However, Petitioner's admitted violation of the attendance policy in this instance did not cause him to deviate sufficiently from

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his employment as to warrant a finding that his injury did not arise out of or in the course of his employment. The Commission does not condone Petitioner's attempt to circumvent Respondent's established attendance policies; however, his hurrying to his car a few minutes early does not negate the fact that there were patches of ice on the parking lot pavement. Petitioner, or any other employee, could have slipped and fallen on the same patch of ice if he had left the building during his designated lunch break five to ten minutes later. Petitioner did not deviate from his normal path from the main entrance to his car in the parking lot in any way. Unfortunately, the normal path from the building to Petitioner's parking space was covered partially in ice. After carefully considering the evidence, the Commission finds Petitioner did not behave recklessly or negligently when he hurried to his car at the time of his accident.

The Commission must also address the remaining disputed issues including, the causal connection of Petitioner's current condition, the reasonableness and necessity of his medical treatment, and TTD benefits. After reviewing the evidence, the Commission finds Petitioner sustained an injury to his lumbar spine as a result of his work accident. Petitioner's orthopedic surgeon, Dr. Gornet, believes Petitioner sustained a disc injury at L5-S1. Petitioner also possibly sustained an injury at L3-L4 and L4-L5. As Respondent submitted no evidence refuting the causal connection of Petitioner's complaints to the work accident, the Commission finds Petitioner's current condition of ill-being regarding his lumbar spine are causally related to the work accident. As Petitioner's current condition of ill-being regarding his lumbar spine is causally related to the work accident, the Commission must award appropriate medical expenses. Respondent has offered no evidence disputing the reasonableness and necessity of Petitioner's medical treatment and expenses. Thus, the Commission finds Respondent is liable for any outstanding medical expenses for reasonable, necessary, and causally related treatment for Petitioner's lumbar spine condition through June 26, 2019, the initial date of hearing.

Finally, the Commission finds Petitioner met his burden of proving he is entitled to TTD benefits. It is undisputed that Petitioner has not returned to work in any capacity since March 3-4, 2019. None of Petitioner's treating physicians have cleared him to return to work full duty since the work accident and Respondent was unable to accommodate any work restrictions. Petitioner's weekly TTD rate is $415.37. The Commission finds Petitioner is entitled to TTD benefits from March 4, 2019, through June 26, 2019, totaling 16-4/7 weeks. Thus, Respondent shall pay $6,883.10 in TTD benefits to Petitioner.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 30, 2019, is reversed in its entirety.

IT IS FURTHER ORDERED that Petitioner sustained an accident that arose out of and in the course of his employment on March 3-4, 2019.

IT IS FURTHER ORDERED that Petitioner's current condition of ill-being relating to his lumbar spine is causally related to the March 3-4, 2019, work accident.

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IT IS FURTHER ORDERED that Respondent shall pay outstanding reasonable and necessary medical charges that relate to treatment for Petitioner's lumbar spine condition as provided in Sections 8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED that Respondent shall pay Petitioner temporary total disability benefits of $**415.37**/week for **16-4/7** weeks, commencing **March 4, 2019,** through **June 26, 2019**, as provided in Section 8(b) of the Act.

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.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $10,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUL 1 - 2020

o: 5/5/20
TJT/jds
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Thomas J. Tyrrell

Maria E. Portela

DISSENT

I disagree with the majority's decision. Based on the evidence presented, I would find that Petitioner failed to prove that he sustained an accident arising out of and in the course of his employment on March 3, 2019, and affirm the decision of the Arbitrator.

It is the burden of every Petitioner before the Workers' Compensation Commission to establish by a preponderance of evidence every disputed issue litigated at trial, including issues establishing Respondent's liability for benefits. *Board of Trustees of the University of Illinois v. Industrial Comm'n*, 44 Ill.2d 207 at 214, 254 N.E. 2d 522 (1969), *Edward Don v. Industrial Comm'n,* 344 Ill.App3d 643, 801 N.E.2d 18 (2003). To obtain compensation under this Act, an

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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)(d).* The words "arising out of" refer to the origin or cause of the accident and presuppose a causal connection between the employment and the accidental injury. *Illinois Bell Telephone Co. v. Industrial Comm'n*, 131 Ill. 2d 478, 483 (1989). "In the course of" refers to the time, place and circumstances under which the accident occurred. *Id.* Both elements must be present at the time of the accidental injury in order to justify compensation under the Act. *Id.*

In this case, Petitioner failed to prove his accident was "in the course of" his employment when he slipped and fell in the parking lot. To determine whether the parking lot exception to the general premises rule applies, the Appellate Court has stated:

> "In determining whether the parking lot exception applies, it is clear that we must determine whether the employer "provided" the parking lot in question to its employees. We make this determination by considering (1) whether the parking lot was owned by the employer, (2) whether the employer exercised control or dominion over the parking lot, and (3) whether the parking lot was a route required by the employer." *Walker Brothers v. Illinois Workers' Compensation Comm'n*, 2019 Ill App (1st) 181519WC.

Petitioner failed to prove Respondent "provided" the lot in question. Mr. Wilson, Respondent's General Manager, testified that past the guard shack is a three-way intersection. Two of the roads are for trucks, and one of the roads crosses into the parking lot. Respondent does not instruct or direct employees where to park in the lot and there are no designated spots for employees or visitors. Any employees, vendors or visitors have access to the lot. Respondent does not own, control or maintain the parking lot and Respondent does not contract for or provide any type of snow or ice removal from the parking lot. In addition, Respondent does not employ the guard stationed at the guard shack. Based on the credible evidence presented, Petitioner failed to prove Respondent "provided" the parking lot in question under the considerations set forth in *Walker Brothers*.

Next, Petitioner is also required to prove his accident "arose out of" his employment. An injury does not arise out of the employment where an employee voluntarily exposes himself or herself to an unnecessary personal danger solely for his own convenience. *Orsini v. Industrial Comm'n*, 117 Ill. 2d 47 (1987). Here, it is undisputed Petitioner left the building 5 minutes before his scheduled break to turn his car on so when he took his break in his car at midnight, his car would already be warm. It is also undisputed Petitioner rushed to his car over snow or ice so he could make it back to the building and clock out timely and not incur any discipline. Petitioner testified:

> "I always used to clock out—not clock out, I used to leave the building a little bit early, like a lot of people would do, about five minutes before clock out and warm up my car...And I wanted to warm up my car, because it was very cold. I have a new car but it still takes some time to get warm, and I usually kept my lunch in there, so I was coming out of the building, I was walking pretty fast,

> I wanted to get back in time to clock out in time because there's penalties if you clock out minutes after so I'd say five minutes before clock out I was coming to my car walking pretty fast looking straight ahead of me, wasn't looking at the ground and I slipped."

The evidence clearly shows Petitioner left early for his break and for his own convenience – to warm up his car. While rushing, he slipped and fell on snow or ice. Petitioner knew he was violating policy by leaving his shift early and without clocking out, and he chose to rush to his car so he would not be disciplined. Petitioner had no permission to leave the building during his shift. Petitioner's actions were a violation of Respondent's policy to leave without clocking out. Petitioner took himself out of his employment and unnecessarily placed himself at risk by his actions, namely, rushing to his car, on ice, so he could have lunch in his warmed car. That was Petitioner's personal choice, not personal comfort, and not an employment risk. Petitioner remained on the clock, but not engaged in any activity that benefited the employer. Respondent provided breakrooms in which Petitioner could eat lunch, yet Petitioner chose to eat lunch in his car. The decision to rush was to avoid discipline because he was knowingly violating company policy. This was a voluntary decision that unnecessarily exposed him to a danger entirely separate from his employment duties. As in *Dodson v. Industrial Comm'n, 308 Ill. App. 3d 572 (1999)*, his choice was personal in nature, designed to serve his own convenience and not the interests of the employer.

I would find that Petitioner failed to prove his accident arose out of and in the course of his employment. Thus, I respectfully dissent.

Kathryn A. Doerries

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

PATTON, BRANDON
Employee/Petitioner

Case# **19WC010831**

D B SCHENKER
Employer/Respondent

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On 9/30/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.86% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4463 GALANTI LAW OFFICE
GIAMBATTISTA PATTI
PO BOX 99
E ALTON, IL 62024

0000 LAW OFFICE OF EDWARD J KOZEL
RANDEE SCHMITTDIEL
530 MARYVILLE CENTRE DR #315
ST LOUIS, MO 63141

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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)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Brandon Patton
Employee/Petitioner

v.

D.B. Schenker
Employer/Respondent

Case # **19** WC **010831**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Lee**, Arbitrator of the Commission, in the city of **Collinsville & Mt. Vernon**, on **6/26/19 & 7/10/19**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
STATE OF ILLINOIS

BRANDON PATTON,	)	
	)	
Petitioner,	)	
vs.	)	Case No.: 19WC010831
	)	
D.B. SCHENKER,	)	
	)	
Respondent.	)	
	)	

ARBITRATION DECISION

Petitioner is alleging that he sustained a low back injury that arose out of and in the course of his employment when he slipped and fell on ice on March 4, 2019 in a parking lot adjacent to his workplace. I find that the accident did not arise out of or was in the course of petitioner's employment with Respondent. The parking lot was not part of the workplace. The personal comfort doctrine does not apply to this case. Petitioner was violating an established and enforced work rule when he fell and he had voluntarily exposed himself to an unnecessary personal danger solely for his own convenience at the time of the accident.

FINDINGS OF FACT

*Unless note, all TR references are to Transcript July 10, 2019

On March 3, 2019 –March 4, 2019 Petitioner was employed with Respondent as a warehouse person responsible for inventory. Respondent provides logistical services to Royal Canine and Eukanuba, dog food manufactures. TR 93-93. Product is delivered to the workplace and Respondent manages the removal of freight from trucks, into storage and the placement of that freight into trailers to be delivered to customers. TR 92. Ron Frost is one of

and snow can been seen around Petitioner's car, including near the driver's door. Petitioner said that he knew that the parking lot had patches of snow and ice that had been present for at least a few days before he fell. TR 42, 10. Contrary to his testimony denying knowledge of snow and ice near his car on the night he fell (TR 28), it is apparent from Respondent's photographs that Petitioner would have known about the patches of ice and snow around this car and on the parking lot when he arrived at work that evening. He would have had to transgress over the ice and snow or gone out of his way to walk around it once he exited his vehicle to walk into the building.

Once petitioner entered the front doorway, he used his badge to gain access to the breakroom. Respondent provided two break rooms. The main breakroom was located in the front of the building right off the entranceway and a second one was located in the warehouse. The main breakroom had restrooms, vending machines, tables and chairs and a full kitchen. Respondent provided photographs of the main breakroom. Respondent Exhibit 4. Even though some changes were made since the date of the accident, the basic set up of the room was the same. The second breakroom also had a refrigerator. TR 96. Both breakrooms were available to all employees during their break times. Employees were allowed to use the full kitchen and store personal items in the cabinets or refrigerator, including meals. TR 32. Petitioner indicated that the refrigerator in the main breakroom was often full. TR 33. He denied knowing about the second refrigerator in breakroom in the warehouse. TR 33. This was contradicted by Wilson. Wilson said that about 15 to 20 employees worked the night shift. There were about 35 employees during the day when he worked. TR 93. He never had a problem finding room in the refrigerator for his lunch. TR 104. Wilson also said that petitioner would have been shown the second breakroom during orientation. TR 96. Also, in the main breakroom are floor to

five associates were written up for going out to the parking lot to start their cars and then coming back in afterwards to clock in and extend their lunch breaks. TR 98. As he was walking, petitioner slipped and fell on the ice near his car. He landed on his buttock. TR 75. The spot where he fell is circled on Respondent's Exhibit 5.

After he fell, Petitioner got up. Petitioner indicated that Frost had witnessed the accident. TR 10. Frost had a medical emergency and was not able to appear at trial. It is not known what Frost saw, but it is undisputed that he had either direct knowledge or knew quickly afterwards that petitioner fell in the parking lot. After petitioner got up he went back inside the building and clocked out at 12:01 a.m. It was now March 4, 2019. Respondent Exhibit 3. Petitioner came back out to his car and spent his lunch break in his vehicle. TR 40. Frost took a photograph with his cell phone of Petitioner's vehicle and the parking lot while Petitioner was still sitting in his car. Respondent Exhibit 5. Frost also had Petitioner fill out a company accident report. Respondent Exhibit 2. In this report, Petitioner admitted he was walking fast to his car. He also wrote on the report that the accident occurred at 12:00 a.m., which contradicted his trial testimony that he fell at 11:55 p.m. There is an implication that petitioner misrepresented the time he fell to hide the fact that he went out to his car before clocking out. Respondent's Exhibit 2. There was a lot of testimony regarding whether or not Frost knew that petitioner was still on the clock when he fell and if Frost routinely allowed his employees to go out to the parking lot to start their cars before clocking out so they would not have to waste break time warming up their cars. Wilson and Walters both testified that this work rule was enforced and employees were regularly disciplined for doing this activity. In fact, five employees were disciplined the week before this incident for going out to their cars before clocking out. TR 98. Walters testified that it was not until hearing Petitioner's trial testimony that Respondent learned

slipped and fallen due to ice and snow on an employer's parking lot. However, this case is distinguishable because Petitioner fell in a parking lot that was not owned, maintained or controlled by Respondent. In addition, Respondent did not provide any type of snow or ice removal for the parking lot. Respondent did not even have the ability to request snow and ice removal if needed. TR 114-115. Furthermore, the parking lot where petitioner fell was open to the public. Visitors to Royal Canine, Eukanuba or Respondent all used this lot in addition to Respondent's employees. There were no assigned spaces except for handicap parking. Respondent's employees were allowed to park in any available space. TR 25.

It is undisputed that Petitioner was injured in a parking lot that was provided by Respondent, but the lot was not under Respondent's control and Respondent had no responsibility to maintain it, including snow and ice removal. In Mores-Harvey v. The Industrial Commission, 345 IllApp.3d 1034 (3rd Dist 2004) the petitioner was injured when she slipped and fell on ice and snow exiting her vehicle coming to work. In determining whether or not the parking lot was an extension of the employer's premises, the Appellate Court said that whether a parking lot is used primarily by employees or by the general public, the proper inquiry is whether the employer maintains *and* provides the lot for its employees use. If this is the case, then the lot is part of the employer's premises. The presence of a hazardous condition that causes a petitioner's injury supports the finding of a compensable claim. Id. at 1040. The Supreme Court also presumes that in order to hold an employer liable for parking lot injuries the employer has to have some responsibility to maintain the lot. See: DeHoyos v. The Industrial Commission, 26 Ill2d.110 (1962).

In this case, there is credible and competent evidence that Respondent did not maintain parking lot. Petitioner did not present any evidence establishing who owned, maintained or

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. The Industrial Commission, 82 Ill.2d 331 (1980). . I find that talking socially on the phone to one's girlfriend is not an act relating to the health or personal comfort of the petitioner or incidental to his employment. Respondent did not derive any benefit by petitioner talking on the phone with his girlfriend at midnight. Therefore, Petitioner's accident is not compensable under the personal comfort doctrine.

PETITIONER'S VIOLATION OF A COMPANY RULE AT THE TIME HE WAS INJURED TOOK HIM OUTSIDE THE SCOPE AND COURSE OF HIS EMPLOYMENT.

Respondent asserts that Petitioner took himself out of the course of employment because he was injured in the act of violating a company work rule. Employees are not allowed to go out to the parking lot during their lunch break unless they are clocked out. TR 72. Petitioner admitted that he violated this rule because he did not want to use any of his break time waiting for his car to warm up. TR 44-45. Respondent's general manager testified that Petitioner was trained on the break system during orientation. TR 94-95. The general manager then provided detailed testimony about how the lunch break rules. He said that employees are clocked out for their lunch breaks, which last thirty minutes. The company uses an engineered labor system to help create performance results for how it drives business. The system has three minutes of transit time for a person to travel from the warehouse to the time clock, which is located in the locker room adjacent to the breakroom. If an employee would arrive early to the locker room then he/she is supposed to clock out before going into the break room. That employee would still be required to clock back within thirty minutes. TR 96-97. The business purpose behind this rule is to insure employee productively which in turn drives business performance. TR 96-97.

involves a determination by the Commission of a combined question of fact and law. Whether an employee in a particular factual setting has placed himself in a position that the injury results from a risk purely personal to the employee, and not incidental to or connected with what the employee had to do to fulfill his duties, is a question of law. Once a well-supported factual finding has been made, the legal question is whether the employee, acting negligently and against the employer's orders, is precluded from recovering under the Act. Recklessly doing something the employee was employed to do incidental to his work differs considerably from doing something unconnected with the work. Saunders v. Industrial Commission, 301 Ill.App.3d 634 (1999).

Based on the competent evidence, it is clear that Petitioner violated the company rule solely for personal reasons unrelated to his employment. He wanted his car warm so he could sit in it and talk to his girlfriend during his thirty minute lunch break despite the freezing temperatures outside. Furthermore, the evidence is undisputed that Petitioner rushed out to his car to warm it up so he would not have to use up any of his allotted break time knowing that he needed to timely clock out and get back inside before getting caught by Frost. This action on his part was the sole cause of his accident. By violating a company rule Petitioner took himself outside the course of his employment and therefore, Petitioner's accident is not compensable.

PETITIONER'S ACCIDENT DID NOT ARISE OUT OF HIS EMPLOYMENT BECAUSE HE VOLUNTARILY EXPOSED HIMSELF TO PERSONAL DANGER FOR HIS OWN CONVENIENCE

Petitioner's accident also did not arise out of his employment because he voluntarily exposed himself to an unnecessary personal danger solely for his own convenience. There was no business reason for petitioner to go out to his car during his lunch break. The Court explained this principle in Dodson v. IWCC, 308 Ill.App.3rd 572 (5th Dist 1999).

the exit routes to prevent all unsafe voluntary acts.' " Hatfill, *202 Ill.App.3d at 553, 148 Ill.Dec. 67, 560 N.E.2d 369.*

We affirmed, observing:

"[T]he Commission could have inferred that the claimant's injuries resulted from a personal risk assumed by the claimant. While the claimant's injuries were incurred upon the employer's premises and were incurred within a reasonable time after leaving his work duties, nevertheless, it is apparent that the claimant's injuries occurred while he was engaged in an activity which only benefitted himself and not his employer." Hatfill, *202 Ill.App.3d at 554, 148 Ill.Dec. 67, 560 N.E.2d 369.*

Similarly, in the instant case, the Commission concluded claimant's injuries resulted from exposure to an ***increased personal risk****. She chose to take a shortcut to her vehicle and walked down a grassy slope that was ostensibly wet and icy from rain. Claimant did so instead of proceeding down the unobstructed stairs and sidewalk, both of which the employer provided for employees' ingress and egress. This was a voluntary decision that unnecessarily exposed her to a danger entirely separate from her employment responsibilities. Moreover, her choice was personal in nature, designed to serve her own convenience and not the interests of employer.*

In this case, Petitioner chose to go out to his car to warm it up so that he could spend his lunch break socially talking to his girlfriend on the phone. Petitioner rushed out to his car and disregarded the conditions of the parking lot because he knew he needed to get back inside in order to timely clock out for his lunch break. It was midnight. It was below ten (10) degrees. The parking lot was snowy and icy. Petitioner was fully aware of the snow and ice near and round his car. Respondent provided two breakrooms where Petitioner could have taken his lunch break and found a place to talk to his girlfriend. There were less than twenty people working that night in a warehouse facility 521,000 square feet. Petitioner's voluntary decision to rush out and warm up his car so he could socially talk to his girlfriend exposed him to a danger entirely separate from his employment responsibilities. This choice was purely personal in nature, designed to serve his own convenience and not the interest of the employer. Respondent provided Petitioner with a safe environment to take his lunch break and plenty of space to find

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

Gena Broner,
Petitioner,

vs. No. 15 WC 03903

Saks Fifth Avenue,
Respondent.

20IWCC0187

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, duration of temporary total disability, medical expenses, prospective medical expenses, and compliance with IWCC Administrative Rule 9110.10 (former Rule 7110.10), and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings including a determination of permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill. 2d 327 (1980).

The Commission notes one portion of the arbitration decision requiring discussion on review. Although neither party included vocational rehabilitation or the implementation of Rule 9110.10 as an issue on the Request for Hearing form, the Arbitrator, as part of his Decision, ordered Respondent to provide a written assessment by a certified rehabilitation counselor of Petitioner's choice. Pursuant to Section 9110.10(a) of the Commission Rules, an employer's vocational rehabilitation counselor shall prepare a vocational rehabilitation written assessment when the period of total incapacity for work exceeds 365 days or when it can be reasonably determined that the injured worker will be unable to resume the regular duties in which she was engaged at the time of her injury. 50 Ill. Admin Code 9110.10(a). The Arbitrator found, and the Commission agrees, that Petitioner was temporarily totally disabled for 187 and 1/7ths weeks, clearly in excess of the 365 days required to trigger the rule's written assessment requirement.

20IWCC0187

The Commission finds that, although the parties did not raise the implementation of the rule as an issue at arbitration, the Arbitrator's findings and conclusions, affirmed here, reaffirm Respondent's duty under the rule. However, the Arbitrator specified that the vocational counselor be of Petitioner's choice. No such proposition is evident from the rule, which requires the contrary. As noted above, the rule specifically provides that the written assessment be prepared by the employer's vocational rehabilitation counselor. For this reason, the Commission modifies the Arbitrator's Decision to provide that Respondent's vocational rehabilitation counselor shall prepare the written assessment in accordance with Section 9110.10(a) of the Commission Rules. All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 22, 2018, is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent have its vocational rehabilitation counselor prepare a written vocational rehabilitation assessment in compliance with Section 9110.10.

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

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 16 2020

Marc Parker

Deborah L. Simpson

Barbara N. Flores

mp/dak
o-02/20/20
68

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BRONER, GENA
Employee/Petitioner

Case# **15WC003903**

SAKS FIFTH AVENUE
Employer/Respondent

20IWCC0187

On 8/22/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.18% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2553 McHARGUE & JONES LLC
MATTHEW C JONES
123 W MADISON ST SUITE 1800
CHICAGO, IL 60602

5001 GAIDO & FINTZEN
GAIL BAMBNISTER
30 N LASALLE ST SUITE 3010
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

GENA BRONER
Employee/Petitioner

v.

SAKS FIFTH AVENUE
Employer/Respondent

Case # 15 WC 3903

Consolidated cases:

20IWCC0187

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **George Andros** Arbitrator of the Commission, in the city of **Chicago**, on **May 15, 2018 & JUNE 18, 2018** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

20IWCC0187

FINDINGS

On **October 14, 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 these accidents was given to Respondent.

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

In the year preceding the injury, Petitioner earned **$36,164.70**; the average weekly wage was **$695.48**.

On September 20, 2013, Petitioner was **33** years of age, ***single*** with 0 dependent children.

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

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

Respondent shall be given a credit of **$64,579.00** 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

IT IS HEREBY ORDERED Respondent shall pay to Petitioner and her attorney of record the temporary total disability benefits of $417.29/week for 187 1/7 weeks, commencing October 14, 2014 through May 15, 2018, as provided in Section 8(b) of the Act. Respondent is entitled to a credit of $63,164.70 in TTD.

Medical Benefits

IT IS HEREBY ORDERED Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of

ILLINOIS BONE AND JOINT INSTITUTE: $1,283.96, STREETERVILLE OPEN MRI: 5,400.00 , ACHIEVE ORTHOPEDIC REHABILITATION INSTITUTE: $1,525.00, ACCELERATED REHABILITATION CENTERS: $6,180.00, MICHIGAN AVE MEDICAL ASSOCIATES: $226.00, PAIN SPECIALISTS OF GREATER CHICAGO: $8,724.23, UNIVERSITY PAIN PHYSICIANS: $58,540.00, RUSH SURGICENTER: $176,836.00, HINSDALE SURGICAL CENTER: $11,742.00, RUSH UNIVERSITY MEDICAL CENTER: $102,455.87, NORTHSHORE UNIVERSITY HEALTH SYSTEM: $23,659.00.

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

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

#001 Arb. George J. Andros
Signature of Arbitrator

8/21/18
Date

AUG 22 2018

Findings of Facts & Conclusions of Law 15 WC 3903

Gena Broner, (Petitioner) testified that she is currently an employee of Saks Fifth Avenue, (Respondent) and has been employed there since 2005. Tx6. Petitioner was employed as a salesworker, specifically in the fragrance department. Tx7. Petitioner's average work day for Respondent was seven and a half hours a day, during which she would spend the entirety of her shift on her feet. Tx9. Petitioner worked at Respondent's place of business at 700 Michigan Avenue, Chicago IL. Tx9.

Petitioner testified that there is an employee entrance, which she was required to use. Tx11. This entrance is located in the back of her building at the corner of Rush and Superior, and is intended solely for employee use. Tx11-12. There is an alternate entrance on Michigan Avenue, but this entrance is meant for customers, and employees were not allowed to use it. Tx11-12. At the entrance on Rush and Superior, there is a sign that says the entrance is for employees only, and it is Petitioner's, unrebutted understanding from her nearly fourteen years' experience working with Respondent, that employees were only allowed to use that entrance. Tx12.

On October 14, 2014 Petitioner was scheduled to work at 9:30, which was her regular start time. Tx11. Petitioner arrived at work at approximately 9:25 when was dropped off by her boyfriend in front of the employee entrance. Tx11. Petitioner exited the vehicle approximately three feet away from the entrance. Tx13. Petitioner estimated that she took no more than three steps outside before she was inside the Respondent's building.

Petitioner does not recall what the weather was like on this day. Tx15. She testified, however, that after she entered the building that she did not notice any moisture or other substances on her shoes tracked in from outside. Tx15. Megan Bornhauser testified for the Respondent that it had rained earlier that morning, but did not remember if it was raining at the time of Petitioner's accident. Tx97.

Petitioner testified that the normal door she used to access the employee entrance was closed off. Tx14. Alternatively, there was another door a few feet away

propped open by a cone. Tx14-15. This door led to the same entrance as the usual employee door. Tx15-16.

After having walked two or three steps into the building, Petitioner slipped and fell on the ground on her left side. Tx16. When she fell, Petitioner's left shoulder, neck, head and the heel of her left foot hit the ground. Tx17. Petitioner testified that, when she fell, it was due to a slip rather than a trip, and that she slipped backwards. Tx17. After she slipped and was on the ground, Petitioner noticed that the ground was wet. Tx18. Petitioner testified that it felt as if she slipped on a liquid when she fell. Tx18. The area of her shirt and pants that hit the ground were wet where they touched the floor, and Petitioner testified that she smelled something on her body after hitting the ground. Tx18. Specifically, Petitioner's clothes were damp, and she smelled a chemical. Tx19. The parts of her body that did not touch the ground were not damp. Tx19.

After falling, Petitioner experienced immediate pain on her neck, left shoulder, left side, and foot. Tx20. There were construction workers who ran to her and put up a wet floor caution sign. Tx20. The construction workers were working on the inside entrance of the closed employee door. Tx20.

One of the construction workers yelled to Nick Marcolini, security for the Respondent, who came to the scene and filled out a report. Tx21.

Petitioner called her boyfriend to pick her up, who took Petitioner to the doctor. Tx22, 24. It took Petitioner's boyfriend approximately 5-7 minutes to come back to get her, and in that time Petitioner briefly spoke Mr. Marcolini and Ms. Bornhauser. Tx22-23.

Petitioner was brought to her primary care doctor, Dr. Yvette Shannon at North Shore Medical Group, immediately following the accident. Tx24; P1. Petitioner reported to Dr. Shannon that she had fallen entering her building, when she slipped on the wet floor. P1. Dr. Shannon ordered x-rays of Petitioner's body and left heel, and an MRI of Petitioner's left shoulder. Tx24; P1. Dr. Shannon took Petitioner off work. Tx25; P1. During the week following Petitioner's fall, she experienced pain on her left side. Petitioner's heel had hurt immediately following the accident, but on the subsequent fourth day, it developed into excruciating, throbbing pain. Tx25.

On October 23, 2014 Petitioner went to see Dr. Douglas Solway at Illinois Bone and Joint Institute. Tx26; P2. Dr. Solway is a podiatrist. Tx26. Petitioner complained to Dr. Solway that she was unable to apply any weight to her left heel. P2. At this time, Dr. Solway also took Petitioner off work and gave her a CAM boot and crutches. Tx26; P2. Dr. Solway referred Petitioner to Dr. Breslow with Illinois Bone and Joint to treat her neck and left shoulder. Tx26; P2.

On October 30, 2014 Dr. Solway noted that Petitioner was significantly hypersensitive to the pain in her left heel. P2.

Petitioner underwent an MRI of her left foot on November 5th, 2014 and underwent an injection into her left heel on November 7th, performed by Dr. Solway. Tx27, P2. The injection provided Petitioner with temporary and incomplete relief. Tx28. Petitioner also underwent physical therapy with Northshore University for her neck and left shoulder. Tx28, P1.

On December 10, 2014 Petitioner was referred to Dr. Daniel Homer, a neurologist, by Dr. Shannon, for treatment of her neck pain and migraines. Tx28; P1. Petitioner had a history of migraines prior to her accident, but experienced a dramatic increase in their frequency, subsequent. Tx29-30; P1. In addition to the increase in frequency, the Petitioner's migraines following the accident were different in quality and location. They were near occipital, shooting up from the left side of Petitioner's neck, as opposed to the aura based migraines she previously had experienced. Tx29, P1. After approximately a month and a half after beginning treatment with Dr. Homer, Petitioner's migraines dissipated. Tx31, P1.

Petitioner began another course of physical therapy in January of 2015 at Accelerated Rehabilitation Centers, under the care of Dr. Solway and Dr. Breslow, for her left foot, left shoulder, and neck. Tx31, P6. The physical therapy helped Petitioner her neck and left shoulder, but the symptoms in her left foot remained unchanged. Tx32, P6. On January 9th, 2015 Dr. Breslow noted that Petitioner's shoulder pain had resolved, although she continued to experience some neck pain. Tx32; P2.

Petitioner went to Michigan Avenue Medical Associates on January 29th, 2015 for a second opinion. Tx32; P3. Dr. David Shafer recommended a nerve block for

Petitioner's foot and an MRI, due to concerns that Petitioner was suffering from Complex Regional Pain Syndrome. P3. Petitioner underwent this nerve block on February 6th, 2015. Tx33-34; P3. Dr. Shafer and Dr. Jain from Michigan Avenue Medical Associates both opined that Petitioner should remain off of work. Tx34; P3.

Following her treatment with Michigan Avenue Medical Associates, on February 23, 2015 Petitioner discussed her treatment with Dr. Solway. P2. Dr. Solway opined that he also believed Petitioner was suffering from CRPS due to her hypersensitivity and coolness to her skin, and subsequently referred Petitioner to Dr. Goodman with Greater Chicago Pain Specialists on March 9th, 2015. Tx34; P2; P3. Dr. Goodman performed a bone scan, and prescribed aqua therapy. Tx35; P3.

At this point, Petitioner's left foot symptoms included discoloration in her left leg, described at almost albino. Tx36. Petitioner noted hair growth changes, and felt as if the pain in her left heel had started to move up into her leg. Tx36.

Petitioner saw Dr. Goodman on April 10, 2015 where he also diagnosed her with CRPS. P4. Dr. Goodman based this on Petitioner's extreme hypersensitivity, cool skin, and pallor. P4. Dr. Goodman recommended a series of nerve blocks, the first of which Petitioner underwent on June 11, 2015. Tx37-38; P4. This first nerve block provided relief for two days. Tx39. Petitioner underwent her second nerve block on July 2nd, 2015. Tx39. Petitioner's pain returned after the nerve block wore off. Tx40.

Additionally, once the nerve block wore off, Petitioner noted that her left leg again lost color and experienced abnormal hair growth on her lower left extremity. Tx40. Petitioner had not experienced hair growth changes or discoloration prior to her accident. Tx41. Petitioner underwent six nerve blocks while under the care of Dr. Goodman, each provided Petitioner with temporary relief and then a subsequent return to usual pain. Tx41; P4. Petitioner did physical therapy and was off work while treating with Dr. Goodman. Tx41.

Dr. Goodman referred Petitioner to Dr. Timothy Lubenow at Rush University, who she saw on March 30, 2016. Tx42; P5. Petitioner reported to Dr. Lubenow that she slipped and fell on a chemical while at work on October 14, 2014, and had had chronic pain and increased sensitivity in her heel ever since. P5. Dr. Lubenow

recommended another series of nerve blocks, and Petitioner underwent one per week over seven weeks. Tx42; P5. These nerve blocks again provided temporary relief, followed by a return of her symptoms. Tx46. Petitioner was also seen by a psychiatrist at Rush, Dr. Merriman, who Petitioner saw in conjunction with her treatment under Dr. Lubenow. Tx43; P5.

On May 5th, 2016 Petitioner suffered an unrelated accident. Tx43-44. Petitioner was at a restaurant, where a 150 pound painting fell on her head. Tx44. This accident re-injured Petitioner's head and neck, which at this point at recovered fully following her injury on October 14, 2014. Tx45. It did not affect her pain in her left lower extremity. Tx45. At the time of this accident, Petitioner was in middle of a series of nerve blocks prescribed by Dr. Lubenow, which she continued to get on schedule. Tx45; P8. This trauma has no bearing on the case at bar.

Petitioner experienced significant relief following a nerve block. Tx46. During the initial series of nerve blocks performed by Dr. Lubenow, Petitioner was still in a CAM boot. Tx46; P5. The nerve blocks, however, allowed Petitioner to remove the boot and put pressure on her left heel. Tx46. On July 7th, 2016 Petitioner told Dr. Lubenow, that the last nerve block provided her with 100% relief for seven days. P5. Following this nerve block, the extreme pain, left foot coldness, and sweating returned, as it had with all previous injections. P5. At this time, Dr. Lubenow recommend a continuous epidural injection. Tx46-47; P5. This was done on August 16, 2016 during which Petitioner was admitted to Rush Hospital for ten days. Tx47; P8. While on the continuous epidural Petitioner experienced lessened pain and participated in more fully in physical therapy at the hospital. Tx48-49; P8. Petitioner's pain again returned once she was taken off the continuous epidural. Tx49; P8.

On September 1, 2016 Petitioner saw Dr. Lubenow. She felt better overall, but continued to experience temperature changes, and abnormal hair growth in her left lower extremity. P9x42. Dr. Lubenow noted that this lack of hair growth on her left leg was difficult to measure because Petitioner shaved. P9x43.

On October 12, 2016 Petitioner still had persistent of pain. P5, P9x46. Additionally, Petitioner had persistent complaints of discoloration of the left leg and

hypersensitivity. P5, P9x47. She had allodynia in her left heel. P5, P9x48. She also complained of an inability to dorsiflex her left ankle on that particular day. P5; P9x47. Petitioner was unable to completely bear weight on her left extremity, and was using a crutch and CAM boot again. P5, P9x47.

Dr. Lubenow recommended that Petitioner proceed with a trial spinal cord stimulator. Tx49; P5. P9x53-54. For this trial, Petitioner was required to get psychological clearance by Dr. Merriman, which she underwent on October 2016. Tx49; P5. The week before Petitioner underwent the stimulator trail implantation, she continued to experience extreme pain, discoloration in her left lower extremity and hair growth changes. Tx50.

After the trial implantation on November 4th, 2016 Petitioner experienced significant pain reduction. Tx50; P5. She was able to put her foot down, something she had only been able to do previously while on a nerve block. Tx51; P5. After the stimulator trial was removed Petitioner's symptoms returned. Tx51. Petitioner underwent one final injection on November 21st, 2016 following her stimulator trial. Tx51; P5.

On December 12, 2016 Dr. Lubenow permanently implanted the DRG stimulator. Tx51; P5. Petitioner still had the DRG stimulator implanted as of the day of trial, May 15, 2018. Tx52. Petitioner has a portable device that allows her to manually activate the stimulator, so that she can adjust it as needed. Tx53-54.

After the initial implantation of the DRG stimulator, Petitioner experienced incomplete relief of approximately 25-30 percent. Tx54; P5. Dr. Lubenow adjusted the implant, and at Petitioner's appointment a month and a half following implantation, Petitioner was receiving maximum relief. Tx55; P5. Petitioner continued physical therapy and remained off work per Dr. Lubenow. Tx55; P5.

Petitioner's relief while on the DRG stimulator allowed her to put her foot down, and participate more successfully with physical therapy, but did not return Petitioner to pre-accident pain levels. Tx55; P5. On April 19th, 2017 Dr. Lubenow sent Petitioner to physical therapy at Achieve Orthopedic Therapy. Tx56-57; P5. On April 19th, 2017 Dr. Lubenow told Petitioner that she would be able to return to

work in a sedentary position that allowed her the flexibility of sitting and standing as tolerated. P5, P9x67. Respondent did not offer light duty to Petitioner at this time. On June 28, 2017 Dr. Lubenow revised his work restrictions so that they limited the amount of standing, walking or sitting to what Petitioner is able to tolerate, in addition to a 10lb weight restriction. P5. These restrictions remained in place through the date of the trial. Tx58. Petitioner contacted Respondent to return to work with light duty. Tx58. As of the date of trial, Petitioner had not received any offer of work conforming to her current restrictions. Tx58.

Petitioner's most recent date of treatment was with Dr. Lubenow on December 21, 2017, with a follow up in June 2018. Tx59; P5. Petitioner was ordered to continue with physical therapy and stay on the light duty restrictions. Tx59-60; P5. Petitioner has not worked anywhere else since her accident on October 14, 2014. Tx60.

Petitioner continues to require a cane for ambulation. Tx60. Weather changes, especially when cold or wet, increase Petitioner's difficulty with putting weight on her left foot. Tx60.

Cold weather causing throbbing in her foot, although at a significantly reduced level than she had experienced while not medicated by a stimulator or nerve block. Tx61. Petitioner continues to perform home exercises, and expects to start another course of physical therapy. Tx61-62.

Petitioner is able to adjust her stimulator, which she does approximately every 45 minutes in the winter. Tx62-63. Petitioner continues to not stand very often, and limits her walking. Tx63. During the summer, Petitioner does not need her cane as much, and makes less frequent adjustments to her stimulator. As a result of the stimulator, Petitioner has been able to drastically reduce her medication use, including elimination Gabapentin entirely. Tx64. Petitioner continues to take five milligrams of Vicodin occasionally, more frequently in the winter. Tx64. Prior to her stimulator, Petitioner was taking 1600-1900 milligrams of Gabapentin and daily doses of Vicodin. Tx64. Prior to Petitioner's workplace accident on October 14, 2014 she had never had CRPS or any other nerve related issues pertaining to her left foot.

Megan Bornhauser

Ms. Megan Bornhauser testified for the Respondent. Tx91. Although not currently employed by Respondent, she was on October 14, 2014 when she worked as a talent development manager. Tx92.

Ms. Bornhauser testified that the employee entrance was behind Respondent's building on Rush St. Tx93. Although there were technically multiple doors to the employee entrance, there was only one door that was generally used because the other doors didn't have handles. Tx92.

All the doors entered into the same main vestibule. Tx92-93. On the day of the accident there was construction happening on the standard employee door. Tx99-100.

On October 14, 2014 Ms. Bornhauser was called to the employee entrance because Petitioner had fallen. Tx95. Ms. Bornhauser was unable to say how much time had elapsed between the accident and her being told it had happened. Tx109. By the time she arrived, Petitioner was sitting on a step, and Petitioner's boyfriend and Nick Marcolini, a member of Respondent's security team, were there. Tx95-96. Ms. Bornhauser testified that Petitioner told her that she had fallen, and that Petitioner had indicated that her shoulder was hurt and that she had difficulty walking. Tx96. She does not remember if Petitioner told her what she fell on or what caused her to trip.

Ms. Bornhauser testified that it had rained that morning, but that she does not remember if it was raining at the time of Petitioner's accident. Tx97. She further testified that she did not see any liquid on the floor. Tx97-98. However, Ms. Bornhauser also testified that she did not look for any liquid on the ground. Tx98. She was unable to say who was present at the time of the accident or whether or not the floor had been cleaned up. Tx109-110.

When Ms. Bornhauser spoke with Petitioner, they were between five and ten feet apart. Tx98-99. She did not notice one way or the other whether Petitioner was wet or dry. Tx99. It was her understanding that Petitioner's boyfriend would be taking her home to rest. Tx100. Ms. Bornhauser is relying on the statements of Petitioner and that of Mr. Marcolini for her understanding of the accident. Tx110.

Ms. Bornhauser testified that this was the extent of her interaction with Petitioner's accident. Tx102. Although she did see Petitioner in October of 2016 at a bar called Arbella. Ms. Bornhauser spoke with Petitioner, who informed her that she had underwent an epidural injection the day prior. Tx104. She did not see whether Petitioner had a cane. Tx104. However, she admitted that it was possible the cane was somewhere else in the bar with her coat. Tx117, Petitioner was wearing heels at that time, but Ms. Bornhauser could not remember whether they were wedges or not or the height of the heels. Tx105. Petitioner testified that sometimes after having underwent a nerve blocks, she was able to wear wedges. Tx87. The testimony of the witness does not in any way erode the Petitioner's testimony nor impact causation or TTD entitlement.

Nick Marcolini

The parties admitted a written stipulation as to what Nick Marcolini would have testified to, had he been called to testify. R3. Mr. Marcolini was employed by Saks Fifth Ave. as a loss prevention officer on October 14, 2014. R3. He did not see Petitioner fall, but reported to the scene after the accident. R3. He authored Respondent's Form 45. R3; R4. Mr. Marcolini did not report in Respondent's Form 45, that Petitioner had told him there were chemicals on the ground, that he had seen any chemicals, or that there were any additional witnesses to the fall. The Form 45 report indicated that Petitioner slipped and fell while entering the back door on her way to work. R4. It indicated that Petitioner slipped and fell on water inside the back door, and that a wet floor sign was out in the area when Mr. Marcolini created the report. R4.

Dr. Kenneth Candido

Dr. Candido performed, over the course of two and a half years, four independent medical evaluations (IMEs) of the Petitioner for the Respondent. Throughout his examinations, Dr. Candido continuously opined that the propriety of care of Petitioner was largely appropriate. R1. In his reports, and testimony, Dr. Candido consistently supported, and even advocated for, Petitioner's ongoing physical therapy and multiple sympathetic nerve blocks, of which Petitioner went 21. R1x36-37, 46-47, 64-65, 77, 108; P5. The only care Dr. Candido opined that he

did not believe was appropriate was the Petitioner's Botox injection on February 3, 2015, the continuous epidural infusion performed by Dr. Lubenow on August 19, 2016, and the DRG Stimulator implanted by Dr. Lubenow on November 4, 2016. R1x36, 65, 77.

On April 28th, 2015 Dr. Candido opined that while Complex Regional Pain Syndrome was a consideration for Petitioner's diagnosis, that neuritis of the left calcaneal nerve was more fitting. R1, April 28, 2015 IME, x14. Dr. Candido continued to express this opinion, based in part on, the belief that Petitioner did not meet enough of the categories outlined in the Budapest Clinical Diagnostic Criteria sufficient to diagnose Complex Regional Pain Syndrome. R1. Throughout his treatment of Petitioner, Dr. Candido consistently identified several signs of CRPS, but believes that she didn't meet enough qualifications to warrant its diagnosis. R1.

Dr. Candido's assessment of Petitioner's injury on April 28, 2015 was that of a calcaneal nerve injury, which he believed would heal within six to twelve months. R1x109. Petitioner was essentially the same at her next appointment with Dr. Candido on October 6, 2015, where he opined that the recovery may actually take up to 24 months. R1x110. Petitioner saw Dr. Candido for a third time on September 20, 2016, almost two years since her accident, at which point Petitioner was still significantly symptomatic per Dr. Candido. R1x110-112. Dr. Candido testified that at this point petitioner was getting "towards as least on standard deviation" when it came to the bell curve of persons diagnosed with calcaneal nerve injuries. R1x113. Dr. Candido opined that, at this time, he would continue the same treatments Petitioner had been receiving, sympathetic nerve blocks and physical therapy ad infinitum, until she healed. Tx114. Dr. Candido saw Petitioner for the last time on March 14, 2017 where he placed her at MMI because her symptoms had changed considerably. R1x116. Dr. Candido opined that Petitioner's recovery was "100 percent" due to the passage of time. Rx116. This last examination took place four months after Petitioner's DRG stimulator had been implanted. P5.

Dr. Candido placed Petitioner on workplace restrictions for the first time on March 14, 2017, saying that she should be provided an opportunity to sit and elevate her left leg and foot once every two hours for ten minutes, and that she

would have difficulty being on her feet for an eight-hour day. R1x79, 125. At all other points, Dr. Candido opined that Petitioner should be kept off work. R1. Dr. Candido opined that, as of the date of his testimony, despite having declared her to be at MMI, he was unsure as to whether or not Petitioner's injury had healed. R1x120. He recommended that Petitioner continue to undergo physical therapy, possibly unlimited in duration. R1x124. The Arbitrator finds the opinions of Dr. Candido are not persuasive at all compared to the opinions of Dr. Lubenow.

Dr. Timothy Lubenow

Dr. Lubenow initially saw Petitioner on March 30th, 2016. P9x11, P5. Petitioner complained of left heel pain, which resulted from a slip and fall on a chemical while at work on October 14, 2014. P9x11; P5. Dr. Lubenow remarked that Dr. Solway did a bone scan on Petitioner, which, combined with her history, indicated possible CRPS. P9x12.

Petitioner complained of sensitivity in her left heel. P9x12; P5. She also felt that there was a temperature difference, and that she had less hair growth over that left extremity. P9x12; P5. Dr. Lubenow noted that these subjective complaints are potential symptoms of CRPS. P9x14.

Dr. Lubenow's objective testing of Petitioner found that she had a decrease in dorsiflexion of the left foot and ankle, and that there was temperature asymmetry between her left foot and right. P9x14-15; P5. Petitioner also had a diminution of pinprick sensation in the left heel, and diminished ability to perceive cold sensation in the left heel. P9x15; P5. Dr. Lubenow testified that at all times he found allodynia in Petitioner's foot and ankle. P9x17-18. CRPS is detected by looking for a number of historical symptoms complained of by patients combined with physical exam findings, known as the Budapest Clinical Diagnostic Criteria. P9x19-20. Dr. Lubenow used these objective findings, combined with Petitioner's subjective complaints, to diagnosis Petitioner with CRPS. P9x16-17. Dr. Lubenow disagreed with Dr. Candido's findings in regards to the criteria necessary to establish CRPS. P9x28-29.

More importantly, however, he opined that Dr. Candido's assessment that Petitioner was suffering from neuropraxia of the calcaneal does not fit with

Petitioner's response to treatment, or the amount of time it took her to recover. P9x 29, 35. The Arbitrator adopts Dr. Lubenow over Dr.Candido on this point and all other medical conclusions and opinions in this case at bar. Dr. Candido's opinions are rejected herein on all points in the case at bar.

Dr. Lubenow recommended that Petitioner undergo a continuous epidural injection. P9x37. This is essentially a continuous nerve block, which is an intermediate treatment step for this condition, according to Dr. Lubenow in his medical expertise. P9x37-38. Thereafter, she experienced a worsening of her condition. P9x49. Dr. Lubenow opined that this development showed him, as an expert in the care and treatment of CRPS, that regional nerve blocks were not going to be successful. P9x49. At this point. Dr. Lubenow felt Petitioner's condition required a more permanent method of managing her pain. P9x49. He recommended that Petitioner undergo a Dorsal Root Ganglion (DRG) stimulator implantation. P9x50.

Dr. Lubenow testified that the DRG stimulator, was a more narrow and focused treatment as opposed a conventional spinal cord stimulator. P9x50-51. It is used for nerve-related pain that is more focused as opposed to wide spread nerve pain. P9x51. Dr. Lubenow opined that this treatment was appropriate for Petitioner, because Petitioner consistently complained of extreme pain in an isolated area of her body, namely her left heel and ankle. P9x51.

Of the three hundred and fifty physicians who are currently trained in this procedure, Dr. Lubenow was one of the first six. P9x52. Dr. Lubenow has trained other physicians in this procedure, and has performed somewhere between a hundred and two hundred of these procedures. P9x52.

The DRG spinal stimulator has generally has a better success rate than the conventional spinal cord stimulator. P9x52. Dr. Lubenow opined that the regular spinal stimulator gives 50% improvement in pain to 50% of patients. The DRG stimulator, however, gives a greater likelihood of reaching 50% or better pain relief. P9x50. Before receiving this stimulator Petitioner was required to undergo a psychological evaluation to ascertain whether or not there's significant psychological variables that may mitigate the potential for a full functional recovery.

P9x56. Petitioner was determined to be an appropriate candidate for the implantation by Dr. Merriman on October 18th, 2016. P5; P9x56-57.

Following the implantation of the DRG stimulator Dr. Lubenow saw Petitioner on December 15, 2016. P5; P9x61. Petitioner was complaining of increased pain, pale discoloration, swelling, and sweating of the left lower extremity. P9x61. Dr. Lubenow reprogramed her stimulator at this time, in order to recapture the pain relief in her lower left extremity. P9x61. When Petitioner followed up on January 26, 2017 Petitioner was endorsing 75% pain relief following the reprograming of her stimulator. P9x64; P5. Petitioner was able to stand on her left lower extremity, and her other symptoms had decreased or dissipated. P9x64-65.

On April 19th, 2017 Petitioner still felt that she was 75% improved. P5; P9x 66. Dr. Lubenow opined that Petitioner would be able to tolerate seated sedentary position that allowed her the flexibility of sitting and standing as tolerated. P5, P9x 67. On June 28, 2017 Dr. Lubenow revised his work restrictions so that they limited the amount of standing, walking or sitting to what Petitioner is able to tolerate, in addition to a 10lb weight restriction. P5. These restrictions remained in place through the date of the trial. Tx58.

Conclusions of Law

C. Accident

Based upon the totality of the evidence, the Arbitrator finds that the Petitioner sustained an accident on October 14, 2014 arising out of and in the course of her employment for Respondent, as alleged in the case at bar. The Petitioner's testimony is adopted in that conclusion. . The Arbitrator relies on the credible testimony of Petitioner, as well as the consistent history of her medical providers. The Arbitrator perrsonally observed the witness in her testimony and demeanor of the Petitioner at hearing. She was subject to extensive , well focused and prepared cross examination. That examination did not cause any detriment to this extremely articulate and good historian/ Petitioner. As such, I found her testimony to be extremely credible and consistent with records of her doctors.

I. Arising out of

See ." *Sisbro, Inc. V. Industrial Comm'n*, 207 Ill. 2d 203 (2003). *Springfield Urban League v. Illinois Workers' Compensation Comm'n*, 2013 IL App (4th) 120219WC, ¶ 27. *First Cash Financial Services*, 367 Ill. App. 3d at 106. *First Cash Financial Services* was read by the Appellate court to say that "injuries may be deemed to arise out of the employment if they are caused by defects or slippery *indoor* surfaces at the worksite." *Dukich v. Illinois Workers' Compensation Comm'n*, 2017 IL App (2d), ¶ 41.

Petitioner testified credibly, and was further supported by Respondent's witness Ms. Bornhauser, that she was required to enter through an entrance strictly used by employees only. Tx11-12, 93-94. She was three steps into this entrance when she slipped and fell on the ground. Tx16. Respondent's Form 45, completed by Nicholas Marcolini, also reports that Petitioner slipped and fell on the floor while entering the back door on her way to work. R4.

Petitioner credibly testified that she slipped on a liquid. Tx18. After falling she noticed that the area that hit the floor was damp. Tx19. Petitioner's clothes were not damp prior to falling, and there was nothing on her shoes prior to entering the building. Tx15, 19. After falling Petitioner saw someone put up a wet floor sign. Tx20. This is supported by Respondent's Form 45 where Nicholas Marcolini also reported that there was a wet floor sign, after being called to the scene of the accident. R4. Petitioner slipped on a liquid, after arriving at work and while in Respondent's building, having entered through an employee only entrance in route to beginning her shift. This is based on Petitioner's credible testimony, the supporting documentation of Mr. Marcolini, the testimony of Ms. Bornhauser, and the consistent accident histories of Petitioner's treating doctors. In summary, based upon the totality of the evidence the Arbitrator finds that Petitioner encountered a risk distinctly associated with her employment, which caused Petitioner to suffer an accident arising out of her employment with Respondent.

II. In the course of

As previously noted, on October 14, 2014 Petitioner was entering her place of work, approximately five minutes before her work shift began. Tx11. She had entered her employer's premises by way of the mandated employee entrance. Tx12-

16. Petitioner was approximately two or three steps into the building when she slipped and fell, where she injured her shoulder, neck, head, and left foot. Tx16–17.

It has long been held 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. *Caterpillar Tractor Company v. The Industrial Commission*. 129 Ill. 2d 52, 57, 541 N.E.2d 665 (1989).

Petitioner was on Respondent's premise, having arrived in order to begin her work duties for Respondent, when she slipped and fell. This is undisputed. Based upon the totality of the evidence the Arbitrator finds that Petitioner's injury occurred in the course of her employment with Respondent.

F. Causal Connection

Based upon the totality of the evidence, the Arbitrator finds that Petitioner's current condition of ill-being is causally related to this accident. In doing so, the Arbitrator adopts and relies upon the credible testimony of the Petitioner, and that of her treating doctors. Specifically, the Arbitrator is persuaded by Dr. Lubenow's testimony, and the medical reports of Petitioner's treating doctors, that on October 14th, 2014 Petitioner's accident resulted in injuries to her left shoulder, neck, an increase in migraines, and trauma to the left heel that developed into Complex Regional Pain Syndrome. Additionally, the Arbitrator finds Dr. Lubenow's assessment of Petitioner's condition to be more consistent with the facts in this case. As such, the Arbitrator rejects in total the opinions of Dr. Candido in this case at bar.

The Arbitrator finds that Petitioner suffered a sprain/strain of her neck and left shoulder due to her workplace accident. Petitioner immediately complained of pain in her left shoulder and neck to Dr. Yvette Shannon at North Shore, and treated conservatively with Dr. Marc Breslow until January 5th, 2015 at which point she was placed at MMI.

The Arbitrator also finds that this accident caused Petitioner to suffer migraines from the date of the accident until January 2015. Petitioner testified that she had a history of migraines prior to her workplace accident on December 10, 2014, but had not been treated for them. Following the accident Petitioner's her migraines became much more frequent, and disparate in location and quality. Tx30.

Petitioner experienced near occipital migraines, radiating from her neck on the left side. Tx30. Petitioner was referred to Dr. Homer, a neurologist, on December 10, 2014 for treatment of her migraines. Tx28; P1. Approximately a month and a half after beginning treatment with Dr. Homer, Petitioner's migraines dissipated. Tx31, P1. The Arbitrator finds that Petitioner's migraines through January of 2016 were causally related to her workplace accident.

In regards to the condition of Petitioner's left heel, there are two issues. First, is: what is Petitioner's current condition of ill being? The second: is this condition of ill being causally connected to her workplace accident?

As to the second question. The Arbitrator finds that Petitioner's current condition of ill-being in relation to her left heel is causally related to her workplace injury on October 14th, 2014. Dr. Candido noted that although Petitioner had many more than a dozen sympathetic blocks, that they were all appropriate treatments for Petitioner's condition. R1x102. Dr. Candido never opines that Petitioner's current state of ill being is related to anything other than her injury on October 14, 2014. There is a dispute about what exactly Petitioner is suffering from, but no dispute as to whether or not Petitioner is suffering. Despite having placed Petitioner at MMI, Dr. Candido notes that he isn't even sure that her injury had healed at the time of his examination. R1x120.

As to the first question, based upon the totality of the evidence, the Arbitrator finds, Petitioner's current condition of ill being is that of suffering from CRPS in her left foot. In so finding, the Arbitrator relies on the testimony of Dr. Lubenow, and specifically rejects the opinions of Dr. Candido, whose diagnosis the Arbitrator does not find at all persuasive and in this case not even credible. Dr. Lubenow has been Petitioner's treating doctor for over two years, and has seen her in excess of thirty visits during this time. The Arbitrator finds persuasive that Dr. Lubenow has had the opportunity to get to know, evaluate, and examine Petitioner on many occasions, was able to credibly assess her condition. The symptoms of CRPS are numerous and variable, and the Arbitrator finds that Dr. Lubenow had the best clinical opportunity to access Petitioner's condition.

The Arbitrator also finds Dr. Lubenow to be more persuasive , in part because his diagnosis and treatment plan has established improvement.

Dr. Candido opined that Petitioner's diagnosis is better explained as left calcaneal nerve neuritis or neuropathic pain. Dr. Lubenow disagrees with this diagnosis. P9x26. Significantly, Dr. Lubenow points out that if this were a simple calcaneal neuritis, it would have resolved within the span of a year after the injury. P9x26. This is supported by Dr. Candido's early records, which indicated that Petitioner should have recovered within the first six to twelve months. R1. Dr. Lubenow also opined that if Petitioner was suffering from a calcaneal neuralgia, she wouldn't have any pain relief from the sympathetic nerve blocks. P9x36.

The Arbitrator finds that Petitioner's condition and response to Dr. Lubenow's treatment fits with the diagnosis of CRPS. At the time of her injury, Petitioner developed an acute pain condition of the left foot and ankle. P1. That acute trauma resolved, but left her with ongoing complaints of neuropathic pain, which is the manner in which CRPS forms. P9x75. Generally, CRPS begins within days to weeks to almost three months following a particular event or combination of events. P9x76. In the case of Petitioner, she began to experience excruciating pain several days following her initial injury. Tx25. Petitioner responded favorably to the treatments for complex regional pain syndrome as carried out by Dr. Lubenow, with short term pain relief as seen in patients who have CRPS. P9x75.

In contrast, Petitioner's treatment did not correspond with Dr. Candido's assessment of her injury. Dr. Candido opined in his first IME that the neuro praxia heals virtually 100% of the time. R1 April 28, 2015 IME at 16. He further opines that, while the time frame for recovery is unpredictable, that it should occur within the next 6-12 months at the longest.

The Arbitrator notes that this section 12 examination took place a year and nine months before Petitioner reported last pain relief, and at the time of hearing Petitioner continued to have ongoing complaints.

Petitioner's second section 12 exam occurred on October 6, 2015, six months after Dr. Candido's first evaluation of Petitioner, and almost a year after her initial

injury. At this time, Dr. Candido again opines that the calcaneal nerve injury he diagnosed Petitioner with, could take another 6-12 months. R1 October 6, 2015 IME, at 17.

Dr. Candido places Petitioner at MMI at his March 14, 2017 IME, almost two a half years after her initial accident. R1 March 14, 2017 IME, at 38. Dr. Candido notes at this time that Petitioner's progress was due to time, rather than the neuromodulation she underwent under the care of Dr. Lubenow. R1 March 14, 2017 IME, at 37.

The Arbitrator is not at all persuaded by Dr. Candido or at times his convoluted testimony -avoiding key points in the treatment and diagnosis at Rush Medical Center. Dr. Candido testified that there is no way of knowing whether the DRG implant provided to Petitioner would have affected a calcaneal nerve injury, as he had diagnosed Petitioner. R1x117. Rather, he testified that the timing of Petitioner's recovery with that of the implantation of her stimulator was purely coincidental. R1x 119. Dr. Candido consistently opined that Petitioner would recover naturally, but was also consistently incorrect in regards to the time frame. Petitioner testified that she felt relief immediately following the adjustment of her DRG stimulator. Tx 54.

Dr. Candido would have the Arbitrator believe that this relief was pure coincidence, and that Petitioner's recovery was completely due to the passage of time rather than the treatment she was receiving. T1x 116. The Arbitrator is not persuaded by this opinion, but rather is persuaded by Dr. Lubenow's explanation that Petitioner's relief was due to the implementation of the DRG stimulator. P9x 64.

Dr. Lubenow engaged in a progressive course of treatment, beginning with sympathetic blocks, then moving to a continuous epidural infusion, and then finally the DRG stimulator. P5. When one course of treatment didn't work, he moved on to the next step in his treatment plan. P9x38. Dr. Candido would have had Petitioner continue with the same course of treatment until it got better, even after two and a half years of that treatment not resolving her condition. R1x 114. Dr. Lubenow opined that the DRG stimulator had a greater than fifty percent chance of providing

fifty percent pain relief or more. P9x 50. Which is what happened after Petitioner's stimulator was properly adjusted, when Petitioner endorsed 75 percent pain relief. P9x 64. Based upon the totality of the evidence, the Arbitrator finds that Petitioner is not at a point of medical stability or even maximum medical improvement; She is currently waiting for an additional office visit/treatment with Dr. Lubenow.

J. Reasonableness and Necessity of Medical Treatment

Based upon the totality of the evidence , the Arbitrator finds that Petitioner's medical services were reasonable and necessary.

As previously noted, Respondent's medical examiner, Dr. Candido, only disputes the reasonableness and necessity of Petitioner's medical treatment on a few points. Most notably, was the continuous epidural infusion and DRG stimulator prescribed by Dr. Lubenow. R1x 65, 77. Dr. Candido specifically opined that all 21 of Petitioner's sympathetic nerve blocks, and physical therapy were reasonable and necessary. R1x 36-37, 46-47, 64-65, 77, 108. Dr. Candido does not dispute the reasonableness or necessity of Petitioner's medication, doctor visits, or imaging. Based on Dr. Candido's opinions, the only issues which need to be addressed in regards to the reasonableness and necessity of Petitioner's treatment are that of the continuous epidural infusion, and that of the DRG stimulator.

Dr. Lubenow recommend Petitioner undergo the continuous epidural infusion as an intermitted treatment step for her condition. P9x 38. The continuous epidural infusion is essentially a continuous nerve block, something Dr. Candido repeatedly opined was reasonable and necessary in regards to Petitioner's treatment. P9x 38; R1. Dr. Lubenow explained that the epidural infusion treatment is done to more effectively couple the beneficial effects of the nerve block, with more aggressive physical therapy and exercise. P9x 38. Dr. Candido opined that the support for the continuous epidural infusion is largely anecdotal, and is not considered to be reliable. R1x 65. For Dr. Lubenow, this was the next step in treating CRPS, after not achieving permanent relief from sympathetic nerve blocks. P9x 40. Dr. Candido would have had Petitioner repeat the same modalities over and over, hoping for different response, until she heals. The Arbitrator is not persuaded by this plan.

After Petitioner underwent the continuous epidural infusion, she initially experienced symptom improvement, which then subsequently deteriorated. P9x49. Dr. Lubenow opined that, as an expert in the care and treatment of CRPS, that this deterioration showed him that the nerve block approach was not going to further rehabilitate Petitioner. P9x 49. Rather than continuing to give her nerve blocks and physical therapy, Dr. Lubenow recommended Petitioner proceed with the DRG stimulator. P9x 49-50.

Following the stimulator's implantation Petitioner experience a 68 percent improvement, and was able to tolerate putting pressure on her heel, which she previously was only able to do while on a nerve block. P9x 57-58.

The Arbitrator finds that Petitioner's accident on May 5th, 2016 Petitioner suffered an unrelated accident. Dr. Lubenow opined, and there is no medical evidence to the contrary, that her accident did not affect the condition or diagnosis of her left foot. P9x32-33. The Arbitrator finds that Petitioner's workplace injuries regarding her neck, shoulder, and migraines had all resolved at this point, and any subsequent treatment is unrelated to her accident on October 14, 2014.

Based upon the totality of the evidence , the Arbitrator finds that Petitioner's medical treatment has been reasonable and necessary. IT IS HEREBY ORDERED the Respondent to pay all bills submitted in connection with Petitioner's October 14, 2014 accident.

K. Temporary Total Disability

Based upon the totality of the evidence, the Arbitrator finds that Petitioner is entitled to 187 1/7 weeks of Temporary Total Disability, to be paid by Respondent to Petitioner and her attorney of record.

Every medical provider, including Respondent's Section Twelve Examiner, has opined that Petitioner should be off work completely, or given her working restrictions. Petitioner currently has work restrictions, which Respondent has not accommodated.

The Arbitrator finds the Dr. Lubenow's June 8th, 2017 restrictions to be appropriate and adopts those findings. Dr. Candido has restrictions , too. No work was offered within the adopted restrictions of Dr. Timothy Lubenow.

OTHER ISSUES : Vocational Rehabilitation

The Arbitrator adopts the medical evidence and the lack of tender of a job within the restrictions to order the Respondent to comply with Rule 7110 of the IWCC and to further authorize an initial assessment of petitioner by a certified rehabilitation counsellor (CRC) of the choice of the Petitioner under section 8(a).

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

Jerzy Solowiej,

Petitioner,

vs. NO. 18WC 19600

Expeditors International of Washington,

20IWCC0375

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19b having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of medical expenses, causal connection, prospective medical care, permanent disability, temporary disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. 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 20, 2019 is hereby affirmed and adopted.

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

20IWCC0375

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUN 29 2020
SJM/sj
o-6/17/2020
44

Stephen J. Mathis

Douglas D. McCarthy

AUTHORIZATION- SPECIAL CONCURRENCE/DISSENT

I concur with the majority in all aspects of its decision other than its order to compel Respondent to authorize medical treatment. This issue was previously addressed by the Court in *Hollywoood Casino-Aurora, Inc. v. Illinois Workers' Compensation Commission*, 2012 IL App (2d) 110426WC, which is dispositive. The Court noted "Assuming for the sake of analysis that this provision of the Act [Section 8(a)] is sufficiently broad so as to include a requirement that an employer authorize medical treatment for an injured employee in advance of the services being rendered, the fact still remains that there is no provision in the Act authorizing the Commission to assess penalties against an employer that delays in giving such authorization." *Id.* at ¶ 19. Ordering Respondent to authorize medical treatment is meaningless where no enforcement mechanism exists under the Act. In accordance with Section 8(a) of the Act and the Court's holding in *Hollywood Casino*, I would order Respondent to provide and pay for the awarded medical expenses and/or treatment.

L. Elizabeth Coppoletti

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

SOLOWIEJ, JERZY
Employee/Petitioner

Case# **18WC019600**

EXPEDITORS INTERNATIONAL OF WASHINGTON
Employer/Respondent

20IWCC0375

On 3/20/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.45% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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2837 JOSEPH A MARCINIAK LAW OFFICES
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STATE OF ILLINOIS)
) ss.
COUNTY OF DUPAGE)

20IWCC0375

☐ 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)

JERZY SOLOWIEJ
Employee/Petitioner

v.

EXPEDITORS INTERNATIONAL OF WASHINGTON
Employer/Respondent

Case # **18** WC **19600**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Frank Soto**, Arbitrator of the Commission, in the city of **Wheaton**, on **01/29/2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **10/07/2017**, 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 **$36,599.16**; the average weekly wage was **$703.83**.

On the date of accident, Petitioner was **41** years of age, ***married*** with **2** dependent children.

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

Respondent shall be given a credit of **$17,562.23** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$17,562.23**.

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, pursuant to the medical fee schedule, of $8,860.00 to AAKS Surgical, $2,480.00 to Dr. Miroslawa A. Kuder, $3,433.00 to Golf MRI and Diagnostic, $5,700.00 to Mark A. Sokolowski, MD, and $294.88 to Prescription Partners, as provided in Sections 8(a) and 8.2 of the Act and subject to the fee schedule, as set forth in the Conclusions of Law attached hereto,

Respondent shall pay Petitioner temporary total disability benefits of $469.22/week for 68 weeks, commencing 10/11/2017 through 01/29/2019, as provided in Section 8(b) of the Act, as set forth in the Conclusions of Law attached hereto,

Respondent shall authorize and pay for the medical treatment and procedures as proposed by Petitioner's treating physician, Dr. Mark Sokolowski, consisting of left sided L4-L5 epidural steroid injection as well as a cervical epidural injection and associated medical treatment, as set forth in the Conclusions of Law attached hereto,

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

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

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

Signature of Arbitrator

3/18/2019
Date

MAR 20 2019

20 IWCC0375

PROCEDURAL HISTORY

This matter was tried on January 29, 2019 pursuant to Section 19(b) of the Act. The issues in dispute are whether Petitioner's current condition of ill-being is causally connected to the injury; whether Respondent is liable for medical bills; whether Petitioner is entitled to prospective medical treatment; and whether Petitioner is entitled to additional TTD benefits for the period of June 30, 3018 through January 29, 2019.

FINDINGS OF FACT

Petitioner testified in Polish with the assistance of a professional translator. He testified he was employed by Respondent for approximately ten years and worked at Respondent's facility in Bensenville, Illinois. He testified he was employed as a warehouse worker. His duties included operating a forklift and removing shipments of goods off of trucks that arrived at the facility.

Petitioner testified he was working for Respondent on Saturday, October 7, 2017, and was performing his normal work duties. He was working with a coworker to unload a number of tubes off of a truck trailer. He explained they had to remove the tubes and lift them onto the forks of a forklift. The tubes were approximately twenty to thirty feet long.

Once the tubes were loaded onto the forklift, Petitioner testified he stood on top of them to keep them stable while his coworker operated the forklift. As he stood on the tubes, his coworker lifted the forks on the forklift to navigate passed an obstruction in their path. As he lifted the forks, Petitioner testified he lost his balance and fell onto the ground. He testified he fell from approximately four to five feet in the air onto the concrete floor. Petitioner testified he landed on his back and was in shock after falling.

Petitioner testified he reported his accident that same day to the warehouse manager. He did not seek medical treatment that day but took Advil due to back pain as he continued to work. Petitioner testified he was off of work the next two

days as Sundays and Mondays were his normal off days. Over the course of those next two days, Petitioner testified his pain worsened and he had pain down to his lower back and all the way up to his head. He attempted to take Tylenol and Advil to reduce his pain, however, these medications did not fully alleviate his pain.

Petitioner testified he returned to work for his normal work day on Tuesday, October 10, 2017. As he worked, he testified he continued to feel pain in his back, up through his head, with radiating pain into both his left and right legs, although he noted the pain in his left leg was worse. The following day, he went to U.K Family Practice in Wheeling, Illinois, for his first medical treatment related to his accident. He testified he chose this facility because it was the closest medical facility in which the providers spoke Polish.

Petitioner's Initial Medical Treatment

At his initial visit to U.K Family Practice, Petitioner treated with Dr. Slawomir Urgacz. (PX1 p.3). At this initial visit, Dr. Urgacz noted Petitioner was injured at work on October 7, 2017 when he fell down from a forklift. (Id.). He noted Petitioner had mild muscle spasms in his cervical spine, moderate spasms in his thoracic spine, and severe tenderness, with limited range of motion in his lumbar spine, and abdominal pain. (Id.). Dr. Urgacz prescribed Tramadol, Flexeril, and recommended physical therapy. (Id.). He also advised Petitioner to remain off of work. (Id.). Petitioner testified he communicated in Polish with the doctors at this facility.

At the recommendation of Dr. Urgacz, Petitioner underwent X-rays of his lower and middle back on October 26, 2017. (PX p. 3-4). At the recommendation of Dr. Urgacz, he underwent a CT scan of his chest and abdomen at this same facility on October 27, 2017. (Id. at 5-7).

Petitioner also testified he proceeded with a course of physical therapy at U.K Family Practice and noticed some improvement in his symptoms. (See PX1 p. 11-22). He continued to follow up with Dr. Urgacz, as well as his wife and partner, Dr. Mira Kuder, at U.K Family Practice over the next several weeks and months. (See PX1). On December 13, 2017, he underwent an MRI of his lumbar spine at Golf

Imaging Center pursuant to the recommendation of Dr. Kuder. (PX3 p. 8-9). The MRI revealed a small left lateral herniation with an annular tear at the L4-L5 level with "perhaps slight mass effect on left L4 nerve root." (Id. at 8). It also revealed a small right later herniation at L5-S1 but with no direct nerve root compression. (Id.). At his December 15, 2017 follow up visit, Dr. Urgacz referred Petitioner for an orthopedic consultation with Dr. Mark Sokolowski. (PX1 p. 10).

Petitioner's Medical Treatment with Dr. Mark Sokolowski

Petitioner began treating with Dr. Sokolowski on December 20, 2017. (PX2 p. 27). Dr. Sokolowski noted Petitioner's history of accident from falling off the forklift on October 7, 2017. (Id.). He noted Petitioner injured his back and neck. (Id.). He performed a physical examination and reviewed the lumbar MRI report from December 13, 2017. (Id.). He diagnosed Petitioner with lumbar pain, lumbar radiculopathy, cervical pain, and trapezial pain and attributed his condition to his work accident. (Id.).

Dr. Sokolowski prescribed a Medrol Dosepak and Dendracin, which he explained is a topical nonnarcotic anti-inflammatory. (PX2 p. 28). Petitioner obtained medications through Prescription Partners. (PX5). He also advised Petitioner to continue with physical therapy and return for a follow-up visit in one month. (PX2 p. 28). He noted the next step would be to proceed with left sided L4-L5 and right sided L5-S1 transforaminal epidural steroid injections if relief was unsatisfactory. (Id.). In the meantime, he advised Petitioner to remain off of work. (Id.). Petitioner testified he communicated in Polish with Dr. Sokolowski.

Petitioner returned to Dr. Sokolowski for his second visit on January 18, 2018. (PX2 p. 33). His cervical complaints were responding well to physical therapy, however, his progress as it pertained to his lumbar spine was slower to respond. (Id. at 33). He recommended proceeding with left sided L4-L5 and right sided L5-S1 transforaminal epidural steroid injections and also refilled his prescriptions for Tramdol and Dendracin. (Id.). He also provided Petitioner with a semi-rigid lumbosacral orthosis and advised him to continue to remain off of work. (Id.).

After obtaining approval from Respondent, Dr. Sokolowski performed a left sided L4-L5 transforaminal epidural injection on March 13, 2018 at AAKS Surgical. (PX2 p. 55-56). They elected only to perform the left sided injection because his left leg pain was more severe and Petitioner was nervous about proceeding with both. (Id. at 55, 71). Petitioner testified he was nervous about the injections and they decided to only proceed with one of them at that time.

Petitioner returned to Dr. Sokolowski's office on April 6, 2018. (PX2 p. 71). He reported improvement following the injection, but his symptoms had subsequently returned. (Id.). Dr. Sokolowski recommended proceeding with a second left sided L4-L5 injection as well as with an initial right sided L5-S1 injection. (Id.). He also recommended a cervical MRI as his improvement in physical therapy had plateaued and he was now having radiating symptoms into both arms. (Id.). He advised Petitioner to continue to remain off work. (Id.).

Petitioner underwent the recommended cervical MRI at Golf Imaging Center on April 17, 2018. (PX3 p. 10-11). The MRI revealed a 3 mm broad-based posterior central herniation contributing to mild central canal stenosis at C4-C5 and a 2 mm posterior central protrusion at C3-C4. (Id. at 11). It also revealed cervical spondylosis with neural foraminal narrowing bilaterally most severe at C5-C6. (Id.).

Petitioner returned to Dr. Sokolowski on May 10, 2018. (PX2 p. 81). He reviewed the cervical MRI and continued to recommend a second left sided L4-L5 injection as well as an initial right sided L5-S1 injection. (Id.). He indicated Petitioner may be a candidate for a cervical injection in the future. (Id.). He modified Petitioner's medication regimen to include Meloxicam and Gabapentin. (Id.). Lastly, he advised Petitioner to resume physical therapy and to remain off work. (Id.).

Section 12 Examination of Dr. Avi Bernstein

At the request of Respondent, Petitioner was examined by Dr. Avi Bernstein pursuant to Section 12 of the Act on June 25, 2018. (RX1 p. 5). Petitioner testified the entire examination by Dr. Bernstein lasted approximately five to seven minutes. Dr. Bernstein testified by way of evidence deposition on November 27, 2018. (RX1 p.

1). He authored one report regarding his examination of Petitioner. (Id. at 6). The Arbitrator notes that Respondent did not move to admit his report into evidence at the deposition or at arbitration.

Dr. Bernstein testified he spoke to Petitioner in English without the use of a Polish interpreter. (RX1 p. 10, 19). Petitioner explained his accident to him. (Id. at 7). He told Dr. Bernstein he fell off of a raised forklift approximately four or five feet onto his back onto the concrete floor. (Id.). Petitioner complained of neck pain and upper extremity pain as well as lower back pain radiating down his left leg. (Id. at 8).

Dr. Bernstein also performed a physical examination of Petitioner. (RX1 p. 9). He noted he could bend forward without sciatic complaints, which he felt indicated a lack of a pinched nerve in his lumbar spine. (Id.). He did not believe he had any findings consistent with a pinched nerve or herniated disc. (Id. at 10).

He reviewed the lumbar MRI of December 13, 2017 but indicated the scans were poor quality. (RX1 p. 11). He also reviewed the April 17, 2018 cervical MRI scans but felt those were of poor quality as well. (Id. at 11-12). He reviewed medical records from Dr. Urgacz. (Id. at 21). He did not, however, reference any of the medical records of Dr. Sokolowski in his report. (Id. at 27). He confirmed he was in possession of the report of the March 13, 2018 epidural steroid injection but did not mention it in his report. (Id. at 27). He was not aware if Petitioner sustained any relief from that injection. (Id. at 28-29).

Dr. Bernstein concluded Petitioner had "age appropriate degenerative change in his neck and his low back." (RX1 p. 14). He did not believe Petitioner's subjective complaints were in concordance with the findings on his cervical and lumbar MRIs. (Id. at 14-15). He stated Petitioner could return to work without restrictions. (Id. at 15). He felt Petitioner had reached maximum medical improvement. (Id.). He agreed the scientific method should be used so that an examiner's biases do not get in the way of their science or testing. (Id. at 32). He testified his hypothesis in evaluating Petitioner was he did not have a problem. (Id.).

Petitioner's Ongoing Medical Treatment

Following his examination by Dr. Bernstein, Petitioner testified he continued to treat with Dr. Sokolowski. On July 16, 2018, he underwent the second recommended left sided L4-L5 injection as well as his first right sided L5-S1 injection. (PX2 p. 89). He then followed up with Dr. Sokolowski on August 2, 2018. (Id. at 91). Petitioner advised Dr. Sokolowski that the right sided injection provided excellent relief, however, the left side relief was not as good. (Id.). Dr. Sokolowski noted Petitioner was frustrated with his ongoing symptoms. (Id.).

Dr. Sokolowski reviewed Dr. Bernstein's. (PX2 p. 91). He noted Dr. Bernstein's opinions that Petitioner could return to work to full duty and had reached maximum medical improvement. (Id.). He disagreed with Dr. Bernstein and indicated Petitioner's improvement following the right sided injection was "diagnostically valuable" and "prognostically positive." (Id.). He noted Petitioner's left sided radicular pain corresponded to the left L4-L5 disc herniation seen on his MRI. (Id.). He recommended a functional capacity evaluation (hereafter referred to as "FCE"). (Id.). Dr. Sokolowski noted this would be the "...most objective means of delineating his actual capabilities..." given Dr. Bernstein concluded he could work full duty. (Id.). He advised Petitioner to remain off work. (Id.).

Functional Capacity Evaluation

Pursuant to the recommendation of Dr. Sokolowski, Petitioner underwent an FCE at Vital Rehabilitation on August 14, 2018. (PX4). The results of the evaluation indicated Petitioner gave a reliable effort with 29 of 31 consistency measures within expected limits. (Id. at 2). The FCE was determined to be a valid representation of his functional capabilities. (Id.). Petitioner met the Sedentary Physical Demand Category for High Lifting, Light Physical Demand Category for Mid Lifting and Full Lifting, and the Medium Physical Demand Category for Low Lifting. (Id. at 3). His demonstrated abilities did not meet the specified job demands for his work for Respondent as a warehouse worker/material handler. (Id. at 2, 4).

Ongoing Treatment and Prospective Medical Care

Following his FCE, Petitioner returned to Dr. Sokolowski on September 11, 2018. (PX2 p. 120). He performed a physical examination and noted Petitioner had back pain radiating to his left leg with extension of his back. (Id.). Straight leg testing reproduced his left L5 radicular pain, sensation was descreased in his left L5 dermatome, among other findings. (Id.).

Dr. Sokolowski also reviewed the FCE report. He noted the report limited Petitioner to lifting ten pounds occasionally, with only occasional walking, stooping, kneeling, balancing, crouching, climbing, and sitting. (PX2 p. 120). He noted this was in direct contradiction to Dr. Bernstein's conclusion that Petitioner could return to full duty work. (Id.). He concluded, "The significant disparity between Mr. Solowiej's actual capabilities and those required of his job substantiate the need for further treatment." (Id.). He recommended a third left sided L4-L5 injection as well as a cervical epidural injection to address his bilateral stenosis at C5-C6. (Id.). He advised Petitioner to remain off of work pending clinical improvement and approval of further treatment measures. (Id. at 120-121).

Petitioner followed up with Dr. Sokolowski on October 24, 2018 and December 13, 2018. (PX2 p. 123, 125). He continued to recommend a third left sided L4-L5 injection as well as a cervical epidural injection (Id.). He also continued to advise Petitioner to remain off work. (Id.).

Petitioner's Testimony Regarding his Ongoing Complaints

Petitioner testified he wants to proceed with the lumbar and cervical injections that have been recommended by Dr. Sokolowski and intends to do so once approved by Respondent. He continues to take the medications that are prescribed to him. He indicated the medications relax his pain complaints, but they also make him drowsy and weaker. His pain continues to wake him up at night on some occasions. He has not had any new accidents or injuries since October 7, 2017. He spends most of his days at home.

The Arbitrator found the Petitioner's testimony credible.

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CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law as set forth below. The claimant bears the burden of proving every aspect of her claim by a preponderance of the evidence. *Hutson v. Industrial Commission*, 223 Ill App. 3d 706 (1992).

F. ***IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?***

To prevail on a claim for benefits under the Act, an employee must establish, among other things, that his or her current condition of ill-being is causally connected to a work-related injury. *Elgin Board of Education School Dist. U-46 v. Illinois Workers' Comp. Commission*, 409 Ill.App.3d 943, 948 (2011).

The Arbitrator has reviewed and considered the medical evidence as well as the testimony. The Arbitrator finds that Petitioner has proven by a preponderance of the evidence that his current condition of ill-being as it relates to his cervical spine and lumbar spine is causally related to his work accident of October 7, 2017. Further, Petitioner has not reached maximum medical improvement.

Petitioner testified regarding his non-disputed accident when he fell from a forklift. Prior to that date, he was not experiencing any pain or issues with his lower back, neck, or any other part of his body. Prior to that fall, he was able to perform his job without any difficulties. The Arbitrator finds Petitioner testified credibly and his testimony was not undermined on cross examination or by any other means.

A few days after his accident, Petitioner began treating with Dr. Urgacz. They spoke in Polish and he documented the work accident of October 7, 2017. Petitioner had muscle spasms in his cervical spine, thoracic spine, and severe tenderness, with limited range of motion in his lumbar spine.

A lumbar MRI completed on December 13, 2017, revealed a small left lateral herniation at the L4-L5 level with possible L4 nerve root compression. It also revealed a small right later herniation at L5-S1 but with no direct nerve root compression. Soon thereafter, he began treating with Dr. Sokolowski, who also

communicated in Polish. He diagnosed Petitioner with lumbar pain, lumbar radiculopathy, cervical pain, and trapezial pain. He attributed his condition to his work accident.

Petitioner was originally nervous and afraid to proceed with the injections recommended by Dr. Sokolowski. However, after the success with the initial left sided lumbar injection, he felt more comfortable proceeding with the additional injections. In fact, the right-side injection provided excellent relief and indicates the treatment was successful in treating the underlying condition.

Respondent is relying wholly on the opinions of Dr. Bernstein in its denial of further benefits in this claim. The Arbitrator, however, does not find his opinions to be persuasive. Dr. Bernstein only met with Petitioner for a total of five to seven minutes and communicated in English rather than Polish.

Dr. Bernstein does not have a clear picture of Petitioner's full medical picture. He felt the lumbar MRI scans of December 13, 2017 and the April 17, 2018 cervical MRI scans were poor quality. Regardless, he indicated he disagreed with the findings included in the MRI reports. He had medical records from Dr. Sokolowski in his file but did not mention that treatment anywhere in his report and was not asked about it on direct examination. He did not reference the epidural injection that occurred before he examined Petitioner. He did not ask Petitioner whether he obtained any benefit from it. He was defensive when questioned about the epidural even suggesting any benefit Petitioner may have received would be due to a placebo effect. This is but one of many instances in which he ignored evidence that did not support his ultimate conclusions.

Dr. Bernstein chose to only reference the early treatment with Dr. Urgacz. He was quick to reject any objective or subjective evidence of Petitioner's injuries. He faulted poor quality MRIs and ignored medical treatment. When confronted on cross examination about not including Dr. Sokolowski's treatment in his report, he suggested this was the fault of Petitioner, "Whatever he told me I included in my report." Dr. Bernstein was sloppy in his examination and evaluation of Petitioner. He

mistakenly, or perhaps purposefully, ignored medical records that did not support his own admitted hypothesis that there was nothing wrong with Petitioner.

Dr. Sokolowski reviewed Dr. Bernstein's report and challenged him. He explained Petitioner's improvement following an epidural injection was "diagnostically valuable" and "prognostically positive." He explained Petitioner's left sided radicular pain corresponded to the left L4-L5 disc herniation seen on his MRI. He also recommended the FCE, which provided objective evidence regarding Petitioner's physical capabilities. After reviewing the FCE report, he noted, "The significant disparity between Mr. Solowiej's actual capabilities and those required of his job substantiate the need for further treatment." Dr. Bernstein admitted he was not aware of Petitioner's job duties when suggesting he could perform at full duty. Dr. Sokolowski obtained and relied upon objective medical evidence in reaching his conclusions. Dr. Bernstein reached ultimate conclusions and ignored evidence that did not support him. For these reasons, the Arbitrator finds the opinions of Dr. Sokolowski to be more persuasive than Respondent's expert.

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?***

Section 8(a) of the Act states a Respondent is responsible ..."for all the necessary first aid, medical and surgical services, and all necessary medical, surgical and hospital services thereafter incurred, limited, however, to that which is reasonably required to cure or relieve from the effects of the accidental injury..." A claimant has the burden of proving that the medical services were necessary and the expenses were reasonable. See *Gallentine v. Industrial Comm'n*, 201 Ill.App.3d 880, 888 (2nd Dist. 1990). The Arbitrator finds that medical services provided to Petitioner have been reasonable and necessary. Respondent has not paid all appropriate charges.

The outstanding medical charges are listed in Petitioner's Exhibit Number 7, which was admitted into evidence without objection by Respondent. Respondent

proffered no evidence to dispute the reasonableness and necessity of the treatment prior to the report of Dr. Bernstein which includes the outstanding charges of U.K. Family Practice in the amount of $2,480.00 and Golf MRI and Diagnostic in the amount of $3,433.00.

For the additional outstanding bills, Respondent relies on the opinions of Dr. Bernstein in its dispute. Given the Arbitrator's findings above, the Arbitrator relies on the opinions of Dr. Sokolowski and finds that this additional treatment was necessary and reasonably required to cure or relieve Petitioner from the effects of his injury. Specifically, Petitioner reported improvement following his injections that he received on July 16, 2018 performed by Dr. Sokolowski at AAKS Surgical. The continued follow up visits with Dr. Sokolowski after this injection, as well as the medication management, is also necessary and reasonable.

For these reasons, Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $8,860.00 to AAKS Surgical, $2,480.00 to Dr. Miroslawa A. Kuder, $3,433.00 to Golf MRI and Diagnostic, $5,700.00 to Mark A. Sokolowski, MD, and $294.88 to Prescription Partners, as provided in Sections 8(a) and 8.2 of the Act.

K. ***IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE?***

Section 8(a) of the Act entitles a claimant to compensation for all necessary medical, surgical, and hospital services "thereafter incurred" that are reasonably required to cure or relieve the effects of injury. Procedures or treatments that have been prescribed by a medical service provider are "incurred" within the meaning of the statute, even if they have not yet been paid. *Plantation Mfg. Co. v. Indus. Comm'n*, 294 Ill.App.3d 705, 710 (2nd Dist. 1997).

Petitioner is seeking prospective medical care pursuant to Section 8(a) of the Act. Dr. Sokolowski recommended a left sided L4-L5 epidural steroid injection as well as a cervical epidural injection. Petitioner's complaints have been consistent throughout his medical treatment. He has obtained significant results with prior treatment and the recommendation to attempt additional injections to alleviate his

complaints is reasonable. In fact, the right sided lumbar injection was effective in eliminating most of his right sided lumbar complaints.

The Arbitrator finds that Respondent shall pay for the injections as recommended by Dr. Sokolowski as well as the additional treatment necessary as recommended by Dr. Sokolowski associated with the injections.

L. ***IS PETITIONER ENTITLED TO ADDITIONAL TEMPORARY TOTAL DISABILITY BENEFITS?***

Petitioner claims to be entitled to temporary total disability benefits from October 11, 2017 to January 29, 2019, which represents 68 weeks.

A claimant is temporarily totally disabled from the time an injury incapacitates him from work until such time as he is as far recovered or restored as the permanent character of his injury will permit. *Westin Hotel v. Indus. Comm'n*, 372 Ill.App.3d 527, 542 (1st Dist. 2007). In determining whether a claimant remains entitled to receiving TTD benefits, the primary consideration is whether the claimant's condition has stabilized and whether he is capable of a return to the workforce. *Interstate Scaffolding, Inc. v. Illinois Workers' Comp. Comm'n*, 236 Ill.2d 132, 148 (2010). Once an injured employee's physical condition stabilizes, he is no longer eligible for TTD benefits. *Archer Daniels Midland Co. v. Indus. Comm'n*, 138 Ill.2d 107, 118 (1990).

Respondent denied liability for the period of June 30, 2018 through January 29, 2019 claiming Petitioner had reached maximum medical improvement and could return to work without restrictions. As stated above, the Arbitrator finds Petitioner's condition of ill-being, including his cervical and lumbar conditions, is causally related to his work accident of October 7, 2017. Petitioner is still off of work pursuant to the recommendations made by Dr. Sokolowski. Dr. Sokolowski's opinion is supported by the objective findings as delineated in the findings of the valid FCE completed at Vital Rehabilitation on August 14, 2018.

The Arbitrator finds that Petitioner is temporarily and totally disabled from October 11, 2017 through January 29, 2019 and entitled to TTD benefits. The

Arbitrator notes Respondent has already issued payment for the 37 3/7 week period of October 11, 2017 through June 29, 2018. Therefore, Respondent shall pay Petitioner for the additional disputed period of June 30, 2018 through January 29, 2019, which is an additional period of 30 4/7 weeks.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MAMTA M. DIXIT,
Petitioner,

vs. No. 12 WC 012483

TCF NAT'L BANK and THE HARTFORD FINANCIAL SERVICES GROUP, INC.,
Respondents.

ORDER OF DISMISSAL

A Petition for Review of the Arbitrator's February 21, 2018 Decision was filed on March 13, 2018 by Petitioner. However, because no Petition for Review was filed following the Arbitrator's issuance of his Corrected Decision on March 30, 2018, the Commission finds that it is without jurisdiction to consider Petitioner's March 13, 2018 Petition for Review. Therefore, the Petition for Review is dismissed.

Petitioner filed her Application for Adjustment of claim in this matter on April 10, 2012, seeking benefits for injuries she sustained in a car accident on December 29, 2011. The matter proceeded to final hearing on January 29, 2018, and the Arbitrator issued his decision on February 21, 2018. Petitioner, on February 27, 2018, timely filed a section 19(f) Motion to Recall and Correct Clerical Error to correct the maximum permanent partial disability rate that appeared in the Arbitrator's decision. While her section 19(f) motion was pending, on March 13, 2018, Petitioner filed a Petition for Review of the Arbitrator's Decision. On March 30, 2018, the Arbitrator granted Petitioner's section 19(f) motion and issued his Corrected Decision on April 4, 2018. No Petition for Review of the Corrected Decision was filed by either party.

The Commission's rules mandate that Petitions for Review shall be filed within the time provided by statute. 50 Ill. Admin. Code § 9040.10(a)(1) (2016). Under section 19(b) of the Act (820 ILCS 305/19(b) (West 2018)), an arbitrator's decision becomes the decision of the Commission and, in the absence of fraud, is conclusive unless a Petition for Review is filed by either party within 30 days after the receipt by such party of a copy of the arbitrator's decision. *Eddards v. Illinois Workers' Compensation Comm'n*, 2017 IL App (3d) 150757WC, ¶ 11. Absent

the filing of a timely Petition for Review, the Commission is without jurisdiction to review the arbitrator's decision. See *Wiscons v. Industrial Comm'n*, 176 Ill. App. 3d 898, 899 (1988).

Section 19(f) of the Act (820 ILCS 305/19(f) (West 2018)) provides the Commission with the authority to correct any clerical or computational errors. *Residential Carpentry, Inc. v. Kennedy*, 377 Ill. App. 3d 499, 503 (2007). An appeal from a decision of the Commission which is commenced prior to the resolution of a motion to correct is premature. *International Harvester v. Industrial Comm'n,* 71 Ill. 2d 180, 188 (1978). In cases where the Commission recalls a decision upon a motion to correct, the decision is not considered final and appealable until the corrected decision is issued; the time for review begins to run from the date of receipt of the corrected decision. See *Residential Carpentry, Inc.*, 377 Ill. App. 3d at 503; 820 ILCS 305/19(f) (West 2018) ("Where such correction is made the time for review herein specified shall begin to run from the date of the receipt of the corrected award or decision.") The issuance of a corrected decision renders the original decision a nullity. See *Garcia v. Industrial Comm'n*, 95 Ill. 2d 467, 468 (1983).

As the Illinois Appellate Court has noted, "[t]he cases are legion that hold that the failure to strictly comply with sections 19(b) and 19(f) of the Act deprives the Commission and the courts of subject matter jurisdiction." *Eschbaugh v. Industrial Comm'n*, 286 Ill. App. 3d 963, 966 (1996) (and cases cited therein).

In this case, Petitioner's Petition for Review, filed on March 13, 2018, sought review of the Arbitrator's Decision which was entered and received by Petitioner on February 21, 2018. The Arbitrator's granting of Petitioner's section 19(f) motion and issuance of a corrected decision on April 4, 2018 rendered the original decision a "nullity." Because Petitioner failed to file a Petition for Review within 30 days after the Corrected Decision was received, that decision became a final order of the Commission, and the Commission is without jurisdiction to consider Petitioner's Petition for Review.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's Petition for Review filed March 13, 2018 is hereby dismissed.

DATED: JUL 1 - 2020

Marc Parker

Barbara N. Flores

Kathryn A. Doerries

o-06/18/20
MP-dak
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STATE OF ILLINOIS)	☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
) SS.	☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
COUNTY OF COOK)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
		☐ PTD/Fatal denied
	☒ Modify Down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

KAREN STROWDER,

Petitioner,

vs. NO: 18 WC 12499

SPEEDWAY,

Respondent.

20IWCC0378

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 disability, permanent disability, and medical expenses, 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 award of permanent partial disability benefits representing a 3% loss of the person as a whole. Petitioner's direct testimony regarding her current condition is minimal. When asked how her pain and injuries affect her daily work life, Petitioner testified only about "[t]he pain and squatting down in certain areas." On cross-examination, Petitioner was asked about the emergency department records indicating a headache and facial contusion, for the purpose of highlighting that those records do not mention pain in Petitioner's neck, shoulder, and arms, and that X-rays of Petitioner's knee were not obtained at the emergency room.

Petitioner was also cross-examined regarding her Application for Adjustment of Claim, at which point her counsel moved to amend the application. Following a colloquy on the question, Petitioner's counsel stated that he sought to amend the application to include the right knee. The Arbitrator did not expressly rule on the motion, but ultimately stated:

> "I've already said that you're claiming injury to the knee. Obviously[,] you've been asking questions about the knee. So that issue will be included as

part of the nature and extent, but you can certainly ask whether or not the original application included a reference to the knee."

Petitioner later testified that on June 27, 2018, the only complaint she had was regarding her knee. Indeed, the transcript quotes the Section 12 report by Dr. Bryan Neal, indicating that Dr. Neal asked Petitioner about specific areas other than the right knee and Petitioner denied current neck pain, low back pain, hip pain, or forearm pain. During the hearing, Petitioner disputed only the denial of the back pain, which she claimed she had "sometimes." However, a low back injury was not alleged in Petitioner's Application for Adjustment of Claim.

The parties and the Arbitrator proceeded through the hearing as though an express grant had been made of Petitioner's oral motion to amend the application for adjustment of claim with regard to the right knee only. Petitioner was also questioned and cross-examined about symptoms and treatment to other body parts that may have been affected at the time of her accident at work. Notwithstanding whether Petitioner's motion to amend was expressly granted, which the Commission finds was implicitly done given the colloquy at arbitration, Petitioner failed to present any evidence regarding residual symptoms or pathology subsequent to her accident establishing that she suffers from permanent partial disability related to any body parts other than the right knee. Thus, given this record, the Commission concludes that Petitioner failed to prove permanent partial disability with respect to body parts other than her right knee.

In all other respects, the Commission affirms and adopts the Decision of the Arbitrator.

IT IS FOUND BY THE COMMISSION that Petitioner proved her current condition of ill-being is causally connected to the accident in this case.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $330.00 per week for the period of April 20, 2018 through June 11, 2018, a period of 7 and 4/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay Petitioner's reasonable and necessary medical bills of: AMCI; MRI-MRAD Imaging; Elite Orthopedics; EQMD; and Petitioner's public aid lien, if previously unpaid and not written off, as listed in Petitioner's Exhibit No. 6, pursuant to the fee schedule and §§8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $330.00 per week for a period of 16.125 weeks, as provided in §8(e)(12) of the Act, for the reason that the injuries sustained caused a 7.55% loss of use of Petitioner's right leg.

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

20 IWCC0378

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $21,300.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUL 1 - 2020
d: 6/29/20
BNF/kcb
045

Barbara N. Flores

Deborah L. Simpson

Concurrence in Part and Dissent in Part

I concur with the Majority's decision to affirm the Arbitrator's Decision as it relates to Petitioner's knee condition. I dissent, however, from the Majority's decision to reverse the Arbitrator's nominal award of three percent of the person as a whole for Petitioner's other injuries.

In addition to her knee injury, Petitioner sustained a closed head injury, a left shoulder strain and a lumbar strain. The Arbitrator's Decision regarding these other injuries is clearly supported by Petitioner's medical records and testimony. Indeed, the emergency department records from April 21, 2018 focused on Petitioner's closed head injury and facial contusion. On April 30, 2018, Petitioner complained of intermittent headaches and rated her pain as 6/10, located over the entire head. Petitioner rated her low back pain as an 8 and stated it increased with sitting and standing. She rated her left shoulder pain up to a 4, which increased with use of the arm, lifting, and carrying. On May 29, 2018, Petitioner reported intermittent headaches and continued daily low back pain rated up to a 5 on the pain scale. While Petitioner reported that her headaches and low back pain had improved in June, her treatment records do not indicate that Petitioner's condition aside from her knee had resolved.

I would have affirmed the Arbitrator's Decision in its entirety. Therefore, I respectfully concur in part and dissent in part with the Majority's decision.

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

STROWDER, KAREN
Employee/Petitioner

Case# **18WC012499**

SPEEDWAY
Employer/Respondent

20IWCC0378

On 11/20/2018, 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 2.45% 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:

6184 LAW OFFICES OF GERALD F CONNOR
222 W MERCHANDISE MART
CHICAGO, IL 60654

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

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Karen Strowder,
Employee/Petitioner

v.

Speedway,
Employer/Respondent

Case # **18** WC **12499**

Consolidated cases: _____

20IWCC0378

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Robert M. Harris**, Arbitrator of the Commission, in the city of **Chicago**, on **9/27/18**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **4/20/18**, 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 $ **N/A**; the average weekly wage was $**330.00**.

On the date of accident, Petitioner was **45** years of age, ***single*** with **9** dependent children.

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

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

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

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

ORDER

Respondent shall pay Petitioner $13,376.62 in medical benefits as found in Petitioner's Exhibit No. 6 pursuant to Section 8(a) and the Section 8.2 Commission medical fee schedule.

Respondent shall pay Petitioner temporary total disability benefits pursuant to Section 8(b) of the Act for the period of April 20, 2018 through June 11, 2018, a period of 7-4/7 weeks, at the minimum TTD weekly benefit rate of $330.00.

Respondent shall pay Petitioner permanent disability benefits for the permanent partial loss of use of the right leg under Section 8(e)12 to the extent of 7.5% thereof, or 16.125 weeks of compensation, at the minimum PPD benefit rate of $330.00.

Respondent shall Petitioner permanent disability benefits for the permanent partial loss of use to the man as a whole under Section 8(d)2 to the extent of 3% thereof, or 15 weeks of compensation, at the minimum PPD rate of $330.00, covering the combined injuries of post-traumatic headache, lumbar sprain, and left shoulder sprain.

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

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

Robert M. Harris

Robert M. Harris, Arbitrator
Dated: November 20, 2018

20 IWCC0378

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner currently works as a cashier for Respondent. On 4/20/18, Petitioner slipped and fell on a wet floor while mopping.

On 4/21/18, Petitioner presented to the ER of Provident Hospital. The record states, "she slipped on the wet pavement and hit her head on the way down." (P. Ex. 1). X-rays were obtained and Petitioner was advised to follow up with her primary care provider. (P. Ex. 1).

On 4/25/18, Petitioner followed up with her primary doctor and Englewood Medical Center. Petitioner again described the fall at work, was taken off work, and was advised to follow up with a specialist. (P. Ex. 2).

On 4/30/18, based on the referral, Petitioner presented to treating physician Dr. Foreman of Beverly Park Medical Center. The record states, "The patient was working on duty as a cashier for Speedway. She slipped on a wet floor and fell forward to the ground, striking her head against a door as she fell." (P. Ex. 3). Petitioner was diagnosed with post traumatic headache, lumbar sprain, left shoulder sprain, and right knee sprain (later revealed to be two tears) (P Ex. 3). Petitioner was advised to remain off work at that time a course of regular therapy was conducted at Beverly Park Medical Center 2-3 days per week. (P. Ex. 3).

On 6/8/18, based on Dr. Foreman's referral, Petitioner underwent an MRI of the right knee. The right knee MRI indicated multiple findings, including, "Radial tear through the posterior horn of medical meniscus, at least partial thickness tear of the anterior cruciate ligament, moderate joint effusion and extensive edema within the patella…"(P. Ex. 4). Regarding these MRI findings, on June 11, 2018 Dr. Foreman in his office visit notes opined that the "MRI findings are causally related to the incident noted in the initial visit. The patient may require surgery." (P. Ex. 3). Dr. Foreman released Petitioner to return to regular duty work per patient request. On 6/11/18, also

based on the MRI results, Dr. Foreman referred Petitioner to Dr. Sompalli of Elite orthopedics (P. Ex. 3).

On 6/26/18, based on the referral, Petitioner presented to Dr. Sompalli. Dr. Sompalli performed an injection on the right knee. Petitioner continued to work full duty.

On 6/27/18, a Section 12 examination was performed at Respondent's request by Dr. Bryan Neal, who only examined Petitioner's knee injury and did not opine on the other injuries. Dr. Neal opined the right knee condition was preexisting because in 2009, 9 years before the date of accident at issue, Petitioner injured her right knee. Petitioner testified that she has had no other medical treatment for her right knee since 2009 and did not undergo surgery for the 2009 accident. (R. Ex. 2).

Petitioner is 45 years old, has only a high school education, and works as a cashier. Presently, Petitioner still works for Respondent as a cashier and testified that the injuries currently have a daily impact on her job duties such as reaching, squatting, and lifting.

CONCLUSIONS OF LAW

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

Based on Petitioner's trial testimony and a review of the entire record, the Arbitrator finds and concludes Petitioner's current condition of post traumatic headache, lumbar sprain, left shoulder sprain, and right knee tears (P Ex. 3) are causally related to the accident. However, Petitioner's conditions of post traumatic headache, lumbar sprain and left shoulder are minimal in nature and do not require any further medical treatment.

The work accident directly aggravated/accelerated Petitioner's undisputed pre-existing knee condition, causing new and far more serious symptoms, the need for an MRI, **new findings on the MRI**, and directly necessitating the time off from work and the need for new medical

treatment incurred, year after any prior knee treatment. Petitioner's pre-existing knee condition was basically asymptomatic for several years and was so shortly before the accident. The preponderance of the evidence leads to the conclusion that Petitioner became far-more symptomatic and needed medical treatment and the MRI ***only after the work accident.***

The Arbitrator does not adopt the opinions of Respondent's Section 12 examiner Dr. Neal who finds no causation, as he places far too much emphasis on the mere fact of Petitioner's undisputed pre-existing condition, some knee symptoms in the year prior to this accident, and occasionally takin Naprosyn, but does not place sufficient emphasis on the clear ***increase*** in her symptoms, the need for medical treatment and the significant findings on the MRI all of which was not needed until ***after*** the work accident, including an injection. Dr. Neal ***did not opine*** that any of the medical treatment Petitioner received was excessive or unreasonable. Further, Dr. Neal also did not specifically offer any explanation or specifically opine that the objective findings noted on the MRI (such as the tears) also pre-existed the work accident (other than the MRI showed pre-existing osteoarthritis). It is obvious Dr. Neal downplayed the significance of the MRI findings, both from a causation standpoint and the nature of the condition. The Arbitrator finds it highly dubious that if the tears and other findings on the MRI pre-existed the accident (as Dr. Neal opines) this did not also cause Petitioner to seek medical treatment - ***she only sought treatment after her fall. Dr. Neal does not comment on this paradox.*** Clearly the fall triggered new symptoms, new conditions and the need to seek medical treatment.

Lastly, Dr. Neal also opined as to Petitioner's post-traumatic headache, lumbar sprain, left shoulder sprain as diagnosed by Dr. Foreman (what Dr. Neal called "soft tissue strains and contusions") and opined "they have completely resolved to an asymptomatic state." This opinion the Arbitrator finds more persuasive.

With respect to issue J, were the medical services that were provided to Petitioner reasonable and necessary and has Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator find as follows:

The Arbitrator adopts the conclusions in part (F) above. The Arbitrator again notes Dr. Neal ***did not opine*** that any of the medical treatment Petitioner received was excessive or unreasonable. As the Arbitrator has found causation, Respondent is responsible for payment the following medical bills pursuant to the fee schedule:

1) Provident Hospital	Paid by Public Aid
2) Englewood Medical Center	Paid by Public Aid
3) AMCI	$7,059.00.62
4) MRI-MRAD Imaging	$1,600.00
5) Elite Orthopedics	$335.00
6) EQMD	$2,733.10
7) Public Aid Lien	$1,649.52
TOTAL:	**$13,376.62**

With Respect to issue K, what temporary benefits are in dispute, the Arbitrator finds and concludes as follows:

The Arbitrator adopts the conclusions in part (F) above. Therefore, Respondent shall pay Petitioner temporary total disability benefits for the period 4/20/18 thru 6/11/18 or 7-4/7 weeks at the minimum TTD rate of 330.00. Petitioner was released to unrestricted full duty as of June 11, 2018.

With Respect to issue L, what is the nature and extent of the injury, the Arbitrator finds and concludes as follows:

Pursuant to Section 8.1b of the Act, five factors are considered when nature and extent of an injury is considered. Petitioner suffered post traumatic headache, lumbar sprain, left shoulder sprain, and right knee tear. Petitioner had a positive MRI and underwent one injection to the right knee.

With regard to subsection (i), the Arbitrator gives no weight to this factor as no AMA impairment report was submitted.

20 IWCC0378

With regard to subsection (ii), the occupation of the employee, the Arbitrator notes the Petitioner works as a cashier and has a high school education. The Arbitrator gives greater weight to this factor.

With regard to subsection(iii), the age of the employee, the Arbitrator notes Petitioner was only 45 years old and has a longer work life expectancy than that of older workers. *See Flexible Staffing Services v. Illinois Workers' Compensation Comm'n*, 68 N.E 3d 846 (1st Dist. 2016).

With regard to subsection (iv) future earnings capacity, the Arbitrator notes that Petitioner works a labor related job and has only labor related job experience. However, no evidence was offered regarding any decrease in Petitioner's earning capacity due to the accident. The Arbitrator gives minimal weight to this factor.

With regard to subsection (v), evidence of disability corroborated by medical records, the Arbitrator notes that Petitioner's testimony was corroborated by the medical records of the treating physician, Dr. Foreman. (P. Ex. 3). On 6/8/18, Petitioner underwent an MRI of the right knee which indicated multiple findings, including, "Radial tear through the posterior horn of medical meniscus, at least partial thickness tear of the anterior cruciate ligament, moderate joint effusion and extensive edema within the patella…"(P. Ex. 4). Dr. Foreman noted the patient may require surgery." (P. Ex. 3). The Arbitrator places greatest weight on this factor.

Given the analysis above, the Arbitrator finds and concludes Petitioner sustained the permanent partial loss of use of her right leg under Section 8(e)12 to the extent of 7.5% thereof, or 16.125 weeks of compensation, and the permanent loss of use to the man as a whole under Section 8(d)2 to the extent of 3% thereof, or 15 weeks of compensation, covering the combined injuries of post-traumatic headache, lumbar sprain, and left shoulder sprain.

20IWCC0378

Robert M. Harris

Robert M. Harris, Arbitrator

Dated; November 20, 2018

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Dawn E. Retherford,

Petitioner,

vs. NO: 16 WC 00742

Wahl Clipper,

Respondent.

20IWCC0379

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, medical expenses, permanent partial disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 12, 2017, is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $40,400.00. 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.

20IWCC0379

DATED: JUL 1 - 2020
o060420
BNF/mw
045

Barbara N. Flores

Marc Parker

DISSENTING IN PART, CONCURRING IN PART

I concur with the Decision of the majority on all issues except for the nature and extent of Petitioner's right wrist injury. As to the award of permanent partial disability benefits, I respectfully dissent from the Decision of the majority and would have found that Petitioner sustained a 30% loss of use of her right hand as a result of the work injury.

After being released to full duty without restrictions, Petitioner returned to her regular job duties in June of 2015. However, in response to her complaints of increased symptoms, Respondent moved her to a light duty position in a different department shortly thereafter. Although Petitioner has worked in that light duty position ever since, she was medically released to her regular full duty job. Petitioner has not required further treatment for the right wrist injury since her final visit with Dr. Cobb on November 30, 2015. At that time, Petitioner rated her wrist pain as a 0/10 at rest and a 4/10 with activity. She further reported that the previously identified mass was gone and its associated pain had resolved. Dr. Cobb released Petitioner to return on a p.r.n. basis. At the time of the hearing, Petitioner testified that she had no other medical appointments scheduled for her right wrist and was not taking any prescription medication.

Given that Petitioner was released to full duty without restrictions, does not require ongoing prescription medication, and has not sought treatment since November of 2015, I would have found that Petitioner established permanent partial disability of 30% loss of use of the right hand. I would have modified the award accordingly while still accounting for Respondent's credit of 25% loss of use of the right hand for the prior award in 04 WC 8597.

DLS/met
46

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

RETHERFORD, DAWN E Case# **16WC000742**

Employee/Petitioner

WAHL CLIPPER

Employer/Respondent

20IWCC0379

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

If the Commission reviews this award, interest of 1.46% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0021 REESE & REESE
TODD S REESE
979 N MAIN ST
ROCCKFORD, IL 61103

1408 HEYL ROYSTER VOELKER & ALLEN
KEVIN J LUTHER
120 W STATE ST 2ND FL
ROCKFORD, IL 61105

20 IWCC0379

STATE OF ILLINOIS)
)SS.
COUNTY OF Rock Island)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Dawn E. Retherford
Employee/Petitioner

v.

Wahl Clipper
Employer/Respondent

Case # **16** WC **00742**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael Nowak**, Arbitrator of the Commission, in the city of **Rock Island**, on **4/5/17**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **6/18/14**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**43,171.66**; the average weekly wage was $**852.52**.

On the date of accident, Petitioner was **41** years of age, ***single*** with **1** dependent child.

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

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

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

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

ORDER

Respondent shall pay reasonable and necessary medical services of $**29,560.48**, as set forth in Petitioner's exhibits 5 - 8, as provided in Sections 8(a) and 8.2 of the Act.

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

Respondent shall pay Petitioner temporary total disability benefits of $**568.35**/week for **3/7** weeks, commencing **12/30/14** through **1/4/15**, as provided in Section 8(b) of the Act.

Based on the factors enumerated in §8.1b of the Act, which the Arbitrator addressed in the attached findings of fact and conclusions of law, and the record taken as a whole, Respondent shall pay Petitioner the sum of $**511.51**/week for a further period of **20.5** weeks (71.75 weeks less credit for 25% of the right hand 51.25 weeks in the previous award 04 WC 8597), as provided in Section **8(e)** of the Act, because the injuries sustained caused **35% loss of use of the right hand**.

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

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

Michael K. Nowak, Arbitrator

11/28/17
Date

FINDINGS OF FACT

The Petitioner, Dawn Retherford, testified that she has been working for Respondent, Wahl Clipper, for approximately 20 years. Wahl Clipper is a manufacturer of hair clippers. Petitioner testified that she began and continued working at Wahl Clipper doing "piece-work" as an assembler of the clippers. She testified that she worked 10 hours a day for 5-6 days a week. Petitioner received two ten minute breaks and a thirty minute lunch break. Petitioner has a prior claim involving the right hand (04 WC 8597) and was awarded 25% loss of use of the right hand.

Petitioner testified to her "piece-work" duties as an assembler and that her wages were determined on the amount of piece-work she was able to complete besides her hourly rate. Petitioner's wages would increase based on her production above the minimum rates required. She worked in two different piece-work assembly jobs and both jobs had minimum rates that were required. The first job was called "arm assembly." This job involved putting together a part of the trimmer with screws and rivets. The part would be placed in a mold that was called a "spoon" and then placed in a die-press. Once the die-press completed the riveting process, the spoon with the assembled part was taken out of the press and the part was removed from the spoon and the process would begin again. Petitioner testified that the spoon weighed about two and one-half pounds. The rate for this job was 216 per hour. Petitioner testified that she regularly exceeded her rate and would average between 250 and 300 per hour. The second piece-work assembly job was called Mold Arms. This job involved getting the assembled arms from the first job and placing them in a molding press. Once the part was molded, she would remove the part and use a utility knife with her right hand to trim the excess flashing from the part and then place the part in a pan. The rate for this job was 432 per hour. She testified that she would regularly exceed the minimum rate and would average over 500 per hour. Petitioner's testimony was unrebutted. The Arbitrator finds Petitioner credible.

Petitioner testified that prior to the current claim she was performing both piece-work assembly jobs in 2001 when she sustained injury to her right wrist. She sought treatment with Dr. Tyson Cobb and underwent right wrist surgery in 2004. Petitioner completed her treatment in 2004 and returned to her piece-work assembly jobs. Petitioner testified that between 2004 and the current work accident on 6/18/14 she had no further treatment to the right wrist, that she had no work restrictions and that she was working full unrestricted piece-work as an assembler in the same jobs that she been working. The Arbitrator notes that no evidence of treatment or continued right hand/wrist complaints was offered from 2005 to the current accident date of 6/18/14. The Arbitrator finds Petitioner uncontradicted and credible.

On 6/18/14, Petitioner testified she was performing her piece-work assembly job with the Arm Assembly. She testified that as she was doing this job, she grabbed the weighted "spoon" with the part that was just put through the press and she immediately noticed weakness and a burning pain in her right wrist and hand. She immediately notified her supervisor, Robbie Stevens, and she was advised to report to the company nurse. She reported to the nurse and the nurse drove her to Now Care (PX 1) for evaluation and treatment.

On 6/18/14, Petitioner was seen at Now Care (PX 1) complaining of a right wrist injury with an onset of 2 hours prior. Petitioner related pain and a pinching sensation when she tried to grasp or grip something with her right hand. Petitioner related the work accident when she felt discomfort in her right wrist when she tried to grab

a tool (spoon) at work and she could not maintain the grasp. She reported that the pain was sharp and burning. On examination, she had a positive fovea sign of the right wrist. She was diagnosed with a wrist sprain and possible TFCC inflammation or small tear. She was placed on work restrictions of no repetitive use of the right hand and no lifting greater than one pound, and also given a Velcro wrist splint to use at work. Petitioner followed up at Now Care on 6/25/14 and indicated that she had not had any improvement. She requested a referral to Dr. Tyson Cobb. Petitioner testified that Dr. Cobb had performed her previous surgery in 2004 and she was more comfortable with his care and treatment since he was already familiar with her right hand/wrist. She was continued on the same restrictions until she could be seen by Dr. Cobb.

On 7/1/14, Petitioner testified and the medical records reflect that she presented to Dr. Tyson Cobb at Orthopedic Specialists. (PX 2). Petitioner related the work accident on 6/18/14 when she grabbed the "spoon" which weighed about two and one-half pounds and she had immediate onset of ulnar-sided wrist pain. Dr. Cobb diagnosed a questionable TFCC tear and recommended an MRI of the right wrist. On 7/14/14, the MRI of the right wrist/hand was obtained. Petitioner followed up with Dr. Cobb and the diagnosis was a re-tear of the TFCC of the right wrist. She was allowed to return to work with the splint and the injury would be monitored.

On 8/6/14, Petitioner followed up with Dr. Cobb and noted difficulty with range of motion while at work while wearing the wrist splint. She was given a different wrist splint. Dr. Cobb performed a cortisone injection. On 8/21/14, Petitioner testified and Dr. Cobb's records reflect that the cortisone injection did not help. Surgery in the form of a repeat wrist scope with TFCC debridement and denervation was discussed as an option for treatment. Petitioner had undergone a similar procedure with Dr. Cobb back in 2004. Petitioner was not sure that she wanted to undergo surgery and wished to think about her options. On 9/30/14, Petitioner was seen again by Dr. Cobb and indicated her frustration with the lack of progress and no improvement. Petitioner agreed to proceed with surgery.

On 10/16/14, Respondent had Petitioner examined, pursuant to Section 12, by Dr. Michael Vender.

On 12/30/14, Petitioner underwent right wrist surgery. Dr. Cobb performed a right wrist arthroscopy with debridement of a partial scapholunate ligament tear and synovectomy, debridement of a triangular fibrocartilage complex (TFCC) tear, arthroscopic resection of the distal ulna, and partial wrist denervation including anterior interosseous nerve, posterior interosseous nerve and articular branches of superficial branch of radial nerve.

On 1/5/15, Petitioner was seen for her first postoperative appointment with Dr. Cobb. She noted right wrist pain as burning and throbbing and rated her pain as 4/10 at rest and 6/10 with activity. She was given a prescription for a new splint, prescribed physical therapy and given work restrictions of no use of the right hand. Petitioner returned to work on 1/5/15 with restrictions and began her physical therapy on 1/7/15 at Plaza Physical Therapy (PX 4). On 2/4/15, Petitioner was seen in follow up and indicated that she was very happy to have proceeded with surgery and felt she was improving, but she continued to experience burning and aching pain in the right wrist. Petitioner continued her follow up care with Dr. Cobb and on 6/8/15 Petitioner testified and the medical records reflect that she had returned to her regular job but she had some wrist swelling within three days of working the piece-work assembly job. Petitioner testified that she and the employer mutually agreed that she move to a different department that was easier on her wrist. Petitioner advised Dr. Cobb of her

new job responsibilities and she was allowed to return to that work without restrictions. Dr. Cobb advised that she would continue to have good days and bad days, but would gradually improve with respect to function over the next four to six months. Petitioner was advised to return to Dr. Cobb if any worsening of problems or as needed.

On 10/8/15, Petitioner testified and the medical records reflect that she returned to Dr. Cobb because of right wrist pain and swelling. She noted that over the last week or so she was cutting a lot of boxes with a box cutter at work and noticed increased pain and swelling in the right wrist. She also noticed a mass that had developed in her right wrist. Dr. Cobb indicated that it is normal for her to have occasional flare-ups of pain in the right wrist for some time after surgery, especially when starting a new or different wrist activity. With regards to the mass, it was quite tender and Dr. Cobb felt that an MRI should be obtained. Dr. Cobb also recommended that she continue to wear her wrist splint, but Petitioner indicated that the splint increased her pain due to the presence of the mass. On 10/15/15, the MRI of the right wrist was obtained and Petitioner followed up with Dr. Cobb on 10/20/15. The MRI showed an inflammatory process with some edema and what appeared to be a small ganglion cyst in the volar radial aspect of her wrist. Petitioner indicated pain as 0/10 at rest and 4/10 with activity intermittently. Dr. Cobb discussed the option of another cortisone injection and also possible surgical excision. However, the ganglion cyst seemed to be getting better and it was decided to just give some additional time to monitor.

On 11/30/15, Petitioner was seen for the last time by Dr. Cobb. She complained of continued dull pain in the right wrist that occurs with activities. She also complained of stiffness in the wrist that occurs in the morning and that the wrist would "pop" on occasion. Her symptoms were relieved with non-steroidal anti-inflammatory medication and rest. On examination, the mass that was present on the volar aspect of the right wrist was now gone and she had no tenderness present. Dr. Cobb released Petitioner from treatment on a prn basis.

The Respondent introduced the evidence deposition of their Section 12 examiner, Dr. Michael Vender (RX 2). Dr. Vender obtained a history from Petitioner that, "As she was performing her normal work activities she stated that she noted a pinching and burning sensation along the ulnar aspect of her wrist." (p. 11, lines 2-6). Dr. Vender was not provided a job description by the Respondent. (p. 16, lines 13-16). Dr. Vender did not inquire about Petitioner's normal job duties. Dr. Vender does not know what Petitioner's normal work duties are (p. 20, lines 3-12). On examination, Dr. Vender confirmed that petitioner had visible prominence of her distal ulna more so on the right than the left, that the range of motion of the right wrist had less flexion as compared to the left, that supination and pronation on the right was mildly decreased as compared to the left, and that there was tenderness to palpation along the ulnar aspect of her right wrist. (p. 12, lines 4-11, p. 19). Dr. Vender opined that Petitioner's right wrist condition was a continuation of the same problem that she underwent surgery for 10 years prior. (p. 13, lines 10-13). Dr. Vender agreed that further treatment was reasonable (p. 18, lines 15-17, p. 21) and that arthroscopy of the right wrist was reasonable. (p. 14, lines 21-24, p. 21).

Petitioner presented the evidence deposition of Petitioner's treating physician and surgeon, Dr. Tyson Cobb. (PX 11). Dr. Cobb did his orthopedic residency at Mayo Clinic and is board certified in orthopedic surgery. (p. 4). Dr. Cobb had previously treated Petitioner back in 2004, performed right wrist surgery on 9/20/2004, released Petitioner without restrictions approximately 3 months postop and had not seen Petitioner

until the current treatment starting on 7/1/14. (p. 6-8). Dr. Cobb obtained a detailed history of the current work accident on 6/18/14. (p. 8). Dr. Cobb was also provided a detailed hypothetical of Petitioner's work duties. (pp 12-14). Dr. Cobb took Petitioner to surgery on 12/30/14 for her right wrist and last saw Petitioner on 11/30/15. Dr. Cobb disagrees with Respondent's examiner, Dr. Vender, that Petitioner's current right wrist conditions of ill-being are continued residuals of the prior 2004 surgery that was 10 years ago. (pp. 20-21). Dr. Cobb opined that Petitioner's treatment and surgery were reasonable and necessary. (p. 16, 21). Dr. Cobb also opined that the treatment and surgery were related to the current 6/18/14 work accident. (pp. 14, 16, 21). Dr. Cobb also authored an opinion letter relating Petitioner's right wrist condition of ill-being to the work accident on 6/18/14 (PX 11, exhibit 4). The Arbitrator finds Dr. Cobb's testimony more persuasive than that of Dr. Vender.

Petitioner testified as to what she currently notices about her right hand/wrist. She testified that she is no longer able to perform the piece-work as an assembler. She had tried to return to those jobs, but her right hand/wrist became irritated and swollen. She has been placed in a permanent job position by the Respondent that involves no piece-work and is less labor intensive than the assembly positions. She is no longer able to increase her wages by exceeding the piece-work rates because she is strictly hourly now. She testified that she continues to notice at work that her right hand/wrist is weaker when she has to lift items. After a long day, she will notice aching. She continues to wear an elastic type glove three to five days per week because it provides extra support for her wrist. She continues to notice achiness off and on. On bad days, she will use ibuprofen. She testified that at home she has difficulty doing the regular duties around the house and yard. If she rakes the yard, then she will experience pain and swelling that is worse the next day. She is not able to use the push lawn mower because of the vibration through her right hand. She needs to limit the amount of time that she does anything physical around the house, such as folding laundry, doing dishes or carrying items. She also testified that she experiences stiffness and achiness with weather changes, especially cold weather. The Arbitrator finds Petitioner credible.

CONCLUSIONS

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

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

The Arbitrator incorporates his above findings.

Based upon the totality of the evidence, the credible and unrebutted testimony of the Petitioner, the medical records, and the persuasive testimony of Dr. Cobb, the Arbitrator finds that Petitioner did sustain an accident on 6/18/14, which arose out of and in the course of her employment and that her right hand conditions of ill-being are causally related to the work accident on 6/18/14.

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

The Arbitrator incorporates his above findings with respect to the Respondent's liability for medical bills. Respondent's only objection to awarding medical bills to Petitioner was one of liability. The medical bills are contained in the record as Petitioner's Group Exhibit 2 (PX 5 through 8).

Given the findings set forth above, the Arbitrator finds that the Respondent is ordered to pay to the Petitioner amounts for the medical related to the care, diagnosis and treatment, pursuant to Sections 8(a) and 8.2 of the Act.

Respondent shall pay reasonable and necessary medical services of $29,560.48, as set forth in Petitioner's exhibits 5 - 8, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Issue (K): What temporary benefits are in dispute?

The Arbitrator incorporates his above findings. The Arbitrator finds from the evidence and Dr. Cobb's records that Petitioner was taken off work on 12/30/14 and returned to work on 1/5/15. Accordingly, the Respondent is liable for TTD payments for a period of 6/7 weeks, less the statutory 3 day waiting period.

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

The Arbitrator adopts and incorporates all the above findings of fact and conclusions of law into these findings.

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

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

With regard to subsection (ii) of Section 8.1(b), the occupation of the employee, the Arbitrator notes that for over 20 years Petitioner was working in a very repetitious job as an assembler that involved constant use of her hands. Since returning to work, Petitioner was unable to continue in the piece-work assembly jobs that she had done for 20 years and was moved into a permanent position that did not involve piece-work and was less physically demanding. Despite the less physical nature of Petitioner's current job duties, she continues to experience weakness and pain and continues to use an elastic wrap for wrist support. Therefore, the Arbitrator gives *some* weight to this factor.

With regard to subsection (iii) of Section 8.1(b), the age of the employee at the time of the injury, the Arbitrator notes that Petitioner was 41 years old at the time of the accident. Because the Petitioner has an extended period of work life left and has to deal with the ongoing disability, the Arbitrator gives *some* weight to this factor.

With regard to subsection (iv) of Section 8.1(b), petitioner's future earnings capacity, the Arbitrator notes that for 20 years Petitioner was working a piece-work assembly job and her wages would increase with the

increase in her production. Petitioner has now been unable to continue in the piece-work assembly jobs and was moved into a permanent position that did not involve piece-work. Petitioner no longer has the opportunity for increased wages based on her production rate. Therefore, the Arbitrator gives *some* weight to this factor.

With regard to subsection (v) of Section 8.1(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that Petitioner sustained a retear of the triangular fibrocartilage complex (TFCC) in the right wrist. Petitioner underwent surgery on 12/30/14 by Dr. Cobb who performed a right wrist arthroscopy with debridement of a partial scapholunate ligament tear and synovectomy, debridement of a triangular fibrocartilage complex (TFCC) tear, arthroscopic resection of the distal ulna, and partial wrist denervation including the anterior interosseous nerve, posterior interosseous nerve and articular branches of the superficial branch of radial nerve. Petitioner followed-up postoperatively with Dr. Cobb and was ultimately returned to full duty work on 6/8/15. Just prior to then, Petitioner had attempted to return to her regular piece-work assembly jobs, but after three days she had increased swelling of the wrist. Petitioner and Respondent mutually agreed that Petitioner would be placed in a permanent position in a different department. Petitioner subsequently developed a mass in her right wrist that did end up going away for the most part. Petitioner was last seen by Dr. Cobb on 11/30/15 and noted that she continued to have complaints of dull aching pain. Petitioner testified that she continues to notice dull aching pain, weakness, weather sensitivity and pain with extended activities. The Arbitrator finds that the evidence of disability is corroborated by the treating medical records and gives *greater* weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator concludes that Petitioner is now permanently and partially disabled to the extent of 35% loss of use of the right hand as provided in Section 8(e) of the Act. The parties agreed that Petitioner received a prior award(s) regarding his right hand. The award(s) totaled 25% loss of use of the right hand. The result of applying that credit is that Respondent shall pay Petitioner an additional 10% loss of use of the right hand on account of the current claim.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

WAYNE CHOLEWIAK,

Petitioner,

20IWCC0380

vs. NO: 16 WC 23150

XPO LOGISTICS FREIGHT, INC.;
INDEMNITY INSURANCE
COMPANY OF NORTH AMERICA,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of medical expenses and nature and extent, and being advised of the facts and law, affirms the the Decision of the Arbitrator, which is attached hereto and made a part hereof, but makes the following additional findings to correct a clerical error and further explain the decision.

The Commission agrees with the Arbitrator's analysis of the first four permanent partial disability factors in §8.1b(b) of the Act. However, for the fifth factor, the Arbitrator wrote:

> With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes. [sic: sentence ends abruptly] This factor tends to show a somewhat greater degree of permanency given Petitioner does have ongoing complaints. *Dec. 7.*

Due to this clerical error, we do not know what the Arbitrator intended to write following, "the Arbitrator notes." Therefore, since it is not clear why this factor should lead to a greater degree of permanency other than "Petitioner does have ongoing complaints," we make the following findings regarding subsection (v).

20IWCC0380

Based on the most recent medical records, it appears Petitioner obtained an excellent result from his rhizotomy. The last work conditioning note, on July 21, 2016, indicates Petitioner still had 1-out-of-10 pain, but 100% of his goals were achieved and his "familiar back and leg symptoms have not returned." Petitioner's last visit with Dr. Salehi, on July 22, 2016, mentions Petitioner felt "sore" after two weeks of work conditioning but had "no recurrent low back pain." Petitioner was not taking any medications and denied any leg pain, paresthesias or weakness. His lumbar examination was essentially normal.

Although Petitioner testified that he "at times" feels pain at work, he did not know if it was from "the procedure [rhizotomy] or not." *T.20.* He testified, "Like I said, my job is physical. So sometimes, it could just be my back muscle or something, but I just get nervous when that happens." *Id.* However, he did not experience this type of pain prior to his work injury. *T.21.*

The Commission gives this factor some weight in support of a greater degree of permanency. With these additional findings to correct the clerical error, we agree that Petitioner is entitled to 8% loss of use of the person as a whole as provided in §8(d)2 of the Act.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $755.22 per week for a period of 40 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the 8% loss of use of the person as a whole.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $30,300.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUL 2 – 2020

Maria Elena Portela
Maria E. Portela

Thomas J. Tyrrell
Thomas J. Tyrrell

Kathryn A. Doerries
Kathryn A. Doerries

SE/
O: 5/19/20
49

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CHOLEWIAK, WAYNE
Employee/Petitioner

Case# **16WC023150**

XPO LOGISTICS FREIGHT INC INDEMNITY INSURANCE COMPANY OF NORTH AMERICA
Employer/Respondent

20IWCC0380

On 4/17/2018, 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 1.94% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0761 GRAUER & KRIEGEL LLC
ANDREW J KRIEGEL
1300 E WOODFIELD RD SUITE 205
SCHAUMBURG, IL 60173

1109 GAROFALO SCHREIBER STORM
DEREK STORM
55 WACKER DR 10TH FL
CHICAGO, IL 60601

20IWCC0380

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

WAYNE CHOLEWIAK
Employee/Petitioner

v.

XPO LOGISTICS FREIGHT, INC.; INDEMNITY INSURANCE COMPANY OF NORTH AMERICA
Employer/Respondent

Case # **16** WC **23150**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Cellini**, Arbitrator of the Commission, in the city of **Chicago**, on **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. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [ ] What temporary benefits are in dispute?
   [ ] TPD [ ] Maintenance [ ] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On **October 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*** sustain an accident that arose out of and in the course of employment.

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

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

In the year preceding the injury, Petitioner earned $**92,890.72**; the average weekly wage was $**1,786.36**.

On the date of accident, Petitioner was **50** years of age, ***married*** with **1** dependent child.

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

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

Respondent shall be given a credit of $**14,460.93** for TTD, $**17,992.00** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**32,452.93**.

ORDER

Both Dr. Murtaza's prescription for, and the cost of, the compound topical medication referenced in Petitioner's Exhibit's 5 and 6 and Respondent's Exhibit 3 is denied as being unreasonable and unnecessary pursuant to Sections 8(a) and 8.2(e) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $755.22 per week, the maximum allowable statutory rate, for 40 weeks, because the injuries sustained caused the 8% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

Respondent shall pay Petitioner compensation that has accrued from **July 22, 2016** through **March 14, 2018**, and shall pay the remainder of the award, if any, in weekly payments.

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

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

Signature of Arbitrator

April 2, 2018
Date

APR 17 2018

STATEMENT OF FACTS

The Petitioner testified that following his graduation from high school and one year of community college, he started driving a truck in approximately 1985. With the Respondent, he worked as a Driver Sales Rep, which involved driving a truck with two pre-loaded trailers to a designated spot, unloading the trailers, reloading other freight and bringing it back to Melrose Park, Illinois. His loading of boxes onto the trailers involved weights from 20,000 to 40,000 pounds per night, at times individually and at times by forklift. The individual boxes involved would vary in weight from 20 pounds to 70 pounds.

In order to disconnect the two trailers, Petitioner testified he would have to remove an axle and twist it over to move it into place. While performing this activity on 10/30/15, he testified he "knew right then something was wrong" in his low back. He reported his injury to Larry Puccini in HR and sought treatment at Concentra.

He testified that at Concentra he reported twisting his back while taking off the converter/ axle on his trailer and twisting it into its parking spot, and that he had sharp back pain radiating down the right leg. The 10/30/15 report from Concentra indicate he developed low back pain as a result of lifting a dolly and twisting his back. Petitioner reported low back pain with numbness and pain down the back of the legs. He was diagnosed with a lumbar strain and was prescribed medication and lumbar x-rays. At the 11/6/15 follow up, Petitioner reported no improvement and that his pain level was 7 out of 10, with sharp pain down the right leg and into the left buttocks. Petitioner was prescribed physical therapy and given work restrictions, and a lumbar MRI was ordered. (Px3). Petitioner testified that Respondent initially accommodated the work restrictions

The 11/13/15 lumbar MRI showed: 1) moderate L3/4 bilateral neuroforaminal stenosis with disc bulging diffusely and superimposed bony spondylitic changes; 2) mild stenosis at L1 to L3 and L4 to S1; 3) no evidence of fracture or destructive process. (Rx1).

On 11/24/15, Petitioner initially saw Dr. Salehi. He reported pain across the low back and into the buttocks and posterior thighs to the knee with occasional cramps in the calves. He reported tingling in the same distribution, more on the left side. The pain ranged from 6/10 to 8/10. He denied any prior history of low back pain. Following examination and review of the lumbar MRI, Dr. Salehi diagnosed lumbar spondylosis with radiculopathy and degenerative lumbar disc disease. He opined the symptoms might be due to L3/4 facet arthropathy and central and lateral recess stenosis, partially due to a disc herniation. Light duty restrictions and physical therapy were continued. (Px4).

On 12/22/15, Petitioner reported continued 5/10 pain. Dr. Salehi prescribed Mobic and recommended bilateral facet injections at L3/4 and ongoing therapy. (Px4). Petitioner underwent therapy at Concentra from 12/3/15 to 2/3/16. (Px3).

Petitioner saw Dr. Heller on 1/21/16 and underwent bilateral facet injections at L3/4 on 1/27/16. On 2/4/16, Petitioner told Dr. Heller he felt about 50% better with the injections.

On 2/5/16, Petitioner saw Dr. Salehi and noted resolved left leg and low back symptoms, as well as 50% improvement on the right side, with the injections. Dr. Salehi recommended 2 weeks of work conditioning, after which Petitioner would be reevaluated for return to work if he improved, or a second round of facet injections if he did not. (Px4). Work conditioning was performed at Concentra from 2/8/16 through 3/2/16. (Px3).

On 3/4/16, Petitioner returned to Dr. Salehi with increased low back pain, especially on the left. A bilateral rhizotomy procedure was recommended at L3/4 for longer lasting symptomatic relief, and work restrictions were continued. (Px4).

Petitioner testified that the injection helped for a day before the relief slowly started to subside. Petitioner testified Dr. Salehi then referred him to Dr. Murtaza in lieu of pursuing a second injection. Petitioner testified his pain would switch at times from one leg to the other.

Petitioner was examined at the Respondent's request on 4/25/16 by orthopedic surgeon Dr. Levin. He provided a consistent history of accident, though Dr. Levin documented that he reported the pain initially went down his left leg. Petitioner reported that, based on his work restrictions, he had been working a desk job for Respondent. He reported that therapy and injections provided some relief, but he continued to have ongoing 5 out of 10 low back pain and intermittent leg pain with numbness when he stands. He was taking ibuprofen. He was noted to be 357 pounds and 6'1". Examination noted discomfort in the lumbosacral junction and slightly in the left buttock, but was otherwise essentially normal. Neurologic exam noted some decreased sensation in the left lateral thigh. Dr. Levin noted the MRI films showed multilevel degenerative changes that appeared to be chronic, with chronic facet hypertrophy with facet arthritis and multilevel neuroforaminal stenosis with secondary spinal stenosis mainly at L3/4, minimal at all other levels. Following review of Petitioner's medical records to date, Dr. Levin opined that the Petitioner aggravated a preexisting spinal stenosis and arthritis at L3/4. He further opined that the bilateral L3/4 rhizotomy recommended by Dr. Salehi was "appropriate to try to resolve him of his symptoms." Per the Petitioner, he had been asymptomatic prior to 10/30/15. Dr. Levin agreed with the work restrictions initiated by Dr. Salehi. He recommended reassessment of Petitioner 4 to 6 weeks after the rhizotomy to determine his improvement level and if he can return to full duty work. (Rx2).

Petitioner underwent the rhizotomy / radiofrequency ablation (RFA) procedure with Dr. Murtaza on 6/7/16. The doctor indicated that, because the facet joint to be addressed was innervated by two levels, the ablation needed to involve both L2/3 and L3/4. Dr. Murtaza also prescribed a compound topical cream that he indicated was medically necessary, and included an analgesic, anti-inflammatory and muscle relaxer. Petitioner testified the cream did help relieve his pain. (Px5).

On 6/10/16, Petitioner reported some continued low back pain, but denied any radiation into the legs and indicated he had taken no ibuprofen since the injections. He had run out of light duty time with Respondent and was off work. Dr. Salehi recommended more time to evaluate the results of the rhizotomy. On 6/24/16, Petitioner reported doing well, only reporting pain with prolonged sitting on the couch, and that this would subside after he would walk around for a while. He was not taking medication but remained off work. Dr. Salehi prescribed two weeks of work conditioning. (Px4). Petitioner testified that he was off work for a period of time between May and July 2016.

Petitioner attended work conditioning from 7/7 through 7/21/16. He reported that he tolerated work conditioning well without adverse reactions, and that his prior back and leg symptoms did not recur. He was performing his home exercise program and felt ready to return to work. (Px3).

On 7/22/16, Dr. Salehi noted the Petitioner: "is doing very well. He has finished two weeks of work conditioning yesterday. He states that he felt sore over all, but had no recurrent low back pain. He is not taking any medications. He denies any leg pain or paresthesias or weakness." Following examination, Dr. Salehi opined that Petitioner could return to his regular duty work, and advised him to continue a home exercise regimen and to follow up as needed. (Px4; Rx4). Petitioner testified he returned to work a couple of days later.

Px6 contains a medical bill from the Metropolitan Institute of Pain / Dr. Murtaza for a prescribed compound topical pain medication, containing Flurbiprofen (20%), Baclofen (2%), Lidocaine (4%) and Versapro (74%). The charge for this compound medication was $2,889.51, the vast majority of which was based on Flurbiprofen ($2,016.08) and Versapro ($644.18). (Px6).

On 6/6/17, the Respondent obtained a utilization review from Dr. Gill, D.O. with regard to a compound medication prescribed by Dr. Murtaza which included Flurbiprofen, Versalide, Baclofen and Lidocaine. Dr. Gill concluded that, based on Official Disability Guidelines (ODG), compound topical analgesic medications generally are largely experimental, and primarily recommended for neuropathic pain when trials of anti-depressants and anticonvulsants have failed. Dr. Gill stated: "There is little to no research to support the use of many these agents." Further, he indicated that, per ODG, if any of the compounded agents are not recommended, the compound is not recommended. As Baclofen would not be a recommended medication in this case on a topical basis, and it was one of the compound ingredients, Dr. Gill determined that the use of the compounded medication was not recommended. Lidocaine was also not recommended outside of use with a patch. He thus could not certify the medication. Dr. Gill recorded that two attempts to contact Dr. Murtaza for peer to peer review resulting in twice leaving phone messages and not receiving a return call. (Rx3).

Currently, the Petitioner testified that he feels pain at work at times, but didn't know if it was due to the back procedure or just muscular pain, as his job is physical. Such pain, when it occurs, makes him nervous and cautious about his back. He testified he did not have any similar symptoms prior to the work accident. At home, he has some minor difficulty with mowing the lawn and snow blowing. He no longer participates in softball or football out of fear of flaring up his pain. During cross-examination, the Petitioner acknowledged that he returned to work unrestricted as a driver and continued to work in that capacity. He has received increases in his hourly wages since returning to work and agreed he earns more now than he was before the accident.

With regard to the statements of Dr. Salehi on 7/22/16, Petitioner agreed he reported he was doing a lot better and that the pain into his legs has resolved. He was not taking any medication at that time. While he was advised to return if he had further problems, he hasn't sought further treatment since that visit. Petitioner denied any other low back injuries either before or after 10/30/15.

The parties stipulated that the Petitioner was temporarily and totally disabled from 5/1/16 through 7/25/16, and temporarily partially disabled from 11/2/15 through 5/1/16, as well as that the Respondent has paid TTD benefits totaling $14,460.93 and TPD benefits totaling $17,992.00. The parties agreed on the record that this constitutes full payment of all due and owing TTD and TPD with no overpayment or underpayment.

CONCLUSIONS OF LAW

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

The parties indicated at hearing and in Arbx1 that the only issue involving medical expenses relates to $2,889.15 in billing from Metrohealth, which involved the prescription of a compound pain medication cream by Dr. Murtaza.

The Arbitrator finds that this recommended cream, based on the greater weight of the evidence, involved unreasonable and unnecessary costs.

This is supported by the utilization review performed by Dr. Gill pursuant to Section 8.7 of the Act. He opined that such compound topical analgesics are generally experimental, with little to no research to support their use, and primarily recommended for neuropathic pain when trials of anti-depressants and anticonvulsants have failed. He also indicated that, per ODG, if any of the agents making up the compound are not recommended, then the compound itself is not recommended. In this case, he indicated that one of those agents, Baclofen, would not be recommended medication in this case. Another agent, Lidocaine, was also not recommended in any form outside of a patch. He therefore could not certify this medication, and Dr. Murtaza never responded to his multiple attempts at a peer to peer review. No evidence was presented regarding Dr. Murtaza's basis for this prescribed compound cream.

Based on this reasoning, the Arbitrator finds that this compound cream prescription was not reasonable and necessary pursuant to Section 8(a) of the Act. As such, the Arbitrator further finds that, pursuant to Section 8.2(e) of the Act, neither the Petitioner nor the Respondent are liable for the costs of this prescription medication.

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

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

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

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

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

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no AMA permanent partial impairment rating or opinion was submitted into evidence by either party. As such, this factor is not part of the permanency determination in this case.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as a truck driver at the time of the accident, and has returned to work in his prior capacity after reaching maximum medical improvement following a rhizotomy / RFA procedure. The Petitioner's testimony indicates that his job can be rather physical in terms of loading/unloading as well as addressing the trailer axle, the activity in which he was injured. This factor is relevant and tends to show an average degree of permanency in the Arbitrator's view for this type of injury.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 50 years old at the time of the accident. Neither party introduced any evidence which would tend to show how the Petitioner's age may impact any permanent disability resulting from this accident and injury. This factor plays no significant role in the permanency determination.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that the Petitioner testified he has returned to his regular job, he has been able to do that job and he is earning more now than he was at the time of the accident. The Arbitrator notes that this factor tends to show a somewhat lesser degree of permanency.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes. This factor tends to show a somewhat greater degree of permanency given Petitioner does have ongoing complaints.

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

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

RANDY SKOLEK,

Petitioner,

20IWCC0381

vs.

NO: 16 WC 39137

INFRASOURCE, LLC,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed under Section 19(b) of the Act by the Petitioner herein and notice given to all parties, the Commission, being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

So that the record is clear, and there is no mistake as to the intentions or actions of the Commission, we have considered the record in its entirety. We have reviewed the facts of the matter, both from a legal and a medical/legal perspective. The Commission has considered all the testimony, exhibits, pleadings, and arguments submitted by the parties. The Commission is not bound by the Arbitrator's findings. Our Supreme Court has long held that it is the Commission's province "to assess the credibility of witnesses, resolve conflicts in the evidence, assign weight to be accorded the evidence, and draw reasonable inferences from the evidence." *City of Springfield v. Indus. Comm'n*, 291 Ill. App. 3d 734, 740 (1997) (citing *Kirkwood v. Indus. Comm'n*, 84 Ill. 2d 14, 20 (1981)). Interpretation of medical testimony is particularly within the province of the Commission. *A.O. Smith Corp. v. Indus. Comm'n*, 51 Ill. 2d 533, 536-37 (1972).

The Commission modifies the Arbitrator's Decision with respect to the issue of credit due to Respondent. The Decision stated that Respondent was entitled to a credit of $32,889.87 for temporary total disability (TTD) and other benefits previously paid. However, no right of credit exists under Section 8(j) of the Act for any benefits or payments made to the employee, or Petitioner herein, other than for compensation payments provided by the Act. In other words, Section 8(j) of the Act allows a credit for benefits paid when compensation pursuant to the Act is awarded.

20IWCC0381

The Commission affirms and adopts the Arbitrator's Decision finding that the Petitioner failed to prove that he sustained a compensable accident at work on December 6, 2016. Thus, all requested compensation and benefits are denied. Respondent is not entitled to a credit where no compensation or benefits were awarded under the Act. Therefore, the Commission modifies the Arbitrator's Decision with respect to this issue and vacates the credit to Respondent totaling $32,889.87; since no compensation has been awarded, the credit is inapplicable. The Commission finds such amounts were paid by the Respondent.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, filed July 25, 2018, is hereby modified as stated above, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner failed to prove that he sustained a compensable accident at work on December 6, 2016 as claimed. By extension, all other issues are rendered moot and all requested compensation and benefits are denied.

IT IS FURTHER ORDERED BY THE COMMISSION that the credit of $32,889.87 for TTD and other benefits previously paid is vacated.

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

DATED: JUL 2 - 2020

D. Douglas McCarthy

Stephen J. Mathis

L. Elizabeth Coppoletti

DDM/pm
O: 6/23/2020
052

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

SKOLEK, RANDY
Employee/Petitioner

Case# **16WC039137**

20IWCC0381

INFRASOURCE LLC
Employer/Respondent

On 7/25/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.14% 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:

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

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

20IWCC0381

STATE OF ILLINOIS)
)SS.
COUNTY OF LaSALLE)

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

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

Randy Skolek
Employee/Petitioner

v.

InfraSource, LLC
Employer/Respondent

Case # **16** WC **39137**

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 **Ottawa**, on **February 23, 2018** and **May 30, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, December 6, 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 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 $76,778.05; the average weekly wage was $1,476.50.

On the date of accident, Petitioner was 57 years of age, *single* with no dependent children.

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 $29,163.04 for TTD, $0 for TPD[1], $0 for maintenance, and $3,726.83 for other benefits, for a total credit of $32,889.87. *See* AX1.

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

ORDER

As explained in the Arbitration Decision Addendum, the Arbitrator finds that Petitioner failed to prove that he sustained a compensable accident at work on December 6, 2016 as claimed. 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

July 17, 2018
Date

ICArbDec19(b) p.2

JUL 25 2018

[1] The parties stipulated that there is no overpayment or underpayment at issue regarding Petitioner's temporary partial disability period. *See* Arbitration Hearing Transcript.

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

Randy Skolek
Employee/Petitioner

v.

InfraSource, LLC
Employer/Respondent

Case # **16** WC **39137**

Consolidated cases: **N/A**

FINDINGS OF FACT

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 December 6, 2016 through May 30, 2018, and whether he is entitled to prospective medical care in the form of a hip surgery as ordered by Dr. Salehi. Arbitrator's Exhibit[2] ("AX") 1(a). The parties have stipulated to all other issues. *Id.*

Background

Randy Skolek (Petitioner) testified that he was employed InfraSource, LLC (Respondent). Randy Skolek testified that he is a union laborer and has been so employed for over 20 years. Tr. at 13-14. He has been injured at work in the past and filed workers' compensation claims. Tr. at 14. Petitioner testified that he passed a drug test before beginning work for InfraSource (Respondent) on December 3, 2016 as a Laborer. Tr. at 15-16.

Pre-Incident Medical Treatment

The records from the VA Hospital confirm that Petitioner was on a prescription for Hydrocodone as recently as July 22, 2016. RX5. The medication records indicate that Petitioner was prescribed Hydrocodone on and off since as far back as May 2011. *Id.*

The VA progress notes document treatment dating back to February 2009 when Petitioner was seen due to hepatitis C. RX5. He also reported a history of undergoing surgery on both knees. *Id.* Petitioner was diagnosed with hepatitis C and arthralgias. *Id.* There is no documented history of any prior cervical issues as of 2009. *Id.* However, he did report a past medical history significant for a prior shoulder surgery. *Id.*

Notes from January 12, 2010 document Petitioner's history of chronic low back pain for which he treated at St. Joseph's Hospital. RX5. He reported he was on Hydrocodone, and signed a narcotic medication contract with the treating physician. *Id.* There were no complaints of cervical pain. *Id.* On December 27, 2010, Petitioner was evaluated regarding his diabetes and a number of personal conditions were noted in the history including diabetes, hypertension, hepatitis C, and tobacco use. *Id.*

[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. The arbitration hearing transcript of February 23, 2018 is referenced with corresponding pages as "Tr. at _" and the transcript of May 30, 2018 is referenced as "Tr2. at _."

In 2010 and 2011, Petitioner followed up regarding pain medication. RX5. On March 30, 2011, he was advised not to take hydrocodone while working and he was seen in the pain clinic on January 13, 2012 when his hydrocodone was restarted due to chronic knee problems. *Id.*

On December 27, 2012, Petitioner was evaluated by a nurse practitioner who noted that Petitioner had a history of narcotic pain medication usage due to his knees and shoulder. RX5. A drug screen obtained on January 11, 2013 was negative for opioids but his pain medication prescription was nevertheless renewed. *Id.*

Petitioner underwent an updated screening in March of 2013, which was positive for opioids consistent with his prescribed medication. RX5. He was seen at the VA in August of 2013 to follow-up on his chronic medical problems including bilateral knee pain and a prior left torn rotator cuff. *Id.* Petitioner denied any illicit drug use and had no complaints of cervical pain. *Id.*

On July 18, 2014, Petitioner was evaluated by a primary care clinic for chronic low back pain with a history of seven knee operations and bilateral knee pain. RX5. He also reported left shoulder pain. *Id.*

Petitioner contacted the pain clinic on December 31, 2014 reporting that his hydrocodone at the prescribed dosage was not controlling his pain. RX5. It was noted that the pain doctor would follow-up with Petitioner regarding his dosage. *Id.* When Petitioner returned on February 11, 2015, he reported no interest in reducing his pain medications, quitting smoking, or quitting drinking. *Id.* Petitioner reported that he had been on pain medication for over 25 years. *Id.* He wanted a different type of hydrocodone and the provider noted that Petitioner was not motivated to improve his lifestyle or eating/drinking/smoking habits. *Id.* Petitioner reported ongoing problems with low back pain on that date. *Id.* He was diagnosed with chronic pain. *Id.*

Petitioner returned to the primary care clinic on August 11, 2015 reporting ongoing chronic pain. RX5. He remained on prescription narcotic pain medication. *Id.* He reported some foot pain and was diagnosed with chronic pain and diabetic neuropathy with uncontrolled diabetes. *Id.*

On October 13, 2015, Petitioner requested a pain medication refill, which was denied as of December 4, 2015 due to a positive drug test for an illicit substance. RX5. The drug screen was negative for opioids. *Id.* Petitioner again tested positive for an illicit substance on December 1, 2015, but negative for opioids. *Id.* Petitioner reported taking 20 Advil pills per day to help with his pain. *Id.*

Petitioner was evaluated by a nurse practitioner on June 20, 2016 complaining of chronic pain and bilateral knee pain at a level of 10 out of 10 for which he requested pain medication. RX5. Petitioner was advised that he needed a drug screen negative for illicit substances before he could get a Norco refill, but he was provided with one Norco refill and referred for an updated urine drug screen. *Id.*

On July 5, 2016 Petitioner called requesting an increase in his Norco prescription reporting that he had only received half of his pain medication. RX5. He was advised that his last urine drug screen of June 20, 2016 tested positive for Benzo, which was not on his active medication list. *Id.* Petitioner was again advised that he needed to be free of positive testing for illicit drugs before he could obtain further pain medication refills. *Id.*

December 6, 2016

Petitioner was assigned to replace some pipe near Starved Rock State Park. Tr. at 16. Petitioner testified that he was injured in a ravine. Tr. at 15-16. He explained that other laborers were also working at the site on the

alleged date of accident. Tr. at 17. Petitioner testified that he was hurt in a big ravine that they had to "flag [it] out." Tr. at 20-21. He explained that there was sleet and rain and that it was snowing all day. Tr. at 21, 23. Petitioner further explained that conditions were wet and muddy with "real slick" drilling mud; "like a skating rink." Tr. at 21, 24. He testified that other laborers would come with some sandbags when they would run back up to the hills using a rope to ascend the steep climb. Tr. at 22.

At the time of the alleged injury on December 6, 2016, Petitioner explained that he was "putting pipe in the chains, removing pipes from semi trailers, climbing down the ramp, putting them on slings, I think we wrapped up the Bentonite tanks and then the sandbags. It was about 8 o'clock at night. It was dark." Tr. at 27-28. He went on to explain that "[i]t was dark. I think it was after 8 o'clock. I am not quite sure. [...and] I was climbing up the hill [...using] a rope that you use to balance and being so slick and muddy, about the only way you can get up there, you can actually crawl up on your hands and knees. You had to use a rope." Tr. at 28-29. Petitioner testified that he was the last one getting out of the ravine and there was one laborer and some other company guy in front of him. Tr. at 29-30. He testified that the other two men were making their way up the hill and "I had ahold at the end of the rope as it was tight, and when they dropped the rope when they got their foot in and put slack in the rope which made me go backwards up the ledge and into the creek." Tr. at 31. Petitioner explained that, going backwards, he "landed neck first, shoulder and then back on the other side of the rocks." Tr. at 31. He maintained that the rope was no longer taut and he went backwards moving quickly. Tr. at 32. Petitioner testified that the fall knocked him out, but he did not recall for how long. Tr. at 32. He explained that his head, neck, and shoulder were what hit first "because I was still up on the rocks. The rest of my body was in the running water in the creek." Tr. at 32.

Petitioner testified that "one of the company guys slapped me in the face and said stay still. Don't move." Tr. at 33. Petitioner testified that another laborer, Mr. Jensen, then attended to him. *Id.*, at 33-34. He explained that they got him out of the water a little more. *Id.* He testified that "[i]t took me a while to get my bearings, and I was asked if I needed like a rescue squad or whatever and I don't know exactly how many minutes. I decided I was going to try on my own to get out." *Id.*, at 34. Petitioner testified that the water was just inches deep, and two laborers helped him get out of the ravine, but he fell again and had to stop, but eventually made it to the top. *Id.*, at 35. Petitioner testified that he then went to the company truck with the foreman who filled out an accident report. *Id.*

Petitioner testified that he felt stiff, cold and he was shaking. Tr. at 35. He also felt pain all over and could not move his neck very well. *Id.*, at 36. Petitioner testified that he never had neck pain or problems prior to this occasion. *Id.* He also testified that someone offered to take him to the hospital, but he just wanted to get home and take a shower and see how it went. *Id.*, at 37. Petitioner explained that night was miserable and he could not sleep much ultimately resulting in more intense pain to the point that he was crying. *Id.* He testified that the pain was located in his neck, left shoulder, and he felt a shooting pain going down his left leg. *Id.*, at 37-38.

Petitioner explained that he had soreness in his left shoulder in the past as well as in the neck, but it always passed. *Id.*, at 38, 57-58. He never had any recommendation for shoulder surgery or treatment for anything that intense. *Id.* Petitioner also testified that he never had low back problems other than soreness prior to the alleged accident. *Id.*

On cross-examination, Petitioner acknowledged that he has filed prior workers' compensation claims related to his knees, right shoulder, and "person as a whole." Tr. at 76-83. He also acknowledged that he underwent prior medical treatment to the low back as far as 2009 for which he received narcotic prescriptions. Tr., at 83. However, he could not recall reporting chronic low back pain in July of 2014. *Id.*, at 84. Petitioner could not

recall reporting on February 11, 2015 that he had been on pain medication for over 25 years or that he reported low back pain. *Id.*, at 86. Petitioner did not recall whether he had a prior left rotator cuff tear treatment in August, 2013. Tr., at 83-84. He did acknowledge that "a while back" physicians at the VA hospital did not renew his pain medication prescriptions. *Id.*, at 86-87. Petitioner could not recall whether his drug screen at the time, however, was negative for prescribed opioids at the time and positive for cocaine. *Id.*, at 87.

Regarding the location of the fall and mechanism of injury, on cross-examination Petitioner testified that there were two hills coming down a ravine, and a creek flowed through it. Tr. at 90. He testified that sandbags were used to dam the creek to limit the amount of water that was there on the side in which they worked. *Id.* Petitioner testified that there was one side of the hill that had a rope coming down so that the laborers could climb up and down. *Id.* He could not recall on cross-examination how far up the hill he was located at the time that he fell, but estimated that it was approximately 10-to-15 feet ascending the hill while holding onto the rope. *Id.*, at 90-91. Petitioner then testified on cross-examination that he had not yet started to ascend the hill, and he was "standing there getting ready to climb." *Id.*, at 92. He explained that he was "waiting for the other two guys that were up on top of the hill. They were getting closer to the top." *Id.* Petitioner further explained that two other laborers were ahead of him halfway up the hill on the rope line. *Id.*, at 92-93. Petitioner testified that these two laborers let go of the rope and "dropped it. They put slack in it." *Id.*, at 93. When asked to clarify where he was located at the time of his fall, the following exchange occurred:

> Q. So you were at the bottom of the hill waiting to go up or you were 10 to 15 up on the --
> A. I was up on the ledge getting ready to go up.
> Q. On the exit side?
> A. I was out of the water on the ledge getting ready to go up.

Tr. at 93. Petitioner testified that he landed in approximately four inches of water and his whole body was wet after he fell. *Id.*, at 72-73. He later clarified that his body landed in the water, but not his head. *Id.*, at 95. Petitioner testified that after he reached the top of the hill, he sat down for a second and limped over to the truck. *Id.*, at 95-96.

On cross-examination, Petitioner testified that he spoke with a woman from the company who contacted him about the incident. Tr. at 99-100. Petitioner testified that she told him to turn around while he was on his way to the hospital because she was going to take him to Springfield. *Id.* at 100. Petitioner testified that he pulled into the Morris Hospital driveway and explained that Springfield is hundreds of miles away. *Id.* He acknowledged that became upset while speaking with her and he was crying. *Id.* Petitioner also testified that he has been required to take drug tests after other accidents at work, but Respondent did not ask him for one. *Id.*, at 100-101.

Post-Incident Medical Treatment

The medical records reflect that Petitioner presented at Morris Hospital on December 7, 2016. PX2. He was complaining of head pain, left arm pain and neck pain. *Id.* Petitioner reported falling 10 feet off of a ledge into a creek the prior evening at approximately 6:45 p.m. *Id.* He further stated that he landed on his neck, head, and back, but he was wearing a hardhat. *Id.* Petitioner confirmed a past medical history significant for diabetes, surgery on the bilateral knees, and surgery of the right shoulder. *Id.* He denied any drug abuse. *Id.* Petitioner also reported that he lost consciousness for a few seconds and it took him 10 minutes to get up after the fall. *Id.* Regarding further symptoms, Petitioner reported tingling to his left hand and fingers, but he was able to move his left hand and fingers and grasp with his left hand on examination. *Id.* Left hand grasping was slightly

weaker than the right. *Id.* Petitioner also reported left trapezius pain and left knee pain. *Id.* On examination, he had tenderness in his cervical spine. *Id.* He denied any symptoms in his lower extremities. *Id.* Petitioner also reported that when he turned his head to the right he became dizzy and nauseous, as well as blurry vision. *Id.* Petitioner reported that it would take him 30 seconds to regain his normal sight and for his nausea and dizziness to subside when he would turn his head back towards the center. *Id.* Petitioner rated his pain at a level of 10 out of 10. *Id.*

Petitioner was reassessed by a nurse at which time his pain levels had decreased and he was in no apparent distress. PX2. Petitioner was provided pain medication and underwent a number of diagnostics. *Id.* A chest x-ray and CT of the head were negative. *Id.* An x-ray of the left shoulder revealed moderate degenerative changes in the AC joint. *Id.* A CT of the cervical spine revealed mild to moderate degenerative changes in multiple levels, and stenosis at C3-4. *Id.* Petitioner was diagnosed with cervical radiculopathy and a head contusion. *Id.*

On cross-examination, Petitioner acknowledged that he reported falling 10 feet from a ledge into a creek landing on his neck, head and back when he presented at the emergency room. Tr., at 59-60. Petitioner explained that he did not know from what height he fell, but estimated the distance between the location from which he fell and where he landed to extend approximately 10 feet. *Id.*, at 60-61. Petitioner acknowledged that he did not have any cuts, scrapes or bruises at the time he presented to the emergency room. *Id.*, at 62.

Petitioner returned to the emergency room on December 14, 2016. PX2. He was complaining of pins and needles sensations into his left fingers. *Id.* He denied any new injuries. *Id.* Petitioner reported that he was changing a light bulb and that his legs felt numb. *Id.* He reported that another time he was looking to his right and had pain radiating into his right arm and legs. *Id.* Petitioner requested a soft cervical collar. *Id.* The examining physician noted that Petitioner's diagnostics were negative. *Id.* Petitioner was diagnosed with cervical radiculopathy, muscle spasms, and a muscle strain. *Id.* Petitioner's condition stabilized and he was discharged under advisement to follow-up with Dr. Rhode. *Id.*

On cross-examination, Petitioner could not recall whether he already had a scheduled appointment with Dr. Rhode on December 14, 2016. Tr., at 63. When asked whether he reported that he felt numbness in his legs after changing a light bulb, Petitioner responded "I do have that problem, yes." *Id.* He acknowledged that he told Dr. Rhode that he fell roughly 12-to-15 feet into a creek after roughly 6-to-7 feet of slack in a rope gave way while he was climbing out of a ravine. Tr. at 69-70.

Petitioner returned to Dr. Rhode on December 16, 2016. PX3. He filled out an intake form reporting neck pain and arm pain. *Id.* Dr. Rhode's physician's assistant noted Petitioner's complaints of neck and left shoulder pain and a mechanism of injury involving a fall roughly 12 to 15 feet into a creek after roughly six to seven feet of slack went into a rope as he was climbing out of a ravine. *Id.* Petitioner also reported that he lost consciousness for less than a minute after which he regained consciousness and felt numbness and tingling in his left arm. *Id.* Petitioner reported ongoing significant neck and shoulder pain and denied any pre-existing conditions for the neck. *Id.* On physical examination, Petitioner had pain on palpation of the cervical bilateral paraspinous muscles, intact sensation, limited range of motion, and a positive Spurling's sign on the left. *Id.* Petitioner was diagnosed with neck pain and shoulder pain as well as cervical radiculopathy and a closed head injury. *Id.* A cervical spine MRI was ordered and Petitioner was placed off work. *Id.*

Petitioner underwent the recommended MRI of his cervical spine on January 9, 2017. PX3. The interpreting radiologist noted multi-level chronic changes with mild protrusions and multi-level chronic hypertrophy and facet arthrosis especially at C6-7. *Id.*

On January 18, 2017, Petitioner returned to Dr. Rhode complaining of neck pain with ongoing symptoms down his left arm as well as left leg symptoms and back pain. PX3. The physician's assistant noted Petitioner's MRI revealed a disc protrusion at C6-7 with foraminal stenosis as well as a disc protrusion at C3-4. *Id.* Petitioner's diagnoses remained unchanged. *Id.* Norco was prescribed and Petitioner was referred to Dr. Kube for further treatment for his spine. *Id.* He remained off work. *Id.*

On February 2, 2017, Petitioner reported to Dr. Rhode that he had significant radicular complaints. PX3. Dr. Rhode continued to recommend a referral to Dr. Kube or Dr. Templin. *Id.*

Petitioner came under the care of Dr. Richard Kube on February 7, 2017. PX4. Dr. Kube obtained a history of Petitioner being involved in "a pretty significant injury." *Id.* Petitioner reported that he was working "the pipeline and there is an area where they usually repel down, and in that process with a couple of other guys there was slack in the rope, and he actually went backward about 10-15 feet, landed down in the water kind of on his head and upper back." *Id.* Petitioner reported that he lost consciousness and denied a past medical history significant for anything other than a prior knee surgery. *Id.* Petitioner also reported immediate pain in the neck, left shoulder, and head noting that he woke up the following morning with numbness and tingling to his fingers on the left side without any improvement. *Id.* On physical examination, Petitioner had a positive Spurling sign on the right side, and diminished strength of his left wrist flexors, left biceps, and left triceps. *Id.* Dr. Kube noted decreased range of motion toward the right side and reviewed Petitioner's MRI, but noted it was of poor diagnostic quality. *Id.* He appreciated degenerative changes at C5-C7 and a disc herniation and tear in his disc. *Id.* Dr. Kube recommended a better quality MRI, a motion analysis study and an EMG of the upper extremities. *Id.*

On February 22, 2017, Petitioner underwent the recommended EMG performed by Dr. Trudeau. PX5. Petitioner reported severe neck pain with headaches and pain both up and down his body especially on the left side of his body. *Id.* Petitioner reported symptoms in his lower extremities, especially his left leg. *Id.* Dr. Trudeau confirmed a left C7 radiculopathy, which was severe in nature, as well as moderately severe left C6 radiculopathy. *Id.* He found no evidence of left C5 radiculopathy, left brachial plexopathy, median neuropathy at the left wrist, or entrapment or neuropathy of the peripheral nerve entities in Petitioner's upper extremities. *Id.* Dr. Trudeau also noted that Petitioner may have a secondary strain or spasm in the left shoulder girdle. *Id.*

Petitioner underwent the recommended motion study on February 24, 2017, which revealed instability in the cervical spine. PX4.

Utilization Review

Respondent offered into evidence a utilization review report prepared on March 1, 2017. RX3. The reviewer did not certify the vertebral motion analysis for the cervical spine recommended by Dr. Kube finding no rationale provided as to what specific information the recommended test by Dr. Kube would provide in light of the fact that Petitioner had a prior MRI. *Id.*

Continued Medical Treatment

Petitioner returned to Dr. Rhode on March 2, 2017. PX3. He reported ongoing pain in his neck and left shoulder and significant lateral left shoulder pain. *Id.* Dr. Rhode noted a positive impingement sign in the left shoulder and slightly diminished strength in the supraspinatus tendon. *Id.* He diagnosed neck and left shoulder pain and recommended a left shoulder MRI. *Id.* Petitioner remained off work. *Id.*

On March 9, 2017, Petitioner was given an ongoing prescription for Norco by Dr. Kube as well as some additional medication. PX4. On March 14, 2017, Dr. Kube noted Petitioner had no frank instability based on the vertebral motion analysis, but noted that the EMG revealed issues on the left side at C6-7. *Id.* He again recommended an updated MRI, and diagnosed a cervical sprain/strain, cervical radiculitis, neck pain, cervical spinal stenosis, cervical degenerative disc disease, and a herniated disc with myelopathy. *Id.*

On March 30, 2017, Petitioner returned to Dr. Rhode. PX3. He reported significant lateral left shoulder pain and upcoming IME. *Id.* A physical examination revealed a positive impingement sign and ongoing diminished strength in the supraspinatus. *Id.* Dr. Rhode's diagnosis was unchanged and he ordered an updated MRI of the cervical and as well as an MRI of the lumbar spine. *Id.* Petitioner remained off work. *Id.*

On April 4, 2017, Petitioner saw Dr. Kube who noted he was still awaiting authorization to get an updated MRI of the cervical spine. PX4. He refilled Petitioner's medications. *Id.*

Section 12 Examination – Dr. Butler

On April 10, 2017, Petitioner underwent a medical evaluation with Dr. Jesse Butler at Respondent's request. RX2. Dr. Butler noted that Petitioner missed his initial appointment on February 27, 2017. *Id.* Petitioner reported a history of falling 10 feet down an embankment into a creek bed. *Id.* He reported that slack went into a rope onto which he was holding that caused him to fall. *Id.* He alleged a loss of consciousness and neck pain and numbness of the left arm to the thumb and index finger as well as left scapula pain. *Id.* Petitioner did not report any low back pain or left lower extremity symptoms. *Id.* He also denied any prior work injury that resulted in permanent restrictions. *Id.*

Dr. Butler noted an abnormal neurologic exam given that Petitioner had some reduced strength. RX2. Petitioner also had abnormal reflex response as well as diminished sensation. *Id.* Spurling's testing was negative. *Id.* Petitioner had mild tenderness on palpation. *Id.*

Dr. Butler did not have the MRI films available for his review. RX2. He indicated that he wanted to review those in order to comment on the need for any further treatment. *Id.* At the time, Dr. Butler indicated that Petitioner was not yet capable of returning to full duty work or at maximum medical improvement. *Id.* Dr. Butler added that, if Petitioner's history of accident was inaccurate, then his opinions regarding causation were likely to change. *Id.* He felt Petitioner's treatment to date was reasonable and necessary, with the exception of the motion analysis study. *Id.* Dr. Butler diagnosed Petitioner with a cervical strain with left upper extremity radiculopathy. *Id.*

Continued Medical Treatment

On April 13, 2017, Petitioner returned to Dr. Rhode reporting left shoulder and neck pain. PX3. Dr. Rhode noted that Petitioner continued to await authorization for an updated MRI of the cervical spine. *Id.* Dr. Rhode's findings and diagnoses were unchanged. *Id.* He refilled Petitioner's prescriptions and kept him off work. *Id.* Petitioner returned to Dr. Rhode on April 27, 2017 at which time Petitioner's complaints, Dr. Rhode's findings and diagnoses remained unchanged. *Id.*

On May 4, 2017, Petitioner returned to see Dr. Kube who continued to recommend an updated MRI. PX4. No physical examination findings were noted. *Id.* Dr. Kube noted he could not refill Petitioner's medications without a new MRI. *Id.*

On May 11, 2017, Petitioner reported to Dr. Rhode the same complaints with ongoing radicular symptoms. PX3. Dr. Rhode maintained the same findings and diagnoses. *Id.* He also refilled Petitioner's Norco. *Id.*

As of May 25, 2017, Dr. Rhode refilled Petitioner's prescriptions and noted no changes in condition or diagnoses. PX3. Petitioner did not report low back pain. *Id.*

Addendum Report – Dr. Butler

On May 26, 2017, Dr. Butler reviewed the MRI films. RX2. He opined that Petitioner's complaints of left arm radiating pain with numbness and tingling affecting the thumb and index finger did not correlate well with the MRI findings. *Id.* Dr. Butler also noted that Petitioner's MRI did not demonstrate any compression at C5-6 or C4-5 on the left side. *Id.* He agreed that C6-7 was poorly visualized and recommended the MRI be repeated with a better quality scan to enhance the accuracy of Petitioner's diagnosis. *Id.* He indicated that if the MRI confirmed the absence of nerve compression, Petitioner could return to work full duty and be discharged from care. *Id.*

Continued Medical Treatment

On May 26, 2017, Petitioner was seen at the VA. RX5. He reporting injuring his neck in December and having six years of knee pain. *Id.* He reported pain going up to a level of 10 out of 10. *Id.* There was no specific history noted of an accident at work on December 6, 2016. *Id.* Petitioner advised that he was satisfied with his pain management as of that date. *Id.*

On June 9, 2017, Petitioner returned to Dr. Rhode. PX3. The chart note is essentially identical to the prior chart notes and Dr. Rhode again refilled Petitioner's prescriptions keeping him off work. *Id.* According to Dr. Rhode's records, Petitioner's condition, prescriptions, diagnoses and his recommendations remained the same as of June 22, 2017. *Id.*

Petitioner underwent the updated MRI on July 5, 2017. PX3. It revealed a disc herniation at C3-4 with degenerative bulging, degenerative bulging at C4-C7, central canal encroachment and left foraminal encroachment at C3-C7, no significant posterior disc extrusion at C7-T1 and no impingement. *Id.*

Following the MRI, Petitioner returned to Dr. Rhode on July 6, 2017. PX3. His examination was unchanged. *Id.* Dr. Rhode's diagnoses were unchanged. *Id.* He refilled Petitioner's prescriptions and continued Petitioner off work with instruction to follow up with Dr. Kube. *Id.*

On July 18, 2017, Petitioner saw Dr. Kube who noted weakness with wrist extension on the left side. PX4. He also reviewed Petitioner's MRI and noted it revealed severe stenosis on the left side at C5-6 and C6-7. *Id.* Dr. Kube recommended an injection, but felt that Petitioner would more likely require surgery. *Id.* He gave Petitioner a prescription for Norco. *Id.*

On July 20, 2017, Petitioner returned to Dr. Rhode reporting the referral for an epidural steroid injection. PX3. Dr. Rhode noted the same examination findings and diagnosed neck pain and shoulder pain. *Id.* He also refilled Petitioner's prescriptions. *Id.*, *but see* PX4 (Dr. Kube order for 90 Norco July 18, 2017).

On July 27, 2017, Petitioner returned to Dr. Kube noting neck pain with decreased range of motion and left greater than right radiculopathy. PX4. Petitioner did not report low back symptoms in the history or intake form. *Id.* Petitioner was diagnosed with cervical stenosis with radiculopathy. *Id.* Dr. Kube also referred Petitioner for a lumbar spine MRI of the lumbar spine. *Id.*

On July 31, 2017, Dr. Kube administered the recommended epidural steroid injection at C5-6 and C6-7. PX4. On August 3, 2017, Petitioner reported ongoing neck and left shoulder pain to Dr. Rhode. PX3. He continued to diagnose neck pain and shoulder pain, kept Petitioner off work, and referred him for ongoing treatment with Dr. Kube. *Id.* On August 8, 2017, Petitioner saw Dr. Kube and denied any improvement from the epidural at which time Dr. Kube recommended cervical surgery consisting of a decompression and fusion at C5-C7. PX4. He also noted that additional therapy was unnecessary given Petitioner's strength deficits. *Id.* Dr. Kube continued Petitioner's pain medications and kept him off work. *Id.*

Petitioner returned to see Dr. Rhode on August 17, 2017 reporting that he was scheduled for surgery on September 11, 2017. PX3. His physical examination remained unchanged. *Id.* Dr. Rhode kept Petitioner off work. *Id.*

On August 28, 2017, Petitioner presented for an initial physical therapy evaluation at Orland Park Orthopedics for his bilateral neck pain. PX3. Petitioner complained of a decreased ability to perform normal work tasks, as well as difficulty with driving. *Id.* Petitioner stated that the neck pain radiated to the left shoulder. *Id.* He reported that nothing seemed to alleviate the pain. *Id.*

On August 30, 2017, Petitioner presented to Orland Park Orthopedics for an MRI of the lumbar spine. PX3. The MRI showed left paracentral disc protrusion at T12-L1 with mild canal encroachment, degenerative bulging disc at L2-L3 with facet arthropathy, a left paracentral inferior disc herniation and spur at L3-L4 with a bulging disc and facet arthropathy, a left-sided inferior disc herniation at the L4-L5 level, and a left paracentral disc herniation at L5-S1 was also noted. *Id.*

On August 31, 2017, Dr. Rhode noted that the spine surgeon requested a repeat MRI of the cervical spine. PX3. Petitioner was continued off work by Dr. Rhode pending the results of the updated cervical MRI. *Id.*

On September 14, 2017, Petitioner continued to complain of severe cervical pain with radicular findings to Dr. Rhode and that he did not undergo surgery as previously set. PX3. Dr. Rhode again continued Petitioner off work pending surgery. *Id.*

On September 25, 2017, Petitioner underwent surgery performed by Dr. Kube. PX4. Specifically, Petitioner underwent a decompression and fusion at C5-67 and C6-C7. *Id.* The procedure also included placement of biomechanical interbody devices at C5-C6 and C6-C7. *Id.* Anterior cervical instrumentation was placed at C5-C7. *Id.* Petitioner was discharged that same day in stable condition. *Id.*

Petitioner was next seen by Dr. Rhode on September 28, 2017. PX3. Petitioner was less than one week status-post anterior cervical fusion and the physical examination of the neck failed to reveal any warmth, erythema or drainage. *Id.* Petitioner's diagnosis was status post-surgery at which time Dr. Rhode continued to prescribe

Norco and Tramadol. *Id.* Petitioner remained off work and Dr. Rhode noted that he would defer to the spinal surgeon relative to instituting a physical therapy program. *Id.*

On October 12, 2017, Dr. Rhode refilled Petitioner's medication, and no physical examination was noted. PX3.

Records Review – Dr. Butler

Dr. Butler performed a record review on October 16, 2017 at Respondent's request. RX2. He reviewed the July 5, 2017 MRI films and compared them to the January 9, 2017 MRI films. *Id.* He opined that Petitioner did not require any additional treatment including cervical surgery. *Id.* He indicated that if Petitioner did undergo surgery it would be due to a degenerative condition. *Id.* Dr. Butler opined there was no documentation of a lumbar injury based on the records he reviewed and that Petitioner did not require a lumbar spine MRI. *Id.*

Continued Medical Treatment

Petitioner followed up with Dr. Rhode on October 26, 2017. PX3. Petitioner continued to report significant shoulder pain one month status-post anterior cervical fusion. *Id.* An examination of the neck was normal. *Id.* An examination of the left shoulder revealed slightly decreased range of motion and slightly decreased strength at the supraspinatus region. *Id.* An ultrasound of the left shoulder revealed a thin supraspinatus attachment. *Id.* Dr. Rhode noted that Petitioner was stable post-surgery and he recommended that Petitioner proceed with an MRI of the left shoulder. *Id.* He also kept Petitioner off work. *Id.*

On October 27, 2017, Petitioner presented to Athletico Physical Therapy for an initial evaluation. PX7. Petitioner was four weeks status-post cervical decompression and fusion at C5-C7 and reported that he tried not to turn his neck too far to the right because he began to feel as though he was going to pass out. *Id.* Petitioner displayed limited range of motion of the cervical spine with flexion and extension, and his range of motion was also limited with rotation to the right and left. *Id.*

A progress note from Athletico dated November 6, 2017 noted increased range of motion of the cervical spine. PX7. Petitioner also had decreased pain complaints although he did report stiffness in the neck, as well as blacking out with right rotation of the cervical spine. *Id.* Petitioner reported that he was not doing very well that day and reported that he had to clean the fan and light and was reaching for a long period. *Id.* Petitioner stated that his legs became numb and rated his pain level at an 8/10. *Id.*

On November 7, 2017, Petitioner returned to Dr. Kube reporting some improvement with his shooting pain, but pain toward the left shoulder and trapezius on the left side. PX4. Petitioner also complained of continued paraesthesia. *Id.* Petitioner had improved range of motion of the neck and an x-ray of the cervical spine demonstrated good position of the surgical implants. *Id.* Dr. Kube recommended continued physical therapy and advanced him to a 20-pound lifting restriction with regard to the neck. *Id.* Dr. Kube noted that Petitioner would continue to have limitations with regard to his left shoulder. *Id.* Petitioner reported some S1 radiculopathy symptoms. *Id.* Dr. Kube reviewed images of Petitioner's lumbar spine MRI and interpreted them to reveal a disc herniation at the S1 root on the left side at L5-S1. *Id.* There was also some degree of protrusion at the L4-L5 level on the left side. *Id.* Dr. Kube recommended a formal back assessment and kept Petitioner off work. *Id.*

On November 9, 2017, Petitioner followed up with Dr. Rhode reporting significant shoulder pain on the left and that he received the "okay" to proceed with left shoulder treatment. PX3. Dr. Rhode ordered a left shoulder

MRI, continued his medication regimen which included Norco, Tramadol, Lidocaine, and Diclofenac, and kept him off work. *Id.*

On November 16, 2017, Dr. Kube noted that Petitioner's subjective complaints remained unchanged. PX4. His physical examination revealed point tenderness in the left sacroiliac area, tenderness inferior to the buttocks area, noticeable decreased strength in the entire left leg, decreased sensation in the lateral portion of the left lower extremity, and decreased range of motion of the left hip. *Id.* Petitioner had a positive straight-leg raise on the left. *Id.* Dr. Kube reviewed Petitioner's lumbar spine MRI finding significant foraminal stenosis on the left side at L4-L5 and a neurocompressive lesion at L4-L5. *Id.* Dr. Kube diagnosed Petitioner with lumbar pain and radiculopathy for which he ordered a nerve conduction study to confirm the diagnosis of radiculopathy and myelopathy. *Id.* Dr. Kube indicated that Petitioner would likely require a decompression at the L4-L5 level. *Id.*

Addendum Report – Dr. Butler

Dr. Butler authored a final addendum report dated November 20, 2017. RX2. He opined that Petitioner did not have any significant nerve compression mandating surgery, indicated that Petitioner could return to full duty work, and placed him at maximum medical improvement noting no objective basis for any work restrictions. *Id.*

Continued Medical Treatment

On November 22, 2017, Petitioner returned to Dr. Rhode reporting that he awaited an MRI of the left shoulder and nerve conduction study. PX3. Petitioner's physical examination remained unchanged. *Id.* Dr. Rhode's His diagnosis remained unchanged. *Id.* Dr. Rhode continued Petitioner on Norco, Tramadol, and Lidocaine medication. *Id.* Petitioner also remained off work. *Id.*

On December 5, 2017, Petitioner returned to Dr. Trudeau for the recommended EMG of the lower extremities. PX4. Dr. Trudeau noted denervation changes in the left at L5 and less so in the left S1 innervation distributions. *Id.* He found that the results were consistent with moderately severe to severe L5 radiculopathy on the left. *Id.*

Petitioner returned to see Dr. Rhode on December 7, 2017. PX3. Petitioner was two months status-post anterior cervical fusion. Petitioner stated that his physical therapy had been discontinued due to insurance issues. Petitioner stated that his current pain level was at a 9/10. Petitioner's baseline pain was a 7/10. Petitioner's physical examination remained unchanged. His diagnosis was the same. Petitioner was continued on his current medications. Dr. Rhode offered Petitioner physical therapy in Orland Park. However, Petitioner stated that the location was too far away from his home. Dr. Rhode noted that he would continue to utilize topical medication to decrease Petitioner's inflammation and improve his neurologic pain. Petitioner received refills for the Lidocaine and Diclofenac cream. Petitioner was continued off work. PX3.

Petitioner was seen by Dr. Kube on December 19, 2017. PX4. Petitioner reported that he slept on his neck funny and that his neck pain flared up. *Id.* Petitioner stated that he had good days and bad days with regard to his neck, and it was noted that he was scheduled for a rotator cuff repair. *Id.* Dr. Kube noted that Petitioner's nerve study indicated an L5 and S1 radiculopathy, L5 much worse than S1. *Id.* Dr. Kube opined that Petitioner may need lumbar spine surgery. *Id.* He also noted that Petitioner would undergo the left shoulder surgery and follow up with physical therapy before he could address the back issues. *Id.* Dr. Kube further recommended that Petitioner lose weight to be under a body mass index of 40 in order to proceed safely with surgery. *Id.* Petitioner was diagnosed as status-post cervical spine surgery and lumbar radiculopathy, instructed to follow up

after he underwent his left shoulder surgery, and his medication regimen was continued. *Id.* Dr. Kube continued Petitioner off work. *Id.*

On December 21, 2017, Petitioner followed up with Dr. Rhode reporting significant shoulder pain on the left side. PX3. A physical examination of the neck revealed cervical paraspinous muscle pain bilaterally. *Id.* Petitioner's range of motion and strength of the left shoulder continued to be slightly decreased. *Id.* An ultrasound of the left shoulder demonstrated a small full thickness tear to the supraspinatus. *Id.* Petitioner's diagnosis and medications remained unchanged. *Id.* It was noted that Petitioner has had difficulty gaining access to an MRI due to his large size. *Id.* Petitioner stated that he wished to proceed with an arthroscopic rotator cuff repair. *Id.* Petitioner was continued off work. *Id.*

As of January 4, 2018, Petitioner continued to complain of left shoulder pain. PX3. Dr. Rhode continued Petitioner off work. *Id.* On January 18, 2018, Petitioner reported continued left shoulder symptoms. *Id.* Dr. Rhode maintained his physical examination findings and diagnoses. *Id.* He also kept Petitioner off work pending the left shoulder surgery and continued Petitioner's pain medication regimen. *Id.* On February 1, 2018, Petitioner reported continued left shoulder pain and had pain on palpation over the cervical paraspinous muscle. *Id.* He had limited range of motion and strength in the left shoulder. *Id.* Dr. Rhode diagnosed Petitioner with neck pain, shoulder pain, cervical radiculopathy, and a closed head injury. *Id.* He continued to prescribe Norco, Tramadol, and Lidocaine and kept Petitioner off work pending his left shoulder surgery. *Id.*

Jason Jensen

Petitioner called Jason Jensen (Mr. Jensen) as a witness. Mr. Jensen testified that he is a union laborer with Local 393 out of Marseilles, Illinois, and has been so employed since 1991. Tr. at 113-114. He testified that he has known Petitioner through the years. *Id.*, at 114.

Mr. Jensen testified that on December 6, 2016 he was also employed as a laborer by Respondent. Tr. at 114-115. The work at that time involved the repair of a pipeline. *Id.*, at 115. He explained that he and Petitioner worked as craft support for pipe fitters or welders, and they performed pretty much anything that was asked by the supervisors. *Id.* Mr. Jensen testified that in the two or three days that Petitioner was employed by Respondent before December 6, 2016, Petitioner made no complaints of pain and discomfort while performing his work. *Id.*, at 118-119.

Regarding the circumstances of the accident, Mr. Jensen testified that they were sequestered at the base of the ravine to set up some type of damming system which involved sandbags to stop any fluids from hitting the secondary waterway. Tr. at 119-120. They completed their work and were ascending out of the ravine, which required them to grab a rope and pull themselves up to the top of the ravine. *Id.*, at 120. There were several of them in a line and Petitioner was at the end of it. *Id.* Mr. Jensen explained that, all he knew was that when they were going up, there was a rustle and then he (Mr. Jensen) and another gentleman kind of turned and looked, and by then Petitioner was already laying in the base of the creek. *Id.* Mr. Jensen testified that Petitioner was in the bottom getting ready to come up and he did not know how far up Petitioner got, but "[a]ll I can attest to is I know the route we were going, and then me and this other gentleman turned because we heard a rumbling. We looked and that's where we found [Petitioner]. So we got down as best we could to him because there was water involved and rocks and whatnot." *Id.*, at 120-121. Mr. Jensen estimated that Petitioner went up the rope a distance of approximately 10-15 feet from where he "ended up." *Id.*, at 121-122.

Mr. Jensen testified that Petitioner was lying face up in water that went up to about calf height. Tr. at 122. He explained that Petitioner was unable to talk at first, but they were able to get him up out of the water and moving. *Id.*, at 122-123. They reached the top of the ravine and Mr. Jensen testified that they were met by a couple of other individuals that kind of took Petitioner, after which Mr. Jensen went to another vehicle and just kind of waited. *Id.*, at 124-125.

On cross-examination, Mr. Jensen testified that he was located a good maybe 30 feet up the hill and there were a couple of others located on the rope line in front of him. Tr., at 127. He testified that there was no one else behind him holding the rope. *Id.*, at 128. Mr. Jensen also testified that he did not let go of the rope causing Petitioner to fall backwards. *Id.*, at 127-128. He was not aware of any slack in the rope between him and Petitioner, but he testified that there was about 30 feet of rope between them. *Id.*, at 131. Mr. Jensen acknowledged that he did not turn around to see Petitioner actually climbing up the hill, or if he was actually holding the rope. *Id.*, at 128. He did not see Petitioner fall or hit his head, neck or shoulder. *Id.*, at 133.

Bryon Sutherland

Respondent called Bryon Sutherland (Bryon Sutherland) as a witness. Tr2. at 61-85. Bryon Sutherland testified that he was employed by Respondent as of the day of hearing, but in February of 2018 he became employed by KS Energy. *Id.*, at 62-63. He was employed by Respondent in December of 2016 and stopped working for them in April or May of 2017. *Id.* He successfully completed the EMT course for the State of Missouri, and has had military training and experience including as an infantry scout sniper for approximately three years prior to which he was a regular infantry soldier in active duty with a total of eight years of experience. *Id.*, at 63-64.

Bryon Sutherland testified that he worked with Petitioner on December 6, 2016 as a laborer and was familiar with the work duties of a laborer. Tr2. at 64-65. The weather on that morning was cloudy and cool, but turned out to be very clear later in the day. *Id.*, at 65. He testified that it did not rain, sleet or snow on December 6, 2016. *Id.* Petitioner had an incident occurring at approximately 6:00 p.m. when the workers had finished putting up sandbags and were waiting to go up the rope line. *Id.*, at 66. He explained that a light plant with four lights as well as a tractor at the bottom of the ravine provided additional lighting. *Id.*, at 67-68. Bryon Sutherland explained that he could see the ground at the bottom of the ravine given the lighting arrangement without difficulty. *Id.*

Bryon Sutherland testified that he was located up the hill slightly and facing to his left when he saw Petitioner fall out of the corner of his eye. Tr2. at 68-69. He testified that Petitioner was not holding on to anything at the time and had not yet started to go up the hill on the rope line. *Id.*, at 69. Bryon Sutherland was located 15-20 feet from Petitioner and explained that two other laborers were at the bottom of the ravine, Jason Sutherland and Mr. McNutt. *Id.* He testified that he, Petitioner and the other two laborers were waiting for everyone to go up explaining that they had to wait until the person in front of them cleared the hill after which you would go up. *Id.*, at 70. This took approximately 1-2 minutes before it was the next person's turn. *Id.* The order in which employees ascended the ravine was random. *Id.* Bryon Sutherland testified that it was unusual and "seemed odd" that Petitioner told him that "[h]e [(Petitioner)] wanted to be last." *Id.* Bryon Sutherland responded "okay" and then proceeded to get in line and wait for his turn to go up. *Id.*, at 73. He testified that "not even minutes" had passed between the time he last looked at Petitioner and the time Petitioner fell. *Id.* Bryon Sutherland was located on the uphill/ascent side of the creek when the incident occurred and Petitioner was on the other side of the creek. Tr2. at 71-72, 73. Mr. Jensen was also on the ascent/rope line side of the creek. *Id.* Petitioner was not on the ascent side of the ravine prior to the fall. *Id.*, at 72.

Bryon Sutherland testified that there was a creek at the bottom of the ravine, but it was not full and the area they crossed did not have a lot of water as the creek was dammed. Tr2. at 70-71. After he saw Petitioner in the last stages of the fall, Bryon Sutherland went over to Petitioner, cleared off debris and made sure he was okay. *Id.*, at 73.74. Bryon Sutherland did not believe that Petitioner was holding the rope when he fell and reiterated that he also was not holding the rope prior to Petitioner's fall. *Id.* No other workers were located at the bottom of the ravine holding the rope prior to the fall. *Id.* Bryon Sutherland testified that it was not possible that Petitioner was located 10-15 feet up the ravine at the time that he fell "because he would have had to roll past me to get to where he was." *Id.*, at 74.

Bryon Sutherland testified that he did not see Petitioner hit his head on anything and while assessing Petitioner, he did not appear to have lost consciousness. Tr2. at 74. He asked Petitioner if he had lost consciousness, which Petitioner denied. *Id.* He also asked Petitioner if he was okay, to which he responded that he was okay. *Id.* Bryon Sutherland denied slapping Petitioner. *Id.*, at 75.

Bryon Sutherland did not believe that Petitioner's upper body was in the creek. Tr2. at 76. Petitioner wanted to get up right away and go up the ravine, to which Bryon Sutherland responded that Petitioner should rest. *Id.* Eventually Petitioner did stand up to go up the hill. *Id.* He testified that he did not necessarily push Petitioner up the hill, but he did let Petitioner rest on him. *Id.*, at 76-77. Once at the top of the hill, Bryon Sutherland testified that he had no further contact with Petitioner. *Id.*, at 77.

Bryon Sutherland testified regarding the rope line and how it was secured explaining that it was secured in the ground with a post and the procedure for going up and down the rope line was one individual at a time with no running or repelling. Tr2. at 77. He testified that this procedure was followed on December 6, 2016 and at no point were there two individuals holding on to the rope line and going up the hill at the same time, which would have been unsafe. *Id.*, at 78.

Bryon Sutherland testified that he visited the accident site in February of 2017 and participated in a reenactment recreating the events at the place where he saw Petitioner fall. Tr2. at 79.

On cross-examination, Bryon Sutherland denied that he would get in trouble if someone was performing an activity incorrectly as one of the senior workers on-site, and also denied that this would be an incentive for him to be dishonest. Tr2. at 79-80. He denied that the area was not fully lit explaining that he could see everything in front of him. *Id.*, at 80. He acknowledged that Petitioner was on the job site when he fell and testified that it was not his testimony that Petitioner did not fall. *Id.*, at 82.

Jason Sutherland

Respondent called Jason Sutherland (Jason Sutherland) as a witness. Tr2. at 26-47. He testified that he was working for Respondent on December 6, 2016. *Id.*, at 26-27. He testified that he was not continuously employed by Respondent after December 6, 2016. *Id.* He stopped working for Respondent in approximately February of 2017 and that he started working for them again in February of 2018. *Id.* As of December 6, 2016, he was working as a foreman. *Id.*, at 27. He testified that in his role he received reports of injuries from employees and/or supervisors. *Id.* He also had special medical training in the form of being EMT licensed in the State of Illinois. *Id.*

Jason Sutherland testified that Petitioner worked for Respondent as a laborer, and he was familiar with Petitioner's work duties. Tr2. at 28. The weather in the morning of December 6, 2016 was chilly, but that there

was no snow, rain or sleet. *Id.*, at 28-29. Jason Sutherland testified that Petitioner reported an injury on that date at approximately 5:30 p.m. or 6:30 p.m. *Id.*, at 29. At the time Petitioner's incident occurred, Jason Sutherland was located at the top of the hill and did not see a fall. *Id.*, at 30-31. He testified that he first came into contact with Petitioner once he reached the top of the hill. *Id.* He explained that there was a "light plant" stationed at the top of the hill, which is a generator with big lights on it. *Id.*

Jason Sutherland testified that he spoke with Petitioner after he reached the top of the hill. Tr2. at 31-32. He asked Petitioner if he was okay to which Petitioner responded that he had fallen. *Id.* Jason Sutherland then questioned Petitioner to determine whether he was alert and oriented, which Petitioner was according to Jason Sutherland. *Id.* He testified Petitioner answered all of his questions appropriately. *Id.*

Jason Sutherland testified that he did not perform any kind of examination on Petitioner as Petitioner refused care. Tr2. at 31. However, Petitioner did not show any signs of pain and he was not wet above the waist or in the upper body. *Id.*, at 31-32. Jason Sutherland testified that Petitioner also denied losing consciousness, but reported that he was sore. *Id.*, at 32. Petitioner further denied any medical assistance including an ambulance and Petitioner was able to stand and walk on his own. *Id.*, at 32-33.

Jason Sutherland testified that after he finished speaking with Petitioner, Petitioner walked on his own approximately 150 feet to Jasper McNutt's truck. Tr2. at 33-34. He testified he had no further contact with Petitioner after that time other than some minimal contact while Mr. Kwilinski was speaking with Petitioner. *Id.*

Jason Sutherland testified that a rope line was being used to go up the ravine and it was secured with a T-post. Tr2. at 35. Employees were supposed to go up and down the rope one at a time. *Id.*

On cross-examination, Jason Sutherland was asked whether slack would be placed on the rope if, for example, there were 2 or 3 people on the line at once and 1 or 2 of the people let go. Tr2. At 36-37. He disagreed that occurred on December 6, 2016 and testified that, even if that had occurred, there would not be slack in the rope as a result. *Id.*

On cross-examination, Jason Sutherland testified that he had visited the job site shortly following the alleged accident for a reenactment. Tr2. at 38. He testified that it was not his intention to help the company, but rather to see "justice prevail." *Id.* He has worked primarily for Respondent, but also for other contractors. *Id.*

On cross-examination, Jason Sutherland disagreed that it was dark at approximately 6:30 p.m. on the alleged date of accident. Tr2. at 40-41. He explained that the entire area was illuminated with "four gigantic lights" such that it was not as bright as in the day time, but lit well enough that you could see. *Id.*

On cross-examination, Jason Sutherland acknowledged that he did not actually see Petitioner coming up on the rope and therefore did not know whether there were more people on the line. Tr2. at 41. However, he also testified that it would have been against the rules if there was more than one individual on the rope line at a time. *Id.* Jason Sutherland further testified that no individual was maintaining the rope or holding the rope at the top of the hill. *Id.*, at 42. He acknowledged that other parts of Petitioner's upper body may have been wet as he simply touched Petitioner on the back one time. *Id.* Jason Sutherland acknowledged that Petitioner did not start the day complaining of soreness, but that Petitioner did complain of soreness at the end of the day. *Id.*, at 43-44.

Mark Kwilinski

Respondent called Mark Kwilinski (Mr. Kwilinski) as a witness. Tr2. at 47-61. He works for Respondent as a Horizontal Directional Drilling Manager. *Id.*, at 48.

Mr. Kwilinski testified that he recalled Petitioner reporting an accident on December 6, 2016 and confirmed that Petitioner was employed as a laborer by Respondent at that time. Tr2. at 48-49. He was not working with Petitioner at the time of alleged accident and he did not see Petitioner fall. *Id.*, at 49-50. However, Mr. Kwilinski testified that he spoke with Petitioner after the incident at approximately 8:00 p.m. *Id.*, at 50-51. He testified that he spoke to Petitioner outside for a moment and then inside of his pick-up truck for approximately 30 minutes. *Id.* He did not recall Petitioner being wet, and Mr. Kwilinski explained that he would have noticed if Petitioner was wet. *Id.* He did not notice any water or dampness on the passenger side of the vehicle after Petitioner exited the truck. *Id.* Mr. Kwilinski did not remember Petitioner being particularly muddy. *Id.*, at 59.

Mr. Kwilinski testified that he and Petitioner called an 800 number to speak with a nurse at which time he asked Petitioner if he was okay, to which Petitioner responded that he was sore. Tr2. at 51-52. He denied that Petitioner reported any hand numbness and could not recall complaints about any specific body parts that were injured. *Id.*, at 52-55. Petitioner did not request to go to the hospital or request pain medication, which was offered in the form of over-the-counter medication. *Id.* He testified that Petitioner was offered medical treatment, and Petitioner was able to get into the truck and exit the truck on his own. *Id.* Mr. Kwilinski testified that he had no further contact with Petitioner after December 6, 2016. *Id.*

On cross-examination, Mr. Kwilinski acknowledged that there was water in the bottom of the creek. Tr2. at 59-61. He acknowledged there was no bridge to cross it, but every employee had to walk through the water in what he described as a very shallow creek. *Id.* Mr. Kwilinski acknowledged that he did not actually touch Petitioner and that it was dark. *Id.*

Lucinda Ramsey

Respondent called Lucinda Ramsey (Ms. Ramsey) as a witness. Tr2. at 8-25. She testified that she was employed by Respondent as the Workers' Compensation Claim Manager. *Id.*, at 9-10. In her position, she receives reports of injuries by employees and/or supervisors. *Id.* Ms. Ramsey testified that she recognized Petitioner as one of Respondent's former laborers, and she was familiar with the general job duties of that position. *Id.*

Ms. Ramsey testified that she first had contact with Petitioner on the morning of December 7, 2016. Tr2. At 11. She contacted him to see if he was okay as she understood there was an incident the prior evening and Petitioner had not shown up for work on December 7, 2016. *Id.* Ms. Ramsey testified that she discussed the December 6, 2016 incident with Petitioner at which time he provided a history of falling backwards down a ravine over a ledge and into a creek. *Id.*, at 12. She asked Petitioner if he needed medical attention and advised him that she needed 20 minutes to make arrangements to have someone pick him up and take him to a clinic. *Id.* Ms. Ramsey testified that Petitioner responded that he was going to obtain medical treatment on his own and he hung up on her. *Id.*

Ms. Ramsey testified that she subsequently contacted the safety manager and requested that she pick up Petitioner and take him to urgent care. Tr2. At 13-14. She then called Petitioner again to let him know that someone would be picking him up to which Petitioner responded that he was already driving to the emergency

room and he was cursing and yelling. *Id.* Ms. Ramsey testified that she tried to reassure Petitioner that she cared for him and wanted to take care of him to which he basically said "f-you and hung up" on her. *Id.*

Ms. Ramsey testified that the urgent care facility was a company clinic that sees injured employees and that every employee has a drug test once seen at the company clinic. Tr2. At 14-15. It was Respondent's policy to have an employee undergo a drug test and Petitioner refused urgent care treatment. *Id.*

Thereafter, Ms. Ramsey testified that she received a call from Petitioner on December 8, 2016 at which time he wanted to know his claim number. Tr2. At 15-16. Ms. Ramsey testified that Petitioner "stated that it was a lot more serious than originally thought and that he was going to need immediate surgery." *Id.* She advised Petitioner that she did not know his claim details at that point and had no further contact with Petitioner. *Id.*

She testified that she contacted other employees to discuss what happened and that their reporting of what happened was inconsistent with what Petitioner alleged. Tr2. at 16-17.

On cross examination, Ms. Ramsey was asked whether her job involved saving the Respondent money, to which she responded that it was not her first priority. Tr2. at 18-20. Ms. Ramsey disagreed that the company clinic would listen to her thoughts after an initial evaluation and explained that the company clinic performs drug testing and evaluates employees as appropriate under the workers' compensation guidelines without any input from her. *Id.* Ms. Ramsey confirmed that Petitioner underwent a pre-employment drug screen the week prior to the incident, which was clear. *Id.*, at 20-21.

On cross-examination, Ms. Ramsey acknowledged that Petitioner reported he was in the Morris Hospital driveway during one of the occasions she spoke with him. Tr2. at 21-22. She testified that the urgent care facility was right down the street and she did not expect Petitioner to turn around from the hospital, but maintained that Petitioner was still required to have a drug test even if he chose Morris Hospital for treatment. *Id.* Ms. Ramsey was asked why she did not call Morris Hospital to have Petitioner undergo a drug test, to which she responded that she was not sure what the hospital at which Petitioner was located at the time. *Id.*, at 22.

Accident Reconstruction

Respondent offered into evidence video footage of an accident reconstruction. RX12. The video shows Bryon Sutherland standing on the other side of the creek in the location that he last saw Petitioner immediately prior the fall. *Id.* The video also documents the creek and ravine at a later point in time, which was described by the various witnesses at the hearing.

Additional Information

Regarding his current condition of ill-being, Petitioner testified that he has limitation in his neck including limited rotation, numbness in his left hand in all of his fingers except the pinky, as well as a shooting pain that comes when it wants to and shoots down his left side down the lower arm and in the left side of his leg. Tr. at 53. Petitioner testified that he wishes to proceed with the recommended surgeries of Dr. Kube and Dr. Rhode. *Id.*, at 54.

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 his employment) to establish that his injury is compensable. *University of Illinois v. Industrial Comm'n*, 365 Ill. App. 3d 906, 910 (1st Dist. 2006).

Based on the totality of the record, the Arbitrator finds that Petitioner failed to establish that he sustained a compensable injury at work on December 6, 2016 as claimed. In so concluding, the Arbitrator finds that Petitioner's testimony regarding his accident is not credible.

Petitioner's testimony about the mechanism of injury is inconsistent. While a claimant may not be expected to recall the minute details of the mechanism of an injury exactly, Petitioner contradicted himself such that his location at the time that he alleges that he fell continued to change. On cross-examination, Petitioner initially testified that he was the last one getting out of the ravine and there were two other laborers in front of him on the rope. He then could not recall how far up the hill he was located at the time that he fell, but estimated that it was approximately 10-to-15 feet while ascending the hill and holding onto the rope. Later still on cross-examination, Petitioner testified that he had not yet started to ascend the hill at the time that he fell and explained that he was "standing there getting ready to climb."

Petitioner's testimony about the mechanism of injury is also inconsistent with his reports during contemporaneous medical treatment regarding the way in which he fell (i.e., from a ledge, while on a rope, while ascending the hill, while getting ready to climb the hill), the distance that he fell (i.e., 10 feet, 10-15 feet), and the symptoms that he experienced immediately after the fall (i.e., neck pain, left shoulder pain, and/or back pain). Of note, Petitioner testified at the hearing that he fell on his neck, head and back. He explained in great detail the very slick and muddy conditions due to rain, sleet, and snow, the water and rocks in the creek at the bottom of the ravine, the time at which he fell while other laborers were ascending the rope to exit the ravine at the end of the day, and the cause of the fall, which was due to others in front of him on the rope that let go causing so much slack that he fell at least 10 feet with such force that it knocked him unconscious. Given the violent fall alleged by Petitioner in slick and muddy conditions into a big ravine with rocks causing him to lose consciousness despite wearing a hard hat from a distance of at least 10-15 feet, it is implausible that Petitioner would have presented at an emergency room of his own choosing after enduring such pain that he was brought to tears without any cuts, scrapes or bruises to be noted by the medical staff.

Petitioner also denied any prior cervical, left shoulder or low back condition of any significance, but years of medical records from the Veteran's Administration reflect otherwise. Petitioner had a history of chronic low back pain reports from January 12, 2010. Petitioner later admitted that he underwent prior medical treatment to the low back as far as 2009 for which he received narcotic prescriptions, but he could not recall reporting chronic low back pain and his admissions on cross-examination were inconsistent with his steadfast testimony on direct examination that he had nothing other than expected soreness as a lifetime laborer. Moreover, Petitioner's first report of back pain or left leg symptoms from the accident as he described it at the hearing occurred almost 45 days after thereafter on January 18, 2017 despite seeking treatment at the emergency room the morning after the alleged accident.

Based on the foregoing, the Arbitrator finds sufficient evidence that Petitioner's testimony is not credible. Notwithstanding, the parties called five other witnesses to testify about the incident and events shortly thereafter.

Petitioner's own witness, Mr. Jensen, did not see Petitioner's fall. He only noted a rustle and then he (Mr. Jensen) and another gentleman looked to see Petitioner already laying in the base of the creek. Notwithstanding, Mr. Jensen testified that estimated that Petitioner went up the rope a distance of approximately 10-15 feet from where he "ended up" despite later admitting that he did not know how far up Petitioner had ascended, if at all, as he did not observe Petitioner behind him until after he heard the "rustle." He also denied that he let go of the rope at any time, and indicated that he was in front of Petitioner 30 feet. Mr. Jensen's testimony does not corroborate Petitioner's version of events and is internally inconsistent. Thus, the Arbitrator does not find Mr. Jensen's testimony to be credible.

The testimony of Respondent's former employee, Bryon Sutherland, who was present in the ravine at the time of the incident controverts Petitioner's testimony regarding the sequence of events undermining his alleged mechanism of injury.

Bryon Sutherland, a former employee of Respondent, testified that he was at the job site at the time of the incident and he particularly recalled Petitioner's odd request to be last to ascend the hill. He explained that he, Petitioner and the other two laborers were waiting for everyone to go up; waiting until the person in front cleared the hill in accordance with safety rules. He did not believe that Petitioner was holding the rope when he fell, but reiterated that he (Bryon Sutherland) also was not holding the rope prior to Petitioner's fall and he was located in front of Petitioner. Bryon Sutherland maintained that it was not possible for Petitioner to be located 10-15 feet up the ravine at the time that he fell "because he would have had to roll past me to get to where he was." Indeed, Petitioner could not have been behind Mr. Jensen on the rope line (who did not let it go causing any slack to cause Petitioner to fall violently) and also be behind Bryon Sutherland on the rope line (who recalled Petitioner's odd request to be last to ascend the hill) when the description by all witnesses present in the ravine at the time of the incident described a single-file procession. Given the testimony of Mr. Jensen as well as Bryon Sutherland that no one let go of the rope, Petitioner's version of how the accident occurred is without merit. Based on the foregoing, the Arbitrator finds that Bryon Sutherland's testimony is credible.

Respondent's remaining witnesses, Jason Sutherland, Mr. Kwilinski, and Ms. Ramsey, all testified about occurrences after Petitioner reached the top of the ravine or during post-incident telephone conversations. The testimony of these witnesses raise concerns about Petitioner's credibility, but they were not in the ravine at the time or witness the incident itself. The Arbitrator finds it unnecessary to delve into the testimony of these witnesses to made a determination regarding Petitioner's credibility. Petitioner's testimony is not credible based

on the inconsistencies in his own testimony on direct and cross-examination, as compared to the remainder of the record, and compared to the testimony of Mr. Jensen and Bryon Sutherland who were present in the ravine at the time of the incident controverting Petitioner's version of events.

Based on the totality of the record, the Arbitrator finds that Petitioner did not sustain a compensable accident as alleged on December 6, 2016. By extension, all other issues are rendered moot and all requested compensation and benefits are denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☐ Affirm and adopt (no changes)
☐ Affirm with changes
☐ Reverse
☐ Modify down

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MARILYN ALVARADO, Petitioner, v. FAITH UNITED PRESBYTERIAN CHURCH, Respondent.	)	NO: 13 WC 33398

ORDER

This matter comes before Commissioner Barbara N. Flores pursuant to the parties' Joint Motion for Entry of Order to Amend Approved Settlement Contract Lump Sum Petition and Order ("Joint Motion").

Pursuant to Section 9070.40(e) of the Rules Governing Practice Before the Illinois Workers' Compensation Commission, the parties may reserve the right to amend an approved Settlement Contract by stipulation and Order of a Commissioner to conform with regulatory requirements including, but not limited to, those of Social Security and Medicare. In no event may those amendments abridge the substantive rights of the parties as listed in the previously approved Settlement Contract.

That by the terms of the Settlement Contract Lump Sum Petition and Order ("Settlement Contract") approved by Arbitrator Maria Bocanegra on July 1, 2015, the Respondent agreed to either fund a Medicare Set-Aside account ("MSA") as approved by the Centers for Medicare and Medicaid Services ("CMS"), or keep Petitioner's medical rights open under Section 8(a).

That Respondent previously had the claim reviewed by Protocols LLC, which proposed an MSA in the amount of $13,959.91. This MSA was never submitted to CMS for approval and was never funded. As such, Petitioner's medical rights under Section 8(a) have remained open since approval of the Settlement Contract.

That Respondent has since had the claim reviewed by another company, NuQuest, which has issued a certified MSA proposal in the amount of $13,976.00. The parties agree this certified MSA will not be submitted to CMS for approval.

That the parties agree the MSA will be self-administered by Petitioner, assisted by Allocations Services, Inc., d/b/a Bridge Pointe and NuQuest, pursuant to a Self-Administration Support Services Agreement between Petitioner and Allocation Services, Inc.

That Respondent elects and is exercising the provisions of the Settlement Contract to terminate Petitioner's medical rights under Section 8(a) by funding the MSA. Respondent further exercises the provisions of the Settlement Agreement that provides for Respondent to fund the MSA with a lump sum payment.

That the parties agree Respondent will fund the MSA and Petitioner will accept the lump sum funding in the amount of $13,976.00. The parties further agree the MSA will be self-administered by Petitioner, per CMS rules and federal regulations, with the assistance of Allocations Services, Inc. Petitioner further agrees to waive all rights pursuant to Section 8(a) of the Illinois Workers' Compensation Act and Occupational Diseases Act upon entry of the Order by the Illinois Workers' Compensation Commission to amend the Settlement Contract.

Therefore, the Commission having jurisdiction over said claim, it is hereby ordered:

1. That the Settlement Contract Lump Sum Petition and Order, approved by Arbitrator Maria Bocanegra on July 1, 2015, is hereby modified as per the Joint Motion (which is attached hereto and made a part hereof), specifically to provide for lump sum funding of the MSA in the amount of $13,976.00, to be self-administered by Petitioner, without submission of the MSA to CMS for approval;

2. That it is the further Order of the Commission that pursuant to the reference Settlement Contract and the parties Joint Motion, Petitioner's continuing rights under Section 8(a) are now closed; and,

3. That the heretofore approved Settlement Contract, as was approved by Arbitrator Maria Bocanegra on July 1, 2015, remains in full force and effect, and shall be read in concert with this Order and Joint Motion.

DATED: June 17, 2020

JUL - 7 2020

Commissioner Barbara N. Flores

STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MARILYN ALVARADO, Petitioner, v. FAITH UNITED PRESBYTERIAN CHURCH, Respondent.	)	Case No. 13WC 33398

JOINT MOTION FOR ENTRY OF ORDER TO AMEND APPROVED SETTLEMENT CONTRACT LUMP SUM PETITION AND ORDER

The parties hereby request entry of an order by the Commission to amend the approved Settlement Contract Lump Sum Petition and Order, and in support state as follows:

1. The parties entered into a "Settlement Contract Lump Sum Petition and Order" (hereinafter "Settlement Contract"), which was approved by Arbitrator Maria Bocanegra on July 1, 2015. (Exhibit A)

2. The Terms of Settlement provided Respondent would either fund a Medicare Set-Aside account (hereinafter "MSA") as approved by the Centers for Medicare and Medicaid Services (hereinafter "CMS"), or keep Petitioner's medical rights open under Section 8(a).

3. The Respondent previously had the claim reviewed by a medical-financial company, Protocols LLC, which proposed an MSA in the amount of $13,959.91. This MSA was never submitted to CMS for approval and was never funded. As such, Petitioner's medical rights under Section 8(a) have remained opened since approval of the lump sum settlement contract.

3. The Respondent has since had the claim reviewed by another medical-financial company, NuQuest. In a report dated May 8, 2019, NuQuest issued a certified MSA proposal in the amount of $13,976.00. (Exhibit B) The parties agree this certified MSA will not be submitted to CMS for approval.

4. The parties agree the MSA fund will be self-administered by Petitioner, assisted by Allocation Services Inc, d/b/a Bridge Pointe and NuQuest, pursuant to a Self-Administration Support Services Agreement between Petitioner and Allocation Services, Inc. (Exhibit C)

5. Respondent elects and is exercising the provisions of the Settlement Agreement to terminate Petitioner's medical rights under Section 8(a) by funding the MSA. Respondent further exercises the provisions of the Settlement Agreement that provides for Respondent to fund the MSA with a lump sum payment.

6. The parties therefore agree Respondent will fund the MSA and Petitioner will accept the funding of $13,976.00. The MSA shall be self-administered by Petitioner, as per CMS rules and federal regulations, with the assistance of Allocation Services, Inc., as noted in paragraph 4 above. Petitioner agrees to waive all rights pursuant to Sections 8(a) of the Illinois Workers' Compensation and Occupational Disease Acts upon entry of the Order by the Illinois Workers' Compensation Commission to amend the Settlement Contract.

7. Pursuant to Section 9070.40(e) of the Rules Governing Practice Before the Illinois Workers' Compensation Commission, the parties may reserve the right to amend an approved Settlement Contract by stipulation and Order of a Commissioner to conform with regulatory requirements including, but not limited to, those of Social Security and Medicare. In no event may those amendments abridge the substantive rights of the parties as listed in the previously approved Settlement Contract.

WHEREFORE, the parties request the Commission enter an Order amending the approved Settlement Contract Lump Sum Petition and Order in this matter, as per the terms noted above, specifically changing the amount of the MSA to be funded in a lump sum to $13,976.00, and closing Petitioner's rights under Section 8(a) of the Act.

Respectfully submitted,

Marilyn Alvarado 1/10/20
Marilyn Alvarado Date
Petitioner

1/15/20
Randall W. Sladek Date
Attorney for Petitioner

James M. Byrnes 2/21/20
James M. Byrnes Date
Attorney for Respondent

ILLINOIS WORKERS' COMPENSATION COMMISSION
SETTLEMENT CONTRACT LUMP SUM PETITION AND ORDER

ATTENTION. Please type or print. Answer all questions. File four copies of this form. Attach a recent medical report.

/orkers' Compensation Act ☒ Occupational Diseases Act ☐ Fatal case? No ☒ Yes ☐ Date of death _____

larilyn Alvarado
nployee/Petitioner

Case # 13WC 33398

aith United Presbyterian Church
nployer/Respondent

Setting Chicago - BOOKING

) resolve this dispute regarding the benefits due the petitioner under the Illinois Workers' Compensation or Occupational Diseases Act, : offer the following statements. We understand these statements are not binding if this contract is not approved.

larilyn Alvarado	17 Bobwhite Lane	Beecher, IL	60401
nployee's name	Street address	City, State, Zip code	
aith United Presbyterian Church	6200 W. 167th Street	Tinley Park, IL	60477
nployer's name	Street address	City, State, Zip code	

ate Employee? Yes ☐ , No ☒ Male ☐ Female ☒ Married ☐ Single ☒

Dependents under age 18 0 Birthdate 6/26/1943 Average weekly wage $ 240.00

te of accident 1/18/2011

)w did the accident occur? Slip and fall on employer's parking lot

hat part of the body was affected? Right foot

hat is the nature of the injury? Trimalleolar fracture of right ankle

e employer was notified of the accident orally ☒ in writing ☐ Return-to-work date 3/28/2011

cation of accident Tinley Park Did the employee return to his or her regular job? Yes ☒ No ☐
lot, explain below and describe the type of work the employee is doing, the wage earned, and the current employer's name and address.

MPORARY TOTAL DISABILITY BENEFITS: Compensation was paid for 9-4/7 weeks at the rate of $ 220.00/week.
e employee was temporarily totally disabled from 1/19/2011 through 3/27/2011 .

DICAL EXPENSES: The employer has ☐ has not ☒ paid all medical bills. List unpaid bills in the space below.
e Terms of Settlement

EVIOUS AGREEMENTS: Before the petitioner signed an *Attorney Representation Agreement*, the respondent or its agent offered
vriting to pay the petitioner $ 0 as compensation for the permanent disability caused by this injury.
arbitrator or commissioner of the Commission previously made an award on this case on N/A regarding
D $ ----- Permanent disability $ ----- Medical expenses $ ----- Other $ -----

EXHIBIT A

MS OF SETTLEMENT: Attach a recent medical report signed by the physician who examined or treated the employee.

e Attached Addendum

al amount of settlement	$ 16,533.00
duction: Attorney's fees	$ 3,306.00
duction: Medical reports, X-rays	$ 232.46
duction: Other (explain)	$ 0
ount employee will receive	$ 12,994.54

TITIONER'S SIGNATURE. *Attention, petitioner. Do not sign this contract unless you understand all of the following statements.*
ve read this document, understand its terms, and sign this contract voluntarily. I believe it is in my best interests for the Commission to prove this contract. I understand that I can present this settlement contract to the Commission in person. I understand that by signing contract, I am giving up the following rights:

1. My right to a trial before an arbitrator;
2. My right to appeal the arbitrator's decision to the Commission;
3. My right to any further medical treatment, at the employer's expense, for the results of this injury;
4. My right to any additional benefits if my condition worsens as a result of this injury.

Karilyn Alvarado — Marilyn Alvarado — 6/26/15

nature of petitioner | Name of petitioner (please print) | Telephone number | Date

TITIONER'S ATTORNEY. I attest that any fee petitions on file h the IWCC have been resolved. Based on the information sonably available to me, I recommend this settlement contract be proved.

nature of attorney — Date 6/29/15

ck Gilhooly #154
orney's name and IC code # (please print)

ol, Bonglorno & Given, Ltd.
m name

0 N. LaSalle St. #1160
eet address

icago, IL 60602
y, State, Zip code

12) 726-5567
lephone number — E-mail address

36-2803701

RESPONDENT'S ATTORNEY. I attest that any fee petitions on file with the IWCC have been resolved. The respondent agrees to this settlement and will pay the benefits to the petitioner or the petitioner's attorney, according to the terms of this contract, promptly after receiving a copy of the approved contract.

Signature of attorney or agent — Date 6/9/15

James M. Byrnes #210
Attorney's name and IC code # or agent (please print)

Ganan & Shapiro, P.C.
Firm name

210 W. Illinois Street
Street address

Chicago, IL 60654
City, State, Zip code

(312) 822-0040
Telephone number — E-mail address

Chubb Indemnity Insurance Company
Name of respondent's insurance service company (please print)

RDER OF ARBITRATOR OR COMMISSIONER:
ving carefully reviewed the terms of this contract, accordance with Section 9 of the Act, by my stamp ereby approve this contract, order the respondent promptly pay in a lump sum the total amount of ttlement stated above, and dismiss this case.

APPROVED BY AUTHORITY OF THE ILLINOIS WORKERS' COMPENSATION COMMISSION
Pursuant to the Illinois Workers' Compensation and Occupational Diseases Acts

JUL - 1 2015

By: Maria S. Bocanegra, Arbitrator

5 page 2

13 WC 33398

MARILYN ALVARADO V. FAITH UNITED PRESBYTERIAN CHURCH

ADDENDUM TO LUMP SUM SETTLEMENT CONTRACT

Respondent offers and Petitioner accepts a lump sum of $16,533.00 and an additional sum for a proposed Medicare Set-Aside (hereinafter "MSA"), per petition below, in full, final and complete settlement. Respondent is hereby released, acquitted and discharged from any and all liability under the Illinois Workers' Compensation or Occupational Disease Acts or otherwise for all accidental injuries or disablements allegedly incurred on January 18, 2011 as described herein and including any and all results, developments and sequelae, fatal or non-fatal, resulting from or allegedly resulting from such accidental injuries or disablements. Issues exist between the parties as to whether the Petitioner sustained injuries or disablements to the degree alleged and whether or not such injuries or disablements are compensable, and this settlement is made to amicably settle those issues. Review under Section 19 (h) is expressly waived by the parties. The lump sum settlement is in the amount of $16,533.00, and represents 45% loss of use of the right foot, or $220.00 per week for a period of 75.15 weeks.

Nothing herein shall be construed to constitute a waiver of the Respondent's rights to reimbursement or workers' compensation lien pursuant to Sections 5(b) of the Illinois Workers' Compensation and Occupational Diseases Acts. This settlement shall be null and void unless accepted and approved by the Illinois Workers' Compensation Commission prior to August 1, 2015.

Petitioner is currently 71 years of age, and is therefore a Medicare beneficiary. It is not the intention of the workers' compensation insurance carrier, Petitioner or Respondent to shift responsibility for future medical expenses to the federal government. Respondent had the claim reviewed by a medical-financial company, Protocols LLC, who recommended a proposed MSA of $13,959.91. As Petitioner is a current Medicare beneficiary and the total value of the settlement exceeds $25,000.00 and is therefore deemed reviewable by CMS, the parties will be submitting the proposed MSA to CMS for approval.

Upon approval of the MSA by CMS, Respondent reserves the right to fund the MSA with a lump sum payment or with the purchase of an annuity. If CMS should determine funding in a different amount is required, regardless of whether the MSA funding amount approved by CMS is greater or lesser than the amount currently anticipated and stated in the terms of this settlement, the parties agree Respondent shall either fund the MSA or at its sole discretion, Respondent may elect to keep Petitioner's rights open pursuant to Section 8(a) of the Illinois Workers' Compensation Act. If Respondent so elects, Respondent shall notify Petitioner of its election in writing and Respondent will not separately fund the MSA. Respondent will not separately fund the MSA if it elects to leave Petitioner's rights open under Section 8(a) of the Act. In addition, *if Respondent elects to keep Petitioner's Section 8(a) medical rights open*, it is agreed that any future treatment must be reasonable, necessary and causally related to the work accident of January 18, 2011 and under such circumstances both parties retain their rights under Sections 8(a), 8.2, 8.7 and 12 of the Act. If Respondent elects to fund the MSA, Petitioner's rights under Section 8(a) will otherwise be waived by Petitioner upon funding of the MSA by Respondent. Under all circumstances, the parties waive all rights to vocational rehabilitation, maintenance and TTD/TPD benefits pursuant to Section 8(a) upon approval of this agreement by the Illinois Workers' Compensation Commission.

The MSA fund is created to provide a resource to satisfy Petitioner's future Medicare eligible expenses, if any, relative to the injuries of January 18, 2011. It is the intention of the parties that the Respondent-funded trust shall be self-administered by Petitioner. In consideration of Respondent's agreement to fully fund the trust, Petitioner agrees to fully cooperate with Respondent to obtain approval for the MSA from CMS and for the purchase of an annuity, if Respondent so elects to fund the MSA in this manner. Petitioner's cooperation shall include, but is not limited to, signing all documents and releases, providing updated medical documentation or reports from his treating physician, providing all prescription drug information, providing any other documentation requested by Respondent and its agents for the purpose of establishing the trust.

Having been advised that certain funds must be set-aside for future Medicare covered expenses which are work-related and to consider and protect Medicare's interest, as required by 42 U.S.C. §1395y(b) (The Medicare Secondary Payer Statute) and in accordance with 42 C.F.R. §411.46, Petitioner acknowledges and agrees to the following:

1. The MSA will be self-administered by Petitioner. Petitioner agrees to take sole responsibility to maintain a separate, interest-bearing account containing said MSA funds. Petitioner acknowledges that the trust funds must be separate from Petitioner's personal savings and checking accounts and that if payment from the account is not used to pay for services that relate to this accident and that are covered by Medicare, Medicare will not pay injury-related claims until the funds are restored to the trust account and then properly exhausted.

2. Petitioner also understands that annual reporting must be prepared for submission to Medicare to include summaries of the transactions and status of the account and that the summaries are to include the date of each service, procedure performed, diagnosis and paid receipt of cancelled check as evidence of payment for the service.

3. Petitioner agrees to disburse funds from the MSA account solely in payment of qualified medical expenses and supplemental medical services he incurs as direct result of the work-related injury for which said funds are being paid. "Qualified Medical Expenses" mean such amounts as are reasonably necessary for Petitioner's medical and surgical care, hospital care, medical and surgical supplies, skilled and immediate nursing care, skilled rehabilitation services that are incurred by Petitioner as a result of the work-injury.

4. Petitioner will ensure that all payments made from this account are in accordance with the Illinois Workers' Compensation Fee Schedule and acknowledges that any amounts paid above the fee schedule will not be considered as proper deductions from the account.

5. Petitioner acknowledges and understands that upon complete exhaustion of the MSA fund, Medicare may only be responsible for additional work-related, Medicare covered expenses if the claimant is a Medicare beneficiary at the time of the complete exhaustion and has paid any enrollment fees, co-pays or deductibles associated with or required by the Medicare Elective Programs, but not limited to, Part B and Part D (Prescription Coverage).

6. Petitioner acknowledges and understands that she may be responsible for any and all future medical expenses, including those which would be covered by Medicare if the Petitioner were a Medicare beneficiary, after exhausting the MSA, should Medicare not be responsible for, or refuses to pay, any such expenses, regardless of the reason.

7. Even if Petitioner is a Medicare Beneficiary, Petitioner understands that Medicare will not pay for any expenses related to the work injury until, and unless, the Petitioner can provide documentation indicating that the entire MSA account, including any accrued interest, was properly expended on Medicare covered treatments and expenses related to the work injury of January 18, 2011.

Respondent agrees to reimburse to Medicare any conditional payments or liens incurred to the date of this settlement agreement only. The expenses subject to reimbursement must be related to the work injury. Respondent reserves the right to appeal or dispute any conditional payments made by Medicare. Respondent reserves the right to negotiate the conditional payments/lien with Medicare directly. Petitioner agrees to fully cooperate with Respondent and provide all necessary documentation/releases necessary for Respondent and Medicare to adjudicate the conditional payments/lien. This provision applies to past conditional payments and liens of Medicare only, and shall have no force and effect on future Medicare medical expenses.

Petitioner — Date: X 6/24/15

Petitioner's Attorney — Date: 6/29/15

Respondent's Attorney — Date: 6/9/15

APPROVED BY AUTHORITY OF THE
ILLINOIS WORKERS' COMPENSATION COMMISSION
pursuant to the provisions of the
Workers' Compensation and Workers'
Occupational Diseases Acts

JUL - 1 2016

By: Maria S. Bocanegra, Arbitrator

NuShield™
The Certified MSA.

NuShield (Certified MSA) Proposal

Claim Information			
Service Coordinator	Myra Peoples	Email Address	mpeoples@mynuquest.com
Report Date	05/08/2019	Case Type	Workers' Compensation
Report Prepared for	Church Mutual Insurance Company/Shane Literski	State of Jurisdiction	Illinois
Report Prepared by	Patrick O'Neal, RN, CRRN, MSCC	Date of Birth	06/26/1943
Claimant	Marilyn A. Alvarado	Type of Settlement	Commutation
Claim Number	1127901	Date of Injury	01/18/2011

MSA Recommendations	
Total Proposed MSA Amount	**$13,976**
Future MSA Medical Treatment Amount	$8,564
Future MSA Prescription Drug Treatment Amount	$5,412

MSA Annuity Funding Recommendation	
Total Seed	$3,993
Seed Payment Due	Recommended within 30 days of final settlement date.
Seed Includes	The cost of the first 2 years of annual payments.
Annual Payment Amount	$1,663
First Annual Amount Due	A set anniversary date which cannot be more than 1 year after the settlement date.
Total Number of Annual Payments	06
MSA Lump Sum Funding Recommendation	
Total Lifetime Funding Amount	$13,976
Funding Payment Due	Recommended within 30 days of final settlement date.

Life Expectancy	
Gender	Female
Date of Birth	06/26/1943
Actual Age	75 Years
Rated Age	85 Years
Life Expectancy	07 Years (Rounded to the nearest whole number)

Medical Review/Document Review Narrative

Date of Injury and ICD-10 Diagnosis Related to This Claim		
01/18/2011	M25.571	Pain in right ankle and joints of right foot
01/18/2011	M25.561	Pain in right knee

Date of Injury and ICD-10 Diagnosis Disputed/Denied

None

Pre-Existing or Co-Morbid Conditions Unrelated To This Claim

- L4 compression fracture in 2018
- Left total hip degenerative joint disease
- Overweight
- Atrial fibrillation
- Chronic kidney disease
- Kidney stones

EXHIBIT B

• Diabetes
• Gastritis
• Gastroesophageal reflux disease
• Hypercholesterolemia
• Hypertension
• Diabetic neuropathy
• Peripheral vascular disease
• Urinary incontinence
• Surgeries include polypectomy, bilateral inguinal stent placement, appendectomy, left breast cystectomy, cataract extraction, coronary angioplasty, and trigger finger release

Summary of Treatment/Current Medical Status

Claimant sustained an industrial injury to her right knee and right ankle on 01/18/2011 after falling. Claimant was diagnosed with a right ankle fracture and underwent an open reduction and internal fixation in 2011. Claimant did well for a number of years, but then began complaining of symptomatic right ankle hardware and underwent hardware removal on 03/29/2018. Claimant developed infected wounds in her right ankle and foot postop and received wound care and antibiotics for several weeks. Claimant's wounds eventually healed and she was discharged by the infectious disease physician at the wound clinic on 10/18/2018. The infectious disease physician noted that the claimant's residual right ankle/foot pain was out of proportion to her physical findings and recommended a referral to pain management. Pain management recommended gradually weaning off of the hydrocodone/APAP and prescribed lidocaine patches and tizanidine. Claimant was last seen by pain management on 01/21/2019 and it was noted that her right ankle/foot pain was minimal and she was off of the hydrocodone/APAP. Pain management assigned maximum medical improvement and recommended tizanidine at bedtime as needed for pain. Claimant was instructed to followup with the orthopedist. Claimant was last seen by the orthopedist on 04/12/2019 and was doing well and reported using Norco one pill per week for pain control. Claimant was requesting a refill of the Norco (hydrocodone/APAP) and the orthopedist noted that she was at risk for chronic pain. The orthopedist opined that no further treatment was needed at this time except pain control and instructed the claimant to followup as needed for medication refills. Per the pharmacy ledger, the claimant is receiving refills of hydrocodone/APAP 10-325mg #120 approximately every three months. Claimant also received a recent prescription for pentoxifylline from the infectious disease physician to improve small vessel circulation in her right ankle/foot. The right knee has not been treated in the last two years of current treatment records.

Please see the following page(s) for the allocation details.

Future MSA Medical Treatment

The below chart summarizes the future medical treatment costs.

Service Description	CPT Code	Service Frequency	Occurring Every X Years	Over Total # of Years	Price Per Service Frequency	Total
Physician Services						
Orthopedist, general	99213	4	1	7	$83.39	$2,334.92
Infectious disease, general	99213	2	1	7	$83.39	$1,167.46
Pain management, general	99213	2	1	7	$83.39	$1,167.46
Physician Services Sub-Total						**$4,669.84**
Therapies						
Physical therapy	97110	6	7	7	$144.96	$869.76
Therapies Sub-Total						**$869.76**
Diagnostic Testing						
Venipuncture	36415	1	1	7	$16.53	$115.71
CMP	80053	1	1	7	$62.50	$437.50
CBC	85025	1	1	7	$43.85	$306.95
X-ray right ankle	73610	1	1	1	$96.21	$96.21
MRI right ankle without/with	73723	1	1	1	$2,067.59	$2,067.59
Diagnostic Testing Sub-Total						**$3,023.96**
Total Future MSA Medical Treatment						**$8,563.56**

Per CMS protocol, the following calculation formula was used: '# of years' divided by 'Every X Years' multiplied by 'Frequency' multiplied by 'Price per Service' = Total

Future Part D Drugs

According to available documentation, Marilyn A. Alvarado is receiving Part D drugs. The following chart summarizes the future Medicare Part D drug costs.

Drug Name and Dosage	NDC	Amount per Month	Months per Year	Total # of Years	Price per Unit	Total
Hydrocodone/APAP 10-325mg (generic)	71930002152	40	9	7	$0.45	$1,134.00
Pentoxifylline ER 400mg (generic)	68682010150	90	9	7	$0.43	$2,438.10
Tizanidine 4mg (generic)	57664050313	30	6	7	$1.46	$1,839.60
Total Future Prescription Drugs (Medicare Part D)						**$5,411.70**

MSA Grand Total (Total Future MSA Medical Treatment and Total Future Part D Drugs)	**$13,975.26**

Complications

While it is impossible to accurately predict the nature and frequency of complications, the historical nature and frequency of complications specific to this case have been considered in the preparation of this report.

The projections contained in the proposed Medicare Set-Aside allocation are based upon the good faith professional judgment of NuQuest, its employees or agents based on the information available to NuQuest as of the time the report was completed. This Medicare Set-Aside (MSA) report only addresses the claims identified on page one of the report. If additional accident dates and claims are included in the settlement terms, separate MSA reports and conditional payment searches may be appropriate.

Self-Administration Support Services Agreement

This Self-Administration Support Services Agreement (the "Agreement"), dated the 8th day of May, 2019, is made by and between Marilyn A. Alvarado (the "Beneficiary") and ALLOCATION SERVICES, INC., D/B/A BRIDGE POINTE ("Bridge Pointe") and NuQuest ("NuQuest"). The Beneficiary and Bridge Pointe are sometimes referred to herein each as a "party" and together as the "parties."

WHEREAS, the Beneficiary and Church Mutual Insurance Company (the "Payer") have entered into a settlement of certain claims (the "Settlement") relating to injuries alleged by the Beneficiary (the "Injury");

WHEREAS, pursuant to the Medicare Secondary Payer Act, Medicare's interests must be considered in any settlement where a claimant may rely on Medicare coverage for payment of future medical expenses related to such settlement;

WHEREAS, the Settlement established a certified Medicare set-aside allocation amount ("MSA") for the payment of the Beneficiary's future Medicare-covered medical expenses arising from or related to the Injury ("Allowable Expenses");

NOW THEREFORE, in consideration of the mutual promises set forth below, the parties to this Agreement agree as follows:

DUTIES OF BRIDGE POINTE

1. Activation of Support Services: Bridge Pointe shall promptly activate MSA support services for the Beneficiary following its receipt of the following: (a) a copy of the MSA report; (b) a copy of the executed settlement documents between the Beneficiary and the Payer; (c) a copy of the final court order, commission order or settlement order, as applicable; and (d) the administration support services fee from the Payer.

2. Resource Manual: Within five (10) calendar days following the support services account activation date (as determined under the previous paragraph), Bridge Pointe will provide the Beneficiary with a resource manual, which contains necessary resources, forms and instructions on how to: establish the MSA account; submit annual self-attestation to Medicare; communicate with providers about services payable from the account; notify Medicare of temporary/permanent depletion of the MSA account funds; determine which medical items and services are typically covered by Medicare; and obtain workers' compensation fee schedule information.

3. Attestation Letter: Bridge Pointe shall provide the Beneficiary with a copy of the attestation letter for annual reporting that states that all payments from the MSA account were made for Medicare covered medical and prescription drug expenses related to the workers' compensation claim, or for Allowable Expenses.

4. Telephonic Support: Bridge Pointe shall provide unlimited support by toll-free help line at 877-551-3900 or by email at Info@NQBP.com for the duration of the Agreement.

EXHIBIT C

5. Access to Discount Services: Bridge Pointe shall provide access to discounted services for injury-related prescriptions, durable medical equipment and disposable supplies. Discount access remains available to the Beneficiary for the life of the Agreement.

6. Set up of MSP Card: Bridge Pointe shall provide assistance with the establishment of the BridgePointe MSP Card that serves as a pharmacy and medical debit card.

7. Unlimited Medical Bill Review: Bridge Pointe shall provide unlimited medical bill review and fee scheduling for treatments and therapies identified in the MSA as payable from the MSA account, and identify equipment, supplies and prescriptions payable from the MSA account.

8. Annual Reminders: Bridge Pointe shall provide annual reminders to Beneficiary for the annual reporting to CMS for the life of the account.

DUTIES OF BENEFICIARY:

1. Section 1862(b)(2) of the Social Security Act: The Beneficiary agrees that Medicare is not permitted to pay for medical items or services, including prescription drug expenses, related to injury until the certified MSA is appropriately exhausted (properly spent) on related medical care that is covered and otherwise reimbursable by Medicare (Medicare covered).

2. Interest Bearing Account: The Beneficiary agrees that the certified MSA funds must be placed in an interest bearing account, separate from the Beneficiary's personal savings or checking account.

3. Allowable Expenses: The Beneficiary agrees that the certified MSA funds may only be used to pay for medical items and services and prescription drug expenses related to the Beneficiary's workers' compensation claim that would otherwise be covered by Medicare, or for the following certain expenses, including:
   - Document copying charges
   - Mailing fees or postage
   - Any banking fees related to the account
   - Income tax on interest income from the account

4. Non Allowable Expenses: The Beneficiary agrees that funds in the NuShield Certified MSA account may not be used to purchase a Medicare supplemental insurance policy or a Medigap policy, or to pay for the premiums for such policies.

5. Rollover of Funds: Beneficiary agrees that if the NuShield Certified MSA is funded as a structured settlement (settlement monies paid out in yearly installments over a number of years), any MSA account funds, along with any accrued interest that are not used in a given year must remain in the account to pay for related medical care during later years.

6. Annual Reporting: Beneficiary agrees that CMS requires the annual submission of the attestation letter, which states that all payments from the NuShield Certified MSA account were made for Medicare-covered medical and prescription drug expenses related to the workers'

compensation claim, or for allowable expenses. CMS requires that the annual attestation be submitted to the BCRC at the address provided no later than 30 days after the end of each reporting year, which starts with the date the account is established and ends on that date in the following year. Beneficiary acknowledges that records may be requested by the BCRC as proof of appropriate payments from the MSA account.

7. Inappropriate Use of Funds: The Beneficiary agrees that if funds from the NuShield Certified MSA are used to pay for services other than Medicare allowable medical expenses related to the workers' compensation claim, Medicare will not pay injury related claims until these funds are restored to the MSA account and then properly spent.

8. Change of Address or Phone Number: The Beneficiary agrees to promptly notify Bridge Pointe upon any change in address or phone number.

IN WITNESS WHEREOF, the Parties have signed this Agreement as of the day and year first above written.

ALLOCATION SERVICES, Inc. d/b/a BRIDGE POINTE AND NUQUEST:

By: _____

Name: _____

Title: _____

BENEFICIARY:

By: Marilyn Alvarado

Name: Marilyn A. Alvarado

Date: 2/12/20

Address: _____

_____

Phone: _____

In order to provide ongoing support via email, please provide your email address:

_____

STATE OF ILLINOIS)
) SS.
COUNTY OF McLEAN)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jack Alpers,

Petitioner,

vs. No. 17 WC 14640

Illinois State University,

Respondent.

20IWCC0382

DECISION AND OPINION ON REVIEW

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

The Commission expands the decision of the Arbitrator to reflect the credit for the temporary total disability benefits is for the periods agreed to and paid by Respondent.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 9, 2019, is hereby affirmed with changes.

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

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

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

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

DATED: JUL - 6 2020
o-06/23/2020
SM/sk
44

Stephen Mathis

L. Elizabeth Coppoletti

DISSENT

I dissent from the Majority's decision to affirm and adopt the Arbitrator's finding that Petitioner only injured his left-sided low back and left lower extremity on March 2, 2017, and that Petitioner failed to prove any causal relationship between his right-sided low back and right lower extremity complaints and the March 2, 2017 work-related accident.

I find instead that Petitioner proved that his condition of ill-being with respect to both sides of his low back and bilateral lower extremities were causally related to the accident of March 2, 2017. Notwithstanding any equivocal opinion from Petitioner's treating physician, Dr. Jhee, the chain of events and the medical records in this case support an additional finding of causation for Petitioner's right-sided injuries.

"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). Additionally, an accident need only be *a* cause of a condition of ill-

being for a claimant to recover under the Act. *Schroeder v. Ill. Workers' Comp. Comm'n*, 2017 IL App (4th) 160192WC, ¶ 29.

Prior to the March 2, 2017 injury date, Petitioner worked for Respondent as a groundskeeper. As noted in the ATI Physical Therapy records, Petitioner's duties were in the heavy physical demand level. His duties included turf maintenance, gardening, landscaping, planting trees, running jackhammers, laying asphalt, removing snow, and digging holes. Two weeks prior to March 2, 2017, Petitioner was assigned the job of dismantling and rebuilding a concrete block wall. Petitioner was able to and did perform his regular duties without restriction.

The record also did not demonstrate any significant history or treatment involving the lumbar spine.

Petitioner testified that after performing the concrete wall project, his initial pain complaints involved the entire low back and left leg; this is so indicated on the injury forms dated March 7, 2017, in the treating records from OSF Saint Joseph Medical Center of March and April 2017, and in Dr. Stroink's May 11, 2017 medical record. The June 8, 2017 MRI of the lumbar spine noted mild disc desiccation, slight disc space loss of height from L3 to S1, some displacement or degenerative retrolisthesis at L5-S1, and mild right-sided neural foraminal narrowing. Dr. Jhee had explained during his deposition that obstruction of the neuroforaminal in the lumbar spine could compress the nerve root thereby resulting in radiculopathy.

Dr. Jhee's initial evaluation of Petitioner, on August 10, 2017, had indicated tenderness on both sides of the sacroiliac joint, and the ATI Physical Therapy Initial Evaluation, dated August 15, 2017, described the nature of injury as low back pain that eventually started referring down Petitioner's left leg. Petitioner also exhibited deficits with lumbar rotation and lumbar side bending to the right. The August 28, 2017 record from ATI added that due to pain in the right, low back, Petitioner could not tolerate certain motions. Here, the contemporaneous medical records noted general low back pain and dysfunction that had been present since the work injury.

There is no dispute that Petitioner sustained left-sided injuries following the March 2, 2017 work accident which necessitated immediate and significant treatment, including a left-sided L5-S1 microdiscectomy on May 24, 2017. However, Petitioner testified that he had felt pain in his entire low back after the work injury. He stated that following his treatment and recovery for the left side, his right-sided symptoms had worsened. Petitioner explained that the initial, lower extremity complaints involved his left leg, but after undergoing and completing a work conditioning program in March 2018, he noted worsening, right-sided symptoms starting to radiate down the right side of his buttocks. Dr. Jhee's May 24, 2018 office visit note indicated that during the last couple of months, Petitioner had been having increasing low back pain that by now was radiating all the way down to the right shin area.

Although Petitioner's treater, Dr. Jhee, did not provide a strong causation opinion at his deposition, he did believe that Petitioner's symptoms could be due to either radicular pain on the right side or due to right sacroiliac joint dysfunction which he had first noted in August 2017. Dr. Jhee further testified that Petitioner may have had gradual worsening of the right sacroiliac joint dysfunction which caused some right-sided leg pain and radicular symptoms.

Based on the record in its entirety, the evidence provides a consistent timeline and corroborates Petitioner's testimony with respect to his right-sided low back and right lower extremity complaints. There was no history with respect to the disputed, affected body parts, there was no evidence of any subsequent, intervening injury, but there was sufficient evidence in the record demonstrating a gradual deterioration of Petitioner's right-sided low back and right lower extremity condition following the March 2, 2017 work accident. This resulting deterioration, which necessitated treatment and affected his ability to work, is sufficient evidence that Petitioner's condition of ill-being with respect to his right-sided injuries was causally related to the accident of March 2, 2017. As such, I dissent from the Majority's decision with respect to Petitioner's alleged injuries to his right-sided low back and right lower extremity and would award benefits accordingly.

D. Douglas McCarthy

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

ALPERS, JACK
Employee/Petitioner

Case# **17WC014640**

20IWCC0382

ILLINOIS STATE UNIVERSITY
Employer/Respondent

On 12/9/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.56% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0564 WILLIAMS & SWEE LTD
WILLIAM D TRIMBLE
2011 FOX CREEK RD
BLOOMINGTON, IL 61701

0988 ASSISTANT ATTORNEY GENERAL
LOUIS LAUGGES
500 S SECOND ST
SPRINGFIELD, IL 62706

0903 ILLINOIS STATE UNIVERSITY
1320 ENVIRONMTL HEALTH SAFETY
NORMAL, IL 61790

0904 STATE UNIVERSITY RETIREMT SYS
PO BOX 2710 STATION A
CHAMPAIGN, IL 61825

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

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

DEC -9 2019

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

20IWCC0382

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)

Jack Alpers
Employee/Petitioner

v.

Case # **17** WC **14640**

Consolidated cases: **N/A**

Illinois State University
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Bloomington**, on **October 24, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **March 2, 2017,** Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

Petitioner's current condition of ill-being ***as it relates to the right-sided low back and right lower extremity is not*** causally related to the accident, but Petitioner's condition of ill-being as it relates to the left-sided low back and left lower extremity is causally related to the accident.

In the year preceding the injury, Petitioner earned **$45,097.06**; the average weekly wage was **$867.25**.

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

Respondent shall be given a credit of **$60,132.80** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of $ **60,132.80.**

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

ORDER

Respondent shall pay all reasonable and necessary medical services as contained in Petitioner's Exhibit 12 **for medical services rendered up to and including November 20, 2018** as provided in Sections 8(a) and 8.2 of the Act. Respondent is to hold Petitioner harmless for any claims for reimbursement from any health insurance provider and shall provide payment information to Petitioner relative to any credit due. Respondent is to pay unpaid balances with regard to said medical expenses **for treatment rendered up to and including November 20, 2018** directly to Petitioner. Respondent shall pay any unpaid, related medical expenses **for treatment rendered up to and including November 20, 2018** according to the fee schedule and shall provide documentation with regard to said fee schedule payment calculations to Petitioner. Respondent is entitled to a credit **for all benefits paid through group insurance** under Section 8(j) of the Act.

As Petitioner has failed to prove that his current condition of ill-being in the right-sided low back and right lower extremity is causally related to the accident of March 2, 2017, Petitioner's request for prospective medical treatment to the right-sided low back and right lower extremity as recommended by Dr. Seibly is hereby denied.

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

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

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

Signature of Arbitrator

12/3/19
Date

ICArbDec19(b)

DEC 9 - 2019

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(B)

Jack Alpers
Employee/Petitioner

Case # **17** WC **14640**

v.

Consolidated cases: **N/A**

Illinois State University
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that in March of 2017 he was employed by Respondent as a grounds worker. He testified that he has been employed by Respondent since 1997, and that he has worked in grounds since he started working there. He testified that before the two-week period of moving concrete blocks, he was able to go to work at a heavy level and that he could pick up heavy things, squat, and bend. He further testified that various tasks that he performed as a grounds worker before the accident included turf maintenance, gardening, landscaping, planting trees, running jackhammers, laying asphalt, removing snow, and digging holes.

Petitioner testified that for the two weeks prior to the date of accident of March 2, 2017, he was assigned the job of dismantling and rebuilding a concrete block wall along College Avenue by the new Science Building. He testified that he was working on that project for two straight weeks and that by the end of the day at the end of the project, he had to stop on his way home to see his primary care physician, Dr. Liu, because his back was so bad. He testified that when he saw Dr. Liu he felt pain in his lower back and also in the left buttock, going down the left side of his leg down to his ankle. He testified that Dr. Liu gave him pain medications to get him through the weekend.

Petitioner testified that when he came to work on Monday he called his supervisor, Larry Milby, and told him how he was feeling, and that he said to come in and fill out a report and to see Dr. Chow. He testified that Dr. Chow prescribed muscle relaxers and pain pills to try for a few weeks, and that she gave him restrictions that precluded him from going back to work. He testified that he then returned to see Dr. Chow again and that she set up for some physical therapy to try since the medications were not giving him much benefit. He testified that she also prescribed him some medications.

Petitioner testified that his condition did not improve in physical therapy. He testified that he returned to Occupational Health with pain in his low back and left leg, and that he was prescribed more therapy and was again given restrictions. He testified that he recalled an event on April 11th where he was caught in the rain. He testified that his wife was a cancer patient at Northwestern, that they were going between appointments, that he ran to try to keep up, and that he about fell on his face.

Petitioner testified that he continued to do physical therapy in April 2017 and that he returned to Occupational Health for more follow-up. He testified that an MRI was ordered, and that after the MRI was performed he had a consultation with Dr. Stroink. He testified that he gave Dr. Stroink a history of severe left leg pain and weakness, that he had had physical therapy and medications, and that he felt that the weakness had gotten worse. He testified that Dr. Stroink recommended surgery.

Petitioner testified that he underwent surgery on May 24, 2017, after which he was sent to Bloomington Rehab. He testified that he saw Dr. Stroink just about a week after surgery and that he was having issues with the wound. He testified that it was determined that he had had an allergic reaction to the surgical glue, and that he was sent to OSF Wound Care for treatment.

Petitioner testified that around July 2017 he was having problems with his calf, that he was told to start walking more for rehab and that when at home walking, the top part of his left calf "popped" and he was unable to bear weight. He testified that his wife called Dr. Stroink's office and that he was told to go to the emergency room in case there was a blood clot. He testified that the testing revealed that he did not have a clot, that he was fit with a boot and crutches, and that he made appointment with McLean County Orthopedics. He testified that he was on the boot and crutches maybe 2-3 days until he saw the doctor, and that they said he could take it off since it was not a fracture.

Petitioner testified that when he saw Dr. Stroink again in August 2017, his wound was healed completely. He testified that he started physical therapy at ATI. He testified that he regularly underwent therapy and was discharged in early October. He testified that he last saw Dr. Stroink on August 8, 2017, and that he was then referred by Dr. Stroink to Dr. Jhee for a rehab program after surgery. He testified that Dr. Jhee recommended that he not work immediately post-surgery, and that he was again seen in September 2017. He testified that he underwent an FCE on October 23rd and October 24th at OSF and that Dr. Jhee gave him work restrictions, but that he was not able to return to work for Respondent. He testified that he wanted to return, but that he was unable to do so.

Petitioner testified that he next saw Dr. Jhee on November 30, 2017, at which time he continued his restrictions. He testified that he kept seeing Dr. Jhee in follow-up in January 2018, at which time he maintained the same restrictions. He testified that he remained in communication with Respondent and that they did not have any work for him within those restrictions. He further testified that he was still having problems going down into his leg, and that he underwent an EMG in March 2018 as ordered by Dr. Jhee. He testified that the pain had started to go down the right side of his right buttock like it had been doing on the other side. He testified that his pain was on the lower right side at that point, and that initially his pain was on the left side.

Petitioner testified that on May 5, 2018 he saw Dr. Stroink again, and that she did not recommend surgery again on the L5 area. He testified that it was recommended that instead he could have injections. He testified that he continued to see Dr. Jhee and that Dr. Stroink referred him to Dr. Li, a pain physician, and that in late May 2018 he underwent an injection. He testified that the injection helped for a couple of days, and then the pain would come back as he increased his activity. He testified that if he drove a longer period of time the pain would be worse, and that he had to have his heated seats on all the time. He testified that on longer trips to see his son in Nashville he would stop every two hours or so and stretch, and that after stretching he felt that he could continue on for another 1-2 hours.

Petitioner testified that Dr. Li gave him a sacroiliac joint injection on July 4, 2018 and that he again saw Dr. Jhee on July 26, 2018, at which time he was having complaints of increasing low back pain radiating to the right lower extremity associated with numbness of the right anterior thigh and pain in his shin. He testified that he told Dr. Jhee that his current right leg symptoms were similar to those in his left leg prior to surgery. He testified that Dr. Jhee again gave him work restrictions. He testified that in October 2018 he was referred to Dr. Seibly for sacroiliac joint dysfunction. He testified that when he saw Dr. Seibly in November 2018, he was having constant pain and tenderness in the lower right side of his back that caused his right buttock to ache. He testified that he was not in physical therapy at that time, and that he did a home exercise program with stretches and walking. He testified that in December 2018 he had a CT of his pelvis, and that they were trying to figure out what going on with his buttock pain. He testified that on December 6, 2018 he saw Dr. Li again, and that he did a diagnostic sacroiliac joint injection. He testified that he continued to see Dr. Jhee during this time, and that he continued his work

restrictions. He testified that he saw Dr. Seibly again on January 28, 2019 after he had an injection and that he suggested that he wanted to try one more injection, which has never been done.

Petitioner testified that Dr. Li gave him another injection in February 2019 and that he had pain relief for about three days after the injection. He testified that he continued to see Dr. Jhee during this time, and that in early March he continued his work restrictions as nothing had really changed. He testified that he saw Dr. Li in follow-up on June 6, 2019, and that he gave him pain medication again. He testified that he was still waiting for another injection from Dr. Li so that Dr. Seibly could determine whether to do a sacroiliac joint fusion.

Petitioner testified that he had been receiving temporary total disability benefits for a while, but not at present. He testified that he last received benefits around the end of February 2019. He testified that since that date, he had not received approval for medical care. He testified that he eventually wants to return to work.

As to his current condition, Petitioner testified that he is in pain if he sits or stands too long or if he bends over too often. He testified that his pain depends on how active he is. He testified that he has grandchildren and that he babysits one or two days a week. He testified that his back condition is affecting him and that there are things he is unable to do such as play and take care of his grandson. He testified that he wishes that he could jog and get on the floor with him, and that squatting is hard. He testified that his grandson weighs approximately 25 pounds.

Petitioner testified that he is unable to work and that he cannot stand very long on hard surfaces. He testified that if he sits for too long in the same position, he may need to get up and move. He testified that he has continued to be told that he cannot return to work with his current restrictions.

On cross examination, Petitioner testified that he owns 250 acres of farmland. He testified that he hires someone to operate his farm, and that a friend of his uses his own equipment and farms the land. He testified that he owns the land, but does not operate the farm himself.

On cross examination, Petitioner testified that he had a prior injury while working for Respondent in 2001 he where ruptured a disc and had surgery. He testified that it was located in his cervical spine at C4 and C5. He denied that his current issues were in that same location, and testified that they were very different areas of his spine.

On cross examination, Petitioner testified that after the two weeks of moving concrete blocks his pain was located in the entire lower back and left leg. He denied having had any problems with his right leg at that point in time. He testified that the pain in his right buttock had started more recently.

On cross examination, Petitioner agreed that the symptoms in his left leg had improved. He testified that he still had tenderness in his upper left calf, but that it was better.

Robert Kinsch was called as a witness by Respondent at the time of arbitration. He testified that he is currently employed by Frasco Investigative Services. He testified that his is a regional manager and that he was previously a team lead in the social media department. He testified that he prepared a report for Frasco, and that Respondent's Exhibit 4 was a fair and accurate representation of the investigation of Petitioner.

The transcript of the deposition of Dr. Won Jhee dated July 17, 2019 was entered into evidence at the time of arbitration as Petitioner's Exhibit 1. Dr. Jhee testified that he is board-certified by the American Board of Physical Medicine and Rehabilitation and the American Board of Electrodiagnostic Medicine. He testified that he has an outpatient physical medicine practice, and that he also acts as a consultant in physical medicine and rehabilitation. (PX1).

Dr. Jhee testified that he first saw Petitioner on August 10, 2017 at the referral of Dr. Stroink, who had performed surgery on him. He testified that Petitioner had issues with loss of reflex on the left ankle jerk and some sensory loss on the left lower extremity, which he related to the left L5-S1 disk herniation and subsequent L5-S1 microdiscectomy that he had on May 24, 2017. He testified that Petitioner was diagnosed with reserving [*sic*] low back syndrome because he was getting back pain after the surgery, that he was status post left L5-S1 microdiscectomy done on May 24, 2017, that he had improving left lumbar radicular pain, and that they had to rule out neurogenic pain of the left calf area because he was having significant pain around that region. He testified that Petitioner was unable to work as of that date because he simply was not ready to return to work with his previous work. (PX1).

Dr. Jhee testified that he next saw Petitioner on September 19, 2017, at which time he saw some sensory changes of the left lower extremity and also loss of left ankle jerk which he related to his back injury. He testified that he recommended that Petitioner undergo a functional capacity evaluation. He testified that he next saw Petitioner on October 26, 2017, at which time he essentially had the same findings. He testified that at that point Petitioner had undergone an FCE on October 23rd and 24th, and that he was able to function at the Light physical demand level. He testified that he agreed with the conclusions of the FCE, and that he recommended that Petitioner return to work starting October 30, 2017 with restrictions of no lifting over 20 pounds, no overhead lifting over 20 pounds, no carrying over 30 pounds, no static push/pull over 80 pounds, and no frequent bending or twisting at the waistline, and that if he could not be returned to work with those restrictions he should undergo a work conditioning/hardening program five days a week. (PX1).

Dr. Jhee testified that he next saw Petitioner on November 30, 2017, at which time the physical examination and findings were consistent with the prior examination. He testified that Petitioner was not allowed to return to work because of the restrictions that he had recommended, so he was undergoing a work hardening program. He testified that apparently Petitioner had had the last work hardening program the day he was seen, so he told him to do a step-down exercise program or continue work hardening if it was approved. He testified that he kept the same restrictions in place for six weeks. He testified that he next saw Petitioner on January 18, 2018, at which time his symptoms remained unchanged and he noted that he felt the left leg was still weak. He testified that he noted mild tenderness in the right sacroiliac joint. When asked whether he had any indication on this date whether that was related to Petitioner's original work injury, Dr. Jhee responded that he was not so sure and that he did have this type of finding from the beginning, so there might have been some relationship between this condition and his work injury. He testified that Petitioner had not returned to work and that he had been attending a work hardening program. He testified that at this point he considered Petitioner to have been functioning but at the Light physical demand level, and that it was consistent with his restrictions of no lifting over 40 pounds on any occasion, no overhead over 20 pounds on any occasion, no carrying over 60 pounds, no push/pull over 50 pounds, and no frequent bending or twisting at the waistline. He testified that he also suggested an EMG because of increasing radicular symptoms and signs. (PX1).

Dr. Jhee testified that he next saw Petitioner on March 20, 2018, at which time he did a physical examination and also performed the EMG and nerve conduction study. He testified that the findings on EMG were that of moderate left S1 radiculopathy, that it was active and ongoing in nature, and that he related it to the original work injury. He testified that Petitioner was not working on that date, and that based on the abnormal findings he recommended that he should undergo an MRI of the low back. He testified that Petitioner had also just recently finished his work hardening program. He testified that the new work restrictions were based upon the test results from physical therapy regarding Petitioner's work activities and functional capacity as noted by Athletico Physical Therapy on February 23, 2018. He testified that after reviewing the test results from Athletico, he recommended that Petitioner should work with no lifting over 70 pounds on any occasion, no overhead lifting over 35 pounds, no carry over 70 pounds, no push/pull over 50 pounds, and no frequent bending or twisting at the waistline. (PX1).

Dr. Jhee testified that he next saw Petitioner on May 24, 2018, at which time his main complaints seemed to be increasing pain radiating to the right lower extremity, and that he had noticed this increasing pain during a couple of months prior to that visit. When asked whether he would relate the pain that Petitioner was experiencing on that date to the original L5-S1 disk herniation and microdiscectomy, Dr. Jhee responded that as far as he remembered Petitioner had a problem on the left side causing left S1 radiculopathy which was treated by surgical management, and that at that time he was having right lower extremity symptoms. He testified that it could be due to radicular pain on the right side or probably due to right sacroiliac joint dysfunction. He testified that if it was already due to the sacroiliac joint problem then there may be some relationship between the sacroiliac joint, the symptoms, and the previous injury. When asked why there would be a relationship between the previous injury and the sacroiliac joint, Dr. Jhee responded that Petitioner had some joint symptoms when he first saw him and that he believed there was some relationship between the injury and his symptoms. He testified that Petitioner's increasing low back pain radiating to the right lower extremity was associated with the numbness sensation in the anterior thigh and shin region, and that it was associated with numbness and some weakness of the right lower extremity. (PX1).

Dr. Jhee testified that Petitioner stated that he felt that his current right lower extremity symptoms were very similar to those of the left lower extremity prior to his lower back surgery. He testified that there might be some correlation between the original injury and the right lower extremity symptoms of May 24, 2018, but that he was not sure. He testified that he continued the same work restrictions at this visit as he had at the previous visit. He further testified that the restrictions were related to Petitioner's previous injury and low back surgery. (PX1).

Dr. Jhee testified that he next saw Petitioner on July 26, 2018, that he had received the injections by Dr. Li, a pain specialist, and that he stated that his back pain became better. He testified that he continued Petitioner's restrictions. He testified that Petitioner was going to continue with Dr. Li for more injections and pain management, and that he noted that he was not accepted to return to work due to the restrictions. He testified that Petitioner was to be re-evaluated in a couple of months and that a physical performance examination, which was equivalent to a functional capacity evaluation, was planned. He testified that he next saw Petitioner on September 27, 2018, and that he still had some tenderness on the right sacroiliac joint and no changes of reflex. He testified that according to his note, Petitioner had a couple of weeks of relief after the injection by Dr. Li. He testified that he maintained Petitioner's restrictions and that he recommended a new FCE, which he did not think had been done. (PX1).

Dr. Jhee testified that Petitioner was next seen on November 29, 2018, and that he said that he was doing okay with the back pain though he stated that his low back pain was about 4/10, that he no longer experienced any radiating pain from the lower back to the lower extremities or any tingling or numbness sensation, and that he was having some increasing pain on the right side of the low back. He testified that Petitioner's reflexes remained basically unchanged, that his sensory findings were "okay," that he was having mild to moderate tenderness on the right sacroiliac joint, and that sacroiliac movements were limited on the right side. He testified that this meant that Petitioner might have right sacroiliac joint dysfunction, which may be responsible for any of the low back pain on the right side and right lower extremity symptoms such as radiating pain, parethesias, or even weakness. He testified that Petitioner was scheduled to undergo a CT of the lumbar spine and to undergo a right sacroiliac joint injection by Dr. Li. He testified that he also recommended that Petitioner continue his home exercise program on a regular basis, and that he also maintained the same work restrictions. (PX1).

Dr. Jhee testified that he next saw Petitioner on January 23, 2019, at which time he was still having low back pain on the right side and that it was spreading to the right buttock area, but not to the distal portion of the right lower extremity. He testified that Petitioner was doing okay with the left lower extremity during this visit. He testified that Petitioner had had his third injection to the right sacroiliac joint per Dr. Li, and that he was supposed to be seeing Dr. Seibly. He testified that he continued

Petitioner on the same work restrictions. He testified that when he saw Petitioner on March 14, 2019 he still showed some moderate tenderness on the right sacroiliac joint with limited movement of the right sacroiliac joint, and that the other neurologic findings were basically unchanged from previous visits. He testified that he recommended that Petitioner continue with the same work restrictions and undergo a new FCE. (PX1).

Dr. Jhee testified that he saw Petitioner on May 22, 2019 for follow-up of back pain. He testified that on physical examination he noted moderate tenderness on the right sacroiliac joint with limited sacroiliac joint improvement and a positive Faber test on the right side, that there was left leg length discrepancy with sitting position, and that the other reflexes and sensory motor tests were basically the same as previous visits. He testified that Petitioner's complaints at that time were that of constant right-sided low back pain. When asked whether he would relate this to the original disk herniation that Petitioner suffered at L5-S1, Dr. Jhee responded that at that point his symptoms were mostly related to right sacroiliac joint dysfunction. He testified that he continued Petitioner's work restrictions and that the continuation was due to either the L5-S1 disk herniation that he suffered or the treatment for that herniation. He testified that he recommended that Petitioner continue with the home exercise program. He further testified that he did not believe that he had seen Petitioner since that date. (PX1).

Dr. Jhee testified that the same work restrictions were recommended unless they found differently as with another FCE. He testified that he believed that it was medically appropriate to continue Petitioner on the work restrictions, and that he was not at maximum medical improvement as he was still having ongoing symptoms and signs. (PX1).

On cross examination, Dr. Jhee agreed that he did not perform Petitioner's surgery and that it was performed by Dr. Stroink. He agreed that he was not present when the FCE was performed and that he could not personally see what type of effort Petitioner was giving. He testified that he had to rely on the therapist's report. (PX1).

On cross examination, Dr. Jhee testified that he believed that all the left lower extremity symptoms were related to the disk herniation resulting in nerve injury and which was treated by surgical means. He testified that after surgery Petitioner's symptoms got better though physical findings continually showed that he had residuals from the left S1 nerve injury. He testified that for the right-sided problem he noted that at the time of the original consultation on August 10, 2017 he noticed some tenderness on both sides of the sacroiliac joint, and that as time went by Petitioner had some gradual worsening of right sacroiliac join inflammation or dysfunction that caused some right-side leg pain and radicular symptoms. When asked whether he would say that he was not sure whether it would have been related to the original injury, Dr. Jhee responded that his answer should be that it "could be yes or could be no." (PX1).

On cross examination when asked as to the May 22, 2019 appointment when Petitioner's symptoms were mostly related to right sacroiliac joint dysfunction whether it was possible that the current work restrictions may not be related to the original injury, Dr. Jhee responded that it could be or may not be. He agreed that at the May 22, 2019 visit, Petitioner's left-sided symptoms that had originally been present were much better. (PX1).

On cross examination, Dr. Jhee testified that Petitioner had been treating with him since August 10, 2017, which was nearly two years. When asked whether he believed that Petitioner was still improving, Dr. Jhee responded that in certain conditions he was improving but that in certain conditions he was status quo. When asked how he believed that Petitioner could get to maximum medical improvement, Dr. Jhee responded that he did not have a good answer at this time. (PX1).

On redirect, Dr. Jhee testified that it was his opinion that the work restrictions in place for Petitioner were necessary for him at this time until he found out otherwise from another FCE. When asked whether it was his opinion that either the March 2, 2017 injury while moving concrete blocks or the subsequent treatment for the disk herniation (or the rehabilitation for that) could have aggravated or made more symptomatic the condition that Petitioner had on the right side, Dr. Jhee responded "maybe so." (PX1).

On redirect, Dr. Jhee testified that he had no written record during the period of time during which he has been treating Petitioner that he had given any history of any other subsequent injury such as a fall, another strain, or a weightlifting accident. He testified that if Petitioner had said something, he would have noted it. (PX1).

The Bloomington Rehabilitation Associates Return to Work/School Form dated March 14, 2019 was entered into evidence at the time of arbitration as Petitioner's Exhibit 2. The records reflect that Petitioner was issued work restrictions of no lifting over 60 pounds any occasion; no overhead lifting over 30 pounds; no carry over 70 pounds; no push/pull over 50 pounds; and no frequent bending/twisting at the waist. It was noted that Petitioner was to be re-evaluated in two months. (PX2).

The medical records of OSF Occupational Health were entered into evidence at the time of arbitration as Petitioner's Exhibit 3.[1] The records reflect that Petitioner was seen on April 24, 2017, at which time it was noted that his chief complaint was that of low back pain with radiation down the left leg to the calf. It was noted that Petitioner had completed 10 physical therapy appointments with traction with no improvement, and that the pain in his left leg remained at 3-4 constantly. It was noted that Petitioner had not worked since March 2, 2017. It was noted that Petitioner's pain location was that of the lower left leg and left thigh, that he had pain traveling down the left thigh into the left leg, and that his toes felt a little numb involving the left 3rd, 4th and 5th mostly. It was noted that Petitioner had been feeling spasms in his left hamstring, that his left buttock did not hurt as much except when sitting on something hard, and that Relafen did not help. The assessment was noted to be that of left side sciatica; left low back strain. Petitioner was recommended to undergo an MRI of the low back to include L5-S1 to evaluate for left leg radiculopathy and continuing low back pain. Petitioner was issued work restrictions at that time, and was recommended to follow-up approximately three days after the MRI. (PX3).

The records of OSF Occupational Health reflect that Petitioner was seen on April 6, 2017, at which time it was noted that he was seen in follow-up for low back pain with radiation down the left leg to the calf. It was noted that Petitioner had pain, spasm, and stiffness, and the location was noted to be that of the lower back and left lower leg. It was noted that Petitioner stated that he had been doing physical therapy, that he stated that therapy was helping with traction, that he stated that he stopped his medication yesterday to see how he felt without it, and that he had six more therapy sessions of the traction. The assessment was noted to be that of low back strain with spasm and sciatica. Petitioner was recommended to continue with physical therapy and to refill the Relafen. Petitioner was also issued work restrictions and was recommended to return on April 20, 2017. (PX3).

The records of OSF Occupational Health reflect that Petitioner was seen on March 21, 2017, at which time it was noted that he had pain travelling from the left buttock down to the left calf in the left ankle and not into the foot, and that his pain was improving a little until the weekend when he went walking for 30 minutes and then the pain worsened. It was noted that Petitioner had been out of medications for several days, that he took two of his spouse's medications, and that he denied increased sedation from the pain medications. It was noted that Petitioner stated that he almost went to the emergency department on Sunday morning, that he had been trying exercises 1-2 days after the last visit, and that he did not get much pain relief from the Tramadol. The assessment was noted to be that of low

[1] Any handwriting that appears in the exhibit was not made by the Arbitrator.

back pain with radiation into the left buttock and left calf; left-sided muscle spasm; left-sided low back pain. Petitioner was recommended to undergo physical therapy, was given prescriptions for Flexeril, Relafen, and Vicodin, and was issued work restrictions. Petitioner was recommended to return on April 6, 2017. (PX3).

Included within the records of OSF Occupational Health was an interpretive report for an MRI of the lumbar spine dated April 28, 2017, which was interpreted as revealing large left paracentral focal disc herniation with caudal extrusion at L5-S1; clinically this may translate into left S1 symptoms. (PX3).

The medical records of OSF Medical Group dated March 2, 2017 were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The records reflect that Petitioner was seen for back pain and leg pain, that he stated that he started feeling discomfort since yesterday, that he stated that it was mainly in the left buttocks region and extending down the leg, that his leg was having a lot of spasm, that there was no numbness or tingling, that there was no specific injury, and that he did work on ground maintenance but did no new activity. It was noted that Petitioner had similar symptoms but on the opposite side about seven months ago, that he denied any lower extremity swelling, and that he had a history of some degenerative joint disease in the back but that it was really not bothering him. The assessment was noted to be that of sciatica of the left side. Petitioner was given a prescription for Skelaxin and Medrol, and was recommended to perform stretches and use moist heat. It was noted that Petitioner was to follow-up as needed and if not improved, he would be sent for physical therapy. (PX4).

The Athletico Work Conditioning Functional Status Report dated February 23, 2018 was entered into evidence at the time of arbitration as Petitioner's Exhibit 5. The records reflect that Petitioner expressed that he still remained limited by left lower extremity pain, back pain, and left shoulder pain, that this impeded his overall functional mobility, activity tolerance, and ability to lift the amount of weights required to safely and fully perform his job duties, and that he had made improvements and increases in strength since work conditioning resumed on January 3, 2018. It was noted that Petitioner also expressed that he did not feel additional work conditioning would help and that he was a pleasure to work with and appeared motivated to improve to return safely and fully to work. It was noted that Petitioner was recommended to return to work with light/restricted duty after his two follow-up appointments with Dr. Jhee in early March and late March. The Pre-Test Subjective section noted that Petitioner verbally reported most pain in the low back and left leg, most often in the calf and toes. It was noted that Petitioner's pain was often increased at the end of the day, that resting and sitting in a comfortable chair decreased the pain, and that initially getting up from a seated position increased the pain. It was noted that Petitioner expressed on January 3rd that his worst pain was located in his left shoulder, and that he also expressed that lifting heavy objects at home could cause pain. (PX5).

The medical records of Bloomington Rehab Associates were entered into evidence at the time of arbitration as Petitioner's Exhibit 6. The records reflect that Petitioner was seen for an EMG by Dr. Jhee on March 22, 2018, at which time it was noted that he had been suffering from left lower extremity paresthesia. It was noted that Petitioner was a known case of status post left L5-S1 microdiscectomy secondary to a large disc herniation which was done on May 24, 2017, that he stated that the low back pain had been rather tolerable at about 2/10 but that he still experienced occasional radiating pain to the left lower extremity, and that this was also associated with constant numbness sensation and occasional tingling sensation of the left foot and toes. It was noted that Petitioner also suffered from pain and tenderness to the left calf area, that he denied having significant weakness of the lower extremity, and that the right lower extremity had been asymptomatic. It was noted that on physical examination no tenderness was noted at the sacroiliac joint and that sacroiliac movements were normal on both sides, among other issues. It was noted that the electrodiagnostics revealed findings compatible with moderate left S1 radiculopathy, perhaps active and ongoing in nature, co-existing mild left tarsal tunnel syndrome affecting sensory and motor nerve of medial plantar nerves, no evidence of lumbosacral radiculopathy on the right side, and no evidence of peripheral neuropathy in the lower extremities. It was noted that

Petitioner was recommended to undergo an MRI of the low back. Petitioner was issued work restrictions. (PX6).

The records of Bloomington Rehab Associates reflect that Petitioner was seen on March 14, 2019, at which time it was noted that he was seen for sacroiliitis. It was noted that Petitioner was seen for follow-up of chronic low back pain, that he stated that his low back pain was about 4/10, and that he denied having radiating pain from the low back to the lower extremities. It was noted that Petitioner experienced occasional numbness and tingling sensation on the feet, mostly on the bottom portion, and that he denied having new weakness of the lower extremities. It was noted that most of the pain on the low back was located at the right side, and that the bladder and bowel had been okay. It was noted that on physical examination moderate tenderness was noted at the right sacroiliac joint area, and that sacroiliac joint movements were somewhat limited on the right side, among other issues. The impression was noted to be that of (1) chronic low back pain syndrome; (2) history of lumbar disc disease; (3) status post left L5-S1 microdiscectomy done on May 24, 2017 secondary to a large disc herniation; (4) improving lumbar radicular pain; (5) right sacroiliac joint dysfunction. It was noted that Petitioner stated that he received a fourth injection per Dr. Li which helped for a couple of days, that this was done almost a couple of months ago, and that he was scheduled to be seen by Dr. Seibly next week. Petitioner was issued work restrictions. It was noted that the last time Petitioner had a FCE was in February 2018, and that a new FCE may be considered. (PX6).

The records of Bloomington Rehab Associates reflect that Petitioner was seen on January 23, 2019, at which time it was noted that he was seen for sacroiliitis. It was noted that Petitioner was seen in follow-up of low back pain, that he stated that most of the pain was located on the right side of the low back area and that it spread to the buttock but not to the distal portion of the lower extremities, and that the left lower extremity had been asymptomatic. It was noted that Petitioner denied having numbness or tingling sensation or any weakness of the right lower extremity. It was noted that on physical examination moderate tenderness was noted in the right sacroiliac joint and that sacroiliac joint movements were limited on the right side, among other issues. The impression was noted to be that of (1) chronic low back pain syndrome; (2) history of lumbar disc disease; (3) status post left L5-S1 microdiscectomy done on May 24, 2017 secondary to a large disc herniation; (4) improving lumbar radicular pain; (5) right sacroiliac joint dysfunction. It was noted that Petitioner stated that he received the third injection to the right sacroiliac joint per Dr. Li in mid-December with temporary relief of the pain, and that he was scheduled to be seen by Dr. Seibly next week. Petitioner was recommended to continue with a home exercise program on a regular basis and was issued work restrictions. It was noted that Petitioner was to be re-evaluated in a couple of months. (PX6).

The records of Bloomington Rehab Associates reflect that Petitioner was seen on November 29, 2018, at which time it was noted that he was seen for sacroiliitis. It was noted that Petitioner was seen for follow-up of low back pain, that he stated that his low back pain was tolerable at the present time at about 4/10, and that he no longer experienced any radiating pain from the low back to the lower extremities or any tingling or numbness sensation. It was noted that Petitioner was, however, having some increasing pain on the right side of the low back area, and that he denied having weakness of the lower extremities. It was noted that lifting had still been difficult but that Petitioner was trying to do home exercises, including treadmill and some lifting activities. It was noted that on physical examination there was mild to moderate tenderness noted in the right sacroiliac joint and that sacroiliac joint movements were consistently limited on the right side and normal on the left side, among other issues. The impression was noted to be that of (1) chronic low back pain syndrome; (2) lumbar disc disease; (3) status post left L5-S1 microdiscectomy done on May 24, 2017 secondary to a large disc herniation; (4) improving lumbar radicular pain; (5) rule out right sacroiliac joint dysfunction. It was noted that Petitioner was seen by Dr. Seibly and was also scheduled to undergo a CT scan of the lumbar spine and diagnostic purpose of right sacroiliac joint injection per Dr. Li. Petitioner was recommended to continue with the home exercise

program on a regular basis and was issued work restrictions. It was noted that Petitioner was to be re-evaluated in a couple of months. (PX6).

The records of Bloomington Rehab Associates reflect that Petitioner was seen on September 27, 2018, at which time it was noted that he was seen for low back pain and other intervertebral disc displacement, lumbosacral region. It was noted that Petitioner was seen in follow-up of low back pain, that he stated that the last time he had an injection per Dr. Ji Li was about a month ago and that the effect lasted a couple of weeks, and that currently his low back pain was about 4/10 and he no longer experienced any radiating pain from the low back to the lower extremities. It was noted that Petitioner also denied having lower extremity weakness, and that he experienced numbness and tingling sensation of the left toes. It was noted that on physical examination Petitioner had mild tenderness noted in the right sacroiliac joint and that sacroiliac joint movements were normal on both sides, among other issues. The impression was noted to be that of (1) chronic low back pain syndrome; (2) lumbar disc disease; (3) improving lumbar radicular pain; (4) status post left L5-S1 microdiscectomy done on May 24, 2017 secondary to a large disc herniation. Petitioner was recommended to continue a home exercise program and was issued work restrictions. It was noted that Petitioner underwent an FCE last in February 2018 and that a new FCE was recommended. It was noted that Petitioner was to be re-evaluated in a couple of months. (PX6).

The records of Bloomington Rehab Associates reflect that Petitioner was seen on July 26, 2018, at which time it was noted that he was seen for low back pain and other intervertebral disc displacement, lumbosacral region. It was noted that Petitioner was seen in follow-up of low back pain, that he stated that he received two injections by Dr. Ji Li and since then the back pain had improved, and that he denied having radiating pain from the low back to the lower extremities. It was also noted that Petitioner denied having any new weakness of the lower extremities. It was noted that on physical examination no tenderness was noted at the sacroiliac joint or gluteal region and that sacroiliac joint movements were normal on both sides, among other issues. The impression was noted to be that of (1) chronic low back pain syndrome; (2) lumbar disc disease; (3) improving lumbar radicular pain; (4) status post left L5-S1 microdiscectomy done on May 24, 2017 secondary to a large disc herniation. Petitioner was recommended to do a home exercise program on a regular basis and was also to follow-up with Dr. Ji Li for possible subsequent injections and pain management. It was noted that Petitioner was also issued work restrictions. It was noted that Petitioner was to be re-evaluated in a couple of months and that a redo of "PPE" was planned. (PX6).

The records of Bloomington Rehab Associates reflect that Petitioner was seen on May 24, 2018, at which time it was noted that he was seen for low back pain and other intervertebral disc displacement. It was noted that Petitioner stated that during the last couple of months he had had been having increasing low back pain which radiated to the right lower extremity, that this was also associated with a numbness sensation or the right anterior thigh area and severe pain in the right thigh and shin region, and that he felt that his current right lower extremity symptoms were very similar to those of the left lower extremity prior to his low back surgery. It was noted that Petitioner's left lower extremity had been relatively asymptomatic. It was noted that Petitioner was able to walk a couple of blocks at the most and was able to lift about 40-50 pounds at most. It was noted that on physical examination Petitioner had no tenderness noted in the sacroiliac joints and that sacroiliac joint movements were normal on both sides, among other issues. The impression was noted to be that of (1) chronic low back pain syndrome; (2) lumbar disc disease; (3) lumbar radicular pain; (4) status post left L5-S1 microdiscectomy done on May 24, 2017 secondary to a large disc herniation. Petitioner was recommended to continue his home exercise program. It was noted that Petitioner was seen by Dr. Stroink for re-consultation and was scheduled to be seen by Dr. Ji Li for injections. Petitioner was issued work restrictions and was to be re-evaluated in a couple of months. (PX6).

The records of Bloomington Rehab Associates reflect that Petitioner was seen on January 18, 2018, at which time it was noted that he stated that the low back pain was rather tolerable at 3/10, that he denied having radiating pain from the low back to the lower extremities, and that he still experienced rather constant toe numbness on the left side and some loss of feeling of the distal portion of the left lower extremity. It was noted that Petitioner felt that the left leg was still weaker than the right side. It was noted that on physical examination there was mild tenderness noted in the right sacroiliac joint and that sacroiliac joint movements were somewhat limited on the right side, among other issues. The impression was noted to be that of (1) chronic low back pain syndrome; (2) lumbar radicular pain; (3) status post left L5-S1 microdiscectomy done on May 24, 2017 secondary to a large disc herniation. It was noted that Petitioner had two more sessions of a work hardening program and that he was currently functioning at the light physical demand level. It was noted that additional work hardening would be requested. Petitioner was also issued work restrictions and was to be re-evaluated in a couple of months. At the time of the November 30, 2017 visit, it was noted that Petitioner stated that his low back pain was about 2-3/10, that he denied having radiating pain from the low back to the lower extremity, and that he still experienced some weakness of the left leg as well as toe numbness. It was noted that Petitioner stated that he started to have restless legs about one month ago during the nighttime. It was noted that on physical examination no tenderness was noted at the sacroiliac joint or gluteal region or greater trochanteric area and that sacroiliac joint movements were normal on both sides, among other issues. The impression was noted to be that of (1) resolving low back pain syndrome; (2) resolving left lumbar radiculopathy; (3) status post left L5-S1 microdiscectomy done on May 24, 2017 secondary to a large disc herniation. It was noted that Petitioner attended a work hardening program, and that the last session was completed that morning. It was noted that Petitioner showed some improvement in overall function but far from the required heavy physical demand level. It was further noted that Petitioner was recommended to stay with the step-down exercise program or work hardening program, if approved. Petitioner was issued work restrictions and was to be re-evaluated in six weeks. (PX6).

The records of Bloomington Rehab Associates reflect that Petitioner was seen on October 26, 2017, at which time it was noted that he stated that he still experienced some pain but the average pain was about 1-2/10, that he no longer experienced any radiating pain to the lower extremities from the low back but still experienced some soreness in the left calf area, and that he still experienced some tingling and numbness sensation of the left foot and toes. It was also noted that Petitioner felt that he was shaky with the left lower extremity. It was noted that on physical examination no tenderness was noted in the sacroiliac joint or gluteal region or greater trochanteric area and that sacroiliac joint movements were normal on both sides, among other issues. The impression was noted to be that of (1) resolving low back pain syndrome; (2) resolving left lumbar radiculopathy; (3) status post left L5-S1 microdiscectomy done on May 24, 2017 secondary to a large disc herniation. It was noted that Petitioner underwent an FCE on October 23rd and October 24th and that he was able to function at the light physical demand level, but that his job required a heavy physical demand level. Petitioner was issued work restrictions and it was noted that if he was not accepted to return to work due to the restrictions, he should undergo a work conditioning/hardening program five days a week. Petitioner was recommended to return in one month. At the time of the September 19, 2017 visit, it was noted that Petitioner stated that the low back pain had been tolerable although different types of physical activities increased some of the low back discomfort, and that he denied having radiating pain from the low back to the lower extremities nor any numbness and tingling sensation. It was noted that Petitioner still felt the left leg was not strong and experienced soreness and a hurting sensation of the left calf area, and that the right lower extremity had been asymptomatic. It was noted that on physical examination no tenderness was noted at the sacroiliac joint and that sacroiliac joint movements were normal on both sides, among other issues. The impression was noted to be that of (1) resolving low back pain syndrome; (2) status post left L5-S1 microdiscectomy done on May 24, 2017 secondary to a large disc herniation; (2) improving left lumbar radicular pain; (3) rule out neurogenic claudication pain of the left calf with progressive improvement. Petitioner was recommended to continue with physical therapy and a home exercise program. It was noted that an FCE

would be performed in the next couple of weeks and that upon completion of the evaluation, Petitioner would be released to work with some type of restrictions. Petitioner was to be re-evaluated upon completion of the FCE. (PX6).

The records of Bloomington Rehab Associates reflect that Petitioner was seen on August 10, 2017, at which time it was noted that he was referred from Dr. Stroink's office for a post-laminectomy rehabilitation program. It was noted that Petitioner stated that he started to experience low back pain in February of 2017 which was getting progressively worse, that this was also associated with radiating pain to the left lower extremity, mostly on the buttock and hip as well as the calf area, and that he was also having some numbness and tingling sensation and weakness of the left lower extremity. It was noted that Petitioner was found to have a large left L5-S1 disc herniation and subsequently underwent L5-S1 microdiscectomy on May 24, 2017, and that since the surgery the low back pain had been much better. It was noted that the radiating pain to the left lower extremity was no longer present nor was the numbness sensation, but that Petitioner frequently experienced severe stabbing-type pain in the left calf area which was also associated with an electric shock-like sensation of the same area. It was noted that stair climbing and distance walking sometimes aggravated the left lower extremity symptoms, and that the right lower extremity had been asymptomatic. It was noted that on physical examination mild tenderness was noted in the bilateral sacroiliac joints and that sacroiliac joint movements were normal on both sides, among other issues. The impression was noted to be that of (1) resolving low back pain syndrome; (2) status post left L5-S1 microdiscectomy done on May 24, 2017; (3) improving left lumbar radicular pain; (4) lumbar radiculopathy; (5) rule out neurogenic pain of the left calf. Petitioner was recommended to undergo physical therapy for instruction of proper body mechanics, gentle core muscle strengthening exercise and gentle stretching exercise of the left calf muscles, as well as mild conditioning exercises. It was noted that Petitioner stated that he was not currently doing any bending or twisting activities and did not lift more than one gallon of milk, but had increased his walking distance. It was noted that Petitioner was not recommended to return to work and that he would be re-evaluated in about six weeks, at which time he may be released to work with some type of restrictions. (PX6).

The medical records of OSF St. Joseph Medical Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 7. The records reflect that Petitioner underwent surgery by Dr. Stroink on May 24, 2017, which was that of (1) microdiscectomy L5-S1, partial laminotomy; (2) operating microscope for a pre-and post-operative diagnosis of left S1 radiculopathy secondary to a large disc herniation, L5-S1 on the left. (PX7).

The records of OSF St. Joseph Medical reflect that Petitioner was seen in the emergency room on July 11, 2017, at which time it was noted that he had complaints of pain in the left calf that occurred while ambulating up stairs that day. It was noted that Petitioner stated that he heard a pop when the pain began, that he was concerned that he may have developed a blood clot as he had a recent back surgery, and that he had a wound VAC in place for the wound on his back but stated that he did not have any fever, chills, or any other concerns regarding this. Petitioner underwent x-rays of the left tibia and fibula on July 11, 2017, which were interpreted as revealing normal bony alignment without any evidence of an acute bony fracture or bony erosion; no soft tissue calcification is seen. Petitioner underwent an ultrasound left duplex lower extremity veins on that date as well, which was interpreted as revealing no evidence of deep vein thrombosis. The clinical impression was noted to be that of pain of the left calf. It was noted that the ultrasound was negative for DVT, that the x-ray was negative for acute bony injury, and that on physical examination they were concerned Petitioner may have damaged his calf or possibly the Achilles tendon. Petitioner was placed in a short-leg post mold splint with plantar flexion crutches for ambulation, and was to follow-up with Orthopedics for further evaluation. (PX7).

The records of OSF St. Joseph Medical reflect that Petitioner underwent a Physical Therapy Initial Evaluation on March 28, 2017, at which time it was noted that he reported a chronic problem, that the incident onset was reported as March 1, 2017, that the problem was affecting the lumbar region of the

back, and that the affected side was that of the left. It was noted that Petitioner believed that the problem was caused by moving a concrete wall prior to the onset of low back pain and frequent lifting of 100# blocks. It was noted that Petitioner had improvement with the low back until two weeks ago when attempting to walk for 30 minutes caused lower extremity aggravation. It was noted that in August Petitioner had injured his back and was helped with medication after two weeks. At the time of the March 30, 2017 physical therapy visit, it was noted that Petitioner reported feeling very sore starting yesterday morning, that he rated his pain at a 5/10 in the hamstring and posterior knee and a little into his calf, and that he thought the increased soreness may be due to traction that was done on March 28th. At the time of the April 3, 2017 physical therapy visit, it was noted that Petitioner reported continued low back pain, that he rated his pain at a 5/10 in the hamstring and posterior knee and a little into his calf, and that he had increased pain over the weekend after standing a long time on Friday night. (PX7).

The records of OSF St. Joseph Medical reflect that Petitioner underwent physical therapy on April 5, 2017, at which time it was noted that he reported that he was feeling a little better that day, that he said he felt good after traction on April 3rd for the rest of the day with less pain down the lower extremity, and that he said that he was able to walk for about an hour and was a little sore when he woke that morning. It was noted that Petitioner rated his pain at a 3/10 that day with pain located in the left hamstring and calf, with a little numbness in the foot. At the time of the April 7, 2017 physical therapy visit, it was noted that Petitioner reported increased left lower extremity pain that day and that his sleep was disturbed last night, which was not usually the case. At the time of the April 11, 2017 physical therapy visit, it was noted that Petitioner did a lot of walking at Northwestern in Chicago due to having to do a slow jog to get out of the rain, that his left leg felt "dead," and that he was unable to walk/jog at a slow pace without his knee and ankle giving out/rolling. At the time of the April 12, 2017 physical therapy visit, it was noted that Petitioner reported increased pain in the left posterior knee and into the calf which had been constant since April 10th, that he said he did a lot of walking Monday and tried to jog to get out of the rain and was not able to not due to pain but that he just felt his leg was "dead" and would not work, and that he stated that he was still taking two pain pills a day. It was also noted that Petitioner stated that his left ankle had given out a few times when he had been more active. At the time of the April 14, 2017 physical therapy visit, it was noted that Petitioner reported increased pain in the left posterior knee and into the calf which had been constant since April 10th, that he had a re-check with his physician set for April 24th, and that he reported that traction helped but only temporarily. (PX7).

The records of OSF St. Joseph Medical reflect that Petitioner underwent physical therapy on April 18, 2017, at which time it was noted that he reported increased pain on that date in the left posterior calf which had been constant since April 10th. It was also noted that Petitioner reported that traction helped, but only temporarily. At the time of the April 21, 2017 physical therapy visit, it was noted that Petitioner reported increased pain on that date in the left posterior calf, that he had traveled to Northwestern for his wife's treatments yesterday which flared-up his symptoms, and that he reported traction helped but only temporarily and poor tolerance to the last session. The discharge note dated June 6, 2017 noted that Petitioner was referred to a neurosurgeon due to lack of progress and would be discharged. (PX7).

The records of OSF St. Joseph Medical reflect that a Wound Assessment was performed on June 16, 2017 and that the wound location was that of lumbar spine – midline. The wounding event was noted to be that of a surgical injury. Petitioner was discharged from wound care as of July 28, 2017. The records reflect that Petitioner underwent a Functional Capacity Evaluation on October 24, 2017. (PX7).

The medical records of Central Illinois Neurohealth Sciences were entered into evidence at the time of arbitration as Petitioner's Exhibit 8. The records reflect that Petitioner was seen on May 11, 2017, at which time it was noted that he presented for evaluation of low back pain that radiated into the left leg associated with numbness. It was noted that Petitioner's symptoms had been present for about three months' duration, that the symptoms first began at work after moving concrete blocks for a retaining wall,

and that he had treated conservatively with physical therapy including traction and pain medication. It was noted that the treatment was unsuccessful in reducing pain. It was noted that Petitioner was well-known from previous surgical treatment, that he presented with a three-month history of severe left leg pain and weakness, and that he had been off work for the last two months. It was noted that Petitioner had had treatment including physical therapy and pain medications, and that he felt his weakness had gotten worse. It was noted that Petitioner could not walk for an extended period of time on his toes without evidence of an ankle drop, that he had contractions of the left leg, and that he had positive straight leg raising. It was noted that Petitioner was recommended an outpatient microdiscectomy and rehab for strengthening after surgery. (PX8).

The records of Central Illinois Neurohealth Sciences reflect that Petitioner was seen on May 30, 2017, at which time it was noted that he was seen for wound drainage and pain. It was noted that Petitioner was there for leakage from his surgical incision, that the fluid started leaking two days ago, that it was a small amount that did not soak through a bandage, and that it was clear with a mild pink tinge. It was also noted that Petitioner also had an allergic reaction to the Dermabond that was used to close his skin incision. Petitioner was started on antibiotics. At the time of the June 6, 2017 visit, it was noted that Petitioner had had a reaction to the glue with blistering on his skin below the glue, so it was removed. It was noted that Petitioner subsequently had a spreading of the rash over his back and was started on Benadryl, that it was ineffective so he started a Medrol dose pack, and that his rash symptoms had improved but that he still had drainage. Petitioner was referred to the wound clinic. Petitioner was also recommended to undergo an MRI of the lumbar spine to assess if there was a deep component given the amount of continued drainage. (PX8).

The records of Central Illinois Neurohealth Sciences reflect that Petitioner was seen on August 8, 2017, at which time it was noted that he had left calf pain that was severe with episodes of feeling sharp pain and then difficulty putting weight on the calf. It was noted that Petitioner reported to still have some residual symptoms involving his leg making it difficult to ambulate at times. It was noted that Petitioner's wound had completely healed, that he continued to have pain in his left calf which was very specific and pinpoint, and that he had a work-up done including ultrasound which turned out to be negative. It was noted that this may be some residual leftover S1 nerve pain and that otherwise, Petitioner had made an excellent recovery. Petitioner was recommended to undergo physical therapy as well as a follow-up for work hardening. Petitioner was also recommended exercises and walking, and was instructed to return as needed. (PX8).

The records of Central Illinois Neurohealth Sciences reflect that Petitioner was seen on May 15, 2018, at which time it was noted that he was seen at the request of Dr. Jhee. It was noted that Petitioner denied any left leg symptoms but that in the last three months he had complained of right leg pain that followed an L5 distribution. It was noted that the MRI showed changes on the left and that the EMG showed changes in the left S1 nerve. Petitioner was recommended to follow-up with Dr. Jhee. It was noted that Dr. Stroink was not recommending surgery, and that she recommended a right L4-5 transforaminal injection and follow-up as needed. At the time of the November 12, 2018 visit with Dr. Seibly, it was noted that Petitioner was referred for consultation by Dr. Li for sacroiliitis. It was noted that Petitioner's pain was very focal to the left sacroiliac region, that it was uncomfortable for him to sit for a long period of time and walk and stand, and that weight bearing exacerbated the symptoms. It was noted that most of the pain was in the right-hand side and occasionally Petitioner would have some on the left. Petitioner was recommended a CT scan of the bony pelvis to assess for any other etiologies and the extent of the degenerative changes of the sacroiliac joint, and he was also to follow-up with Dr. Li for a diagnostic right-sided sacroiliac joint injection using anesthetic only (no steroid). It was noted that if this provided temporary pain relief this would also aid and confirm the diagnosis, and that further work-up could be pursued from that point addressing that specific problem. (PX8).

The records of Central Illinois Neurohealth Sciences reflect that Petitioner was seen by Dr. Seibly on January 28, 2019, at which time it was noted that he wanted to discuss a further plan of care following failed injections. It was noted that Petitioner continued to have a significant amount of right-sided sacroiliac pain after a work-related injury, that he had one diagnostic injection by Dr. Li, that he felt better for three days, and that he had had therapeutic steroid injections as well which had helped but were also short-lived. It was noted that they were continuing to work-up Petitioner to see if he was a candidate for a minimally invasive sacroiliac joint fusion. It was noted that Dr. Seibly had reviewed Petitioner's CT of the pelvis, and that he had very low grade degenerative changes at the sacroiliac joint but there were also no significant degenerative changes of the lumbar spine or any other osseous abnormalities that could explain his pain. Petitioner was recommended one additional diagnostic injection and if he continued to have greater than 80% pain relief for the expected duration (1-3 hours), this would aid in the diagnosis and he would likely be determined to be a surgical candidate. (PX8).

Included within the records of Central Illinois Neurohealth Sciences was an interpretive report for an MRI of the lumbar spine performed on June 8, 2017 at Diagnostic Neuro Technology, which was interpreted as revealing (1) interval post-surgical changes of left hemilaminectomy and discectomy for removal of a previously large left paracentral focal disc herniation at this level; there is decompression of the central canal and left lateral recess since prior examination; (2) no significant interval change in degenerative changes within the remainder of the lumbar spine. Included within the records of Central Illinois Neurohealth Sciences was an interpretive report for an MRI of the lumbar spine performed on April 10, 2018 at Diagnostic Neuro Technology, which was interpreted as revealing (1) stable post-operative appearance of the lumbar spine with changes of left-sided laminectomy at L5-S1 level; there is mild post-operative scarring in the left lateral recess and around the left S1 nerve root sleeve but no evidence of recurrent or residual disc herniation is seen; the rest of the lumbar spine is also stable since the prior study of June 8, 2017. Also included within the records of Central Illinois Neurohealth Sciences was an interpretive report for a CT of the pelvis performed on December 4, 2018 at Ft. Jesse Imaging Center, which was interpreted as revealing mild degenerative changes in the visualized lower lumbar spine; no osseous erosions. (PX8).

The medical records of Dr. Won Jhee dated March 4, 2019 were entered into evidence at the time of arbitration as Petitioner's Exhibit 9. The records reflect that Petitioner was seen for a follow-up visit on that date. (PX9).

The medical records of Applied Pain Institute were entered into evidence at the time of arbitration as Petitioner's Exhibit 10. The records reflect that on February 15, 2019, Petitioner underwent two right sacroiliac joint diagnostic injections, the first of which was on December 11, 2018 with a duration of pain relief of three days, and the second of which was on February 12, 2019 with a duration of pain relief of two days. The "To Whom It May Concern" letter dated February 15, 2019 noted that Petitioner's low back pain was overall improved after surgery, but that he still had chronic low back pain due to sacroiliac joint instability related to the injury and his back pain. It was noted that Petitioner continued having a constant pain at his right sacroiliac joint region, while intensity of his pain varied over time. It was noted that it was medically necessary to take Norco PRN for Petitioner's severe low back pain. It was also noted that there was no sign of opioid abuse or addiction from Petitioner, and that they were monitoring his pain medications through regular office visits and urine screening. (PX10).

The records of Applied Pain Institute reflect that Petitioner was seen by Dr. Li on December 6, 2018, at which time it was noted that he said his pain was still in his sacroiliac joint area radiating to his right buttock, and that he had no tingling of his legs. It was noted that Petitioner saw Dr. Seibly who ordered a CT of his sacroiliac joint, and that Dr. Seibly wanted him to do right diagnostic right sacroiliac joint injection of [*sic*] possible sacroiliac fusion. The assessment was noted to be that of sacroiliac pain. It was noted that Petitioner was to continue his pain medications and was to follow-up with Dr. Seibly. It was also noted that they would request a right sacroiliac injection. At the time of the October 8, 2018

visit, it was noted that Petitioner stated that his pain was the same and that it was at his right buttock at the right sacroiliac joint area. It was noted that it was a continuous achy and sharp pain radiating to Petitioner's right hip area, that he had some tingling of his right toes, and that prolonged sitting and standing would increase his pain. The assessment was noted to be that of sacroiliac pain. Petitioner was referred to Dr. Seibly for sacroiliac joint dysfunction. Petitioner was also to continue his pain medications and return in two months. (PX10).

The records of Applied Pain Institute reflect that Petitioner was seen by Dr. Li on September 10, 2018, at which time it was noted that he said that he had pain relief after his right sacroiliac joint injection for a few weeks, that now his pain was coming back, that it was at his right sacroiliac joint area, and that it was not radiating to his legs. The assessment was noted to be that of sacroiliac pain. Petitioner was recommended to continue his pain medications and to follow-up after his visit to Dr. Jhee and Stroink. It was noted that Petitioner was recommended to see Dr. Seibly for right sacroiliac fusion. Petitioner was also recommended to continue physical therapy and to return in one month. The records reflect that Petitioner underwent a right sacroiliac joint injection on July 24, 2018 at Ireland Grove Center for Surgery. It was noted that Petitioner had some left hip pain which was still existing after injection. (PX10).

The records of Applied Pain Institute reflect that Petitioner was seen by Dr. Li on July 2, 2018, at which time it was noted that he was seen in follow-up after an injection. It was noted that the percent of relief was 100% for 10 days and then the low back pain had gradually increased back to pre-injection level, that now it was a 4/10, improved with lying down and heat therapy daily, and that he was taking Norco daily. It was noted that Petitioner was needing medication refills. It was noted that Petitioner was tolerating his pain medications, that he had been off work for one year, and that he was taken off work by Dr. Jhee, whom he would see in a few weeks. It was also noted that Petitioner was having low back pain that radiated occasionally to the right buttock, that the pain in the lower right leg had resolved since the injection, and that he had occasional right hip ache with extended sitting and/or driving. Petitioner was recommended to undergo a right sacroiliac joint injection. Petitioner was also recommended to continue his pain medications and his home exercise program. At the time of the June 4, 2018 visit, it was noted that Petitioner was seen in follow-up after an injection. It was noted that the percent of relief from the last injection was that of 30% and that Petitioner was not using Norco, but had used Aleve a couple of times. It was noted that Petitioner's pain was worse with driving longer periods and that he remained off work. Petitioner was recommended to start Mobic and Rabeprazole, to continue his Norco as needed, to do physical therapy at home, and to return in one month. (PX10).

The records of Applied Pain Institute reflect that Petitioner was seen by Dr. Li on May 24, 2018, at which time it was noted that he was a new consult from Dr. Stroink for low back pain. It was noted that Petitioner was injured March 2, 2017 when working to build a concrete wall and that he started having low back pain and right leg pain. It was noted that Petitioner had wound issues for several months, that he had had an EMG done a few months ago, and that he remained off work. It was noted that routine drug screening was performed on that date. It was noted that Dr. Li thought that Petitioner's low back and right leg pain was due to the lumbar radiculopathy secondary to the right L4-5 disc herniation, and that he was scheduled for a right L4-5 transforaminal epidural steroid injection the next day. It was noted that Petitioner's pain would be evaluated in one week after the injection and that if he was better from the injection, he was recommended a course of physical therapy and otherwise may be referred to Dr. Stroink for other surgical options. Petitioner was given Norco for pain. (PX10).

The medical records of Applied Pain Institute dated June 6, 2019 were entered into evidence at the time of arbitration as Petitioner's Exhibit 11. The records reflect that Petitioner was still following up with Dr. Seibly for his right sacroiliac joint pain, that Dr. Seibly was still considering a sacroiliac fusion, that now his pain was still mainly at his right buttock without radiating to his leg,s and that he had some tingling of his feet. It was noted that Petitioner was having low back pain that radiated into the right

buttocks but did not go into the right leg, and that he stated that he was having some episodes of RLS. The assessment was noted to be that of sacroiliac pain. Petitioner was recommended to continue his pain medications and home exercise program, to follow-up with his WC coverage of his right sacroiliac joint injection, and to follow-up in three months. (PX11).

The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 12. The Petition for Immediate Hearing was entered into evidence at the time of arbitration as Petitioner's Exhibit 13. The Notice of Motion & Order was entered into evidence at the time of arbitration as Petitioner's Exhibit 14.

The CMS Work Comp Packet was entered into evidence at the time of arbitration as Respondent's Exhibit 1. The Illinois Form 45 dated March 9, 2017 noted that Petitioner developed pain in the left lower back and that it radiated to the left leg, and that he was constructing a concrete block wall for two weeks at the time of the accident. The Workers' Compensation Employee's Notice of Injury dated March 7, 2017 noted that Petitioner was moving concrete blocks at the time of injury and that he had severe back pain from lifting the blocks. The body parts affected were noted to be that of the lower back and left leg. The Supervisor's Report of Injury or Illness dated March 14, 2017 completed by Larry Milby noted that the date of accident was that of March 2, 2017, that Petitioner had severe back pain from lifting concrete blocks, and that the body parts injured were that of the lower back and left leg. (RX1).

The transcript of the deposition of Dr. Jesser Butler dated August 16, 2019 was entered into evidence at the time of arbitration as Respondent's Exhibit 2. Dr. Butler testified that on December 8, 2017, he performed an IME of Petitioner. When asked of his understanding of Petitioner's injuries, Dr. Butler testified that Petitioner worked as a groundskeeper and was performing a construction project with concrete blocks when he developed back and left leg pain. He testified that Petitioner had a microdiscectomy at L5-S1 on the left for a large extruded disk herniation, and that he found that there was a causal connection between the reported accident and the injury. (RX2).

Dr. Butler testified that after he saw Petitioner, he conducted a records review on July 27, 2018. He testified that Petitioner was recommended to have some additional work conditioning and had had a follow-up MRI scan which showed no recurrent disk herniation or residual nerve compression, and that he still had some subjective complaints of pain. He testified that Petitioner's back pain scores were 0-3/10 and that his leg issues were 0-2/10, so he felt that he could go back to work on a regular duty capacity. He testified that the natural history after a microdiscectomy was that there would be some residual symptoms that just tended to improve with time, and that he felt that Petitioner would be safe to go back to work and did not need additional work conditioning or an FCE. He testified that Petitioner's pain scoring at that level was quite consistent with a successful outcome of a microdiscectomy surgery, and that the scores were all subjective. (RX2).

Dr. Butler testified that he prepared a second records review report dated November 20, 2018, in which he indicated that he reviewed the post-operative imaging from Petitioner's post lumbar disk herniation with discectomy at L5-S1, and that he believed that he did not require any additional medical treatment. He testified that he did not believe that Petitioner was an appropriate candidate for a sacroiliac joint fusion based on the imaging studies that he had seen. He testified that sacroiliac joint fusions were rarely done, and that it was an arthritic or degenerative condition in most cases. He testified that the only times that he had done it in his medical practice were in patients who had long fusions of the lumbar spine or had an inflammatory condition that attacked the sacroiliac joint, which would be completely unrelated to the work injury. He testified that he did not believe that Petitioner needed work restrictions as it related to the work injury that caused his lumbar disk herniation. He further testified that he believed that Petitioner had reached maximum medical improvement, and that he could return to work full duty with no restrictions based upon this injury. (RX2).

On cross examination, Dr. Butler agreed that the last medical record that he reviewed was dated October 9, 2018 and that if Petitioner had treatment after that, he had not seen the medical records. He testified that the last FCE that he was aware of was that dated October 23, 2017. He agreed that he did not see the functional status report from Athletico from February 23, 2018. He testified that he did not see any medical records from Dr. Jhee from March 20, 2018 giving Petitioner work restrictions based on the functional status report from Athletico. He further testified that he did not see the medical records from Dr. Jhee dated May 24, 2018. (RX2).

On cross examination, Dr. Butler testified that he did not know whether the FCE recommended by Dr. Jhee on September 27, 2018 ever took place. He agreed that he indicated in his records review report dated November 20, 2018 that Petitioner's prognosis was good. When asked whether that meant that Petitioner was still going to continue to improve, Dr. Butler responded that he did not believe he was necessarily going to change much because he felt that he was at maximum medical improvement and that he felt that he had essentially plateaued from his work-related care and treatment. He testified that Petitioner had a good prognosis because his post-operative imaging studies showed really no herniation, and that he had essentially a stable lumbar spine with a successful discectomy. (RX2).

On redirect when asked whether there was a big difference between a pain score of 3/10 and a pain score of 4/10, Dr. Butler responded "not really." He agreed that subjective pain was what the scores were based on, and further testified that they were filled out by the patient. When asked whether subjective pain levels could differ by a couple of numbers even if the actual pain did not increase, Dr. Butler responded that it was a subjective interpretation. (RX2).

On further cross examination, Dr. Butler testified that when he provided his addendum report of November 20, 2018, no one had indicated that Petitioner was done treating. (RX2).

The medical records of ATI Physical Therapy were entered into evidence at the time of arbitration as Respondent's Exhibit 3. The records reflect that Petitioner was seen for an Initial Evaluation on August 15, 2017, at which time it was noted that he presented with signs and symptoms consistent with the physician's diagnosis of lumbar discectomy. It was noted that Petitioner was tearing down a wall in February 2017 that resulted in a gradual onset of low back pain that eventually started referring down his left leg. At the time of the August 17, 2017 visit, it was noted that Petitioner reported that he was feeling the same, that he stated that he was a little sore after the last session, and that he stated that the pain in his calf was more bothersome. It was noted that Petitioner stated that he was tender to the touch, and that he had been tested for DVT. At the time of the August 18, 2017 visit, it was noted that Petitioner reported feeling the same, that he reported being sore after the last session, and that he still continued to report excessive tightness, tenderness, and pain in his left calf. At the time of the August 21, 2017 visit, it was noted that Petitioner reported feeling better, that he felt better after the last session until he tripped over a hose on Sunday, and that something felt like it popped in the middle of the calf and had been sore ever since. (RX3).

The records of ATI Physical Therapy reflect that Petitioner was seen on August 22, 2017, at which time it was noted that he reported feeling better, that he was able to walk a little better but was still sore in his calf and low back, and that he was sleeping approximately six hours per night. At the time of the August 24, 2017 visit, it was noted that Petitioner reported feeling the same, that he reported feeling good after therapy for most of the day, and that his symptoms returned as the day progressed, especially if he did not stretch. It was also noted that Petitioner reported cramping in his left hamstring that morning and that he attributed it to too much coffee and not enough water the day before. At the time of the August 28, 2017 visit, it was noted that Petitioner reported feeling worse, that he felt better after the last session, and that he was putting a hand rail on the stairs causing debilitating pain that took him to his knees. It was noted that Petitioner used heat and medication to help decrease his symptoms at home. (RX3).

The records of ATI Physical Therapy reflect that Petitioner was seen on August 29, 2017, at which time it was noted that he reported feeling better, that his calf was feeling better, and that he did not have as much discomfort in his low back. It was noted that Petitioner stated that he stretched on days he was not at physical therapy. At the time of the September 1, 2017 visit, it was noted that Petitioner reported feeling better and that he reported that his back was feeling better since twisting it last weekend. At the time of the September 5, 2017 visit, it was noted that Petitioner's calf was still tender, that he felt a little better and was able to put more weight on it than before, and that his low back was getting better. It was noted that Petitioner was having more trouble with his left shoulder when sitting more than 20 minutes and that he had pain that felt like a toothache above the elbow. It was noted that Petitioner came back in from getting glasses, that he stated that he had a pop in the medial/posterior calf last time and ended up in the hospital when it occurred, and that it had occurred 3-4 times since the surgery and had not lasted as long the last couple of days. (RX3).

The records of ATI Physical Therapy reflect that Petitioner was seen on September 7, 2017, at which time it was noted that he reported feeling worse. It was noted that Petitioner reported walking down an incline that led to cramping in his calf recently, but not to the extent that was previously noted. At the time of the September 11, 2017 visit, it was noted that Petitioner reported feeling better, that he walked a lot that weekend and that his calf felt better, that it popped on Saturday but not to the degree in the past, and that he said his clavicle was still sore but felt better. It was noted that Petitioner stated that he still had not lifted anything heavier than eight pounds. At the time of the September 13, 2017 visit, it was noted that Petitioner reported feeling better, that he stated that he felt much better, that his calf, low back and clavicle felt better with less pain, and that he was able to mow the other day with breaks and no issues. At the time of the September 15, 2017 visit, it was noted that Petitioner reported feeling the same, that he arrived with complaints of increased soreness, 3-4/10 pain rating in the left calf, and that he reported that he did a lot of walking yesterday while at Northwestern. It was noted that Petitioner also experienced a "pop" that morning while going down the stairs which felt like he was being "tased." (RX3).

The records of ATI Physical Therapy reflect that Petitioner was seen on September 18, 2017, at which time it was noted that he reported feeling better, that he walked a lot on Saturday, that his low back was a little sore Saturday, and that his left calf was better with pain but had been spasming like before the surgery. At the time of the September 19, 2017 visit, it was noted that Petitioner stated that he was sore and fatigued from the last session, but that it was a good thing. At the time of the September 22, 2017 visit, it was noted that Petitioner reported feeling better, that he stated that his hips were a little sore from use, that he did a lot of walking, and that he was not feeling well due to allergies. At the time of the September 25, 2017 visit, it was noted that Petitioner reported feeling better and that he stated that his calf felt much better after the last session and through the weekend. At the time of the September 27, 2017 visit, it was noted that Petitioner reported fewer cramps, that his tenderness was more centralized, and that he was sleeping about six hours. At the time of the September 29, 2017 visit, it was noted that Petitioner reported feeling the same, that he was very sore in his core musculature secondary to upgrades in the last session, and that he used medications to address his symptoms. It was noted that Petitioner's calf pain was unremarkable and that he was scheduled for an FCE on October 11th and 12th. The Discharge Summary dated October 3, 2017 noted that Petitioner's estimated current physical demand level was that of Sedentary-Light ,and that his laborer position in grounds at ISU required a physical demand level of Heavy. (RX3).

The Frasco Investigation Report was entered into evidence at the time of arbitration as Respondent's Exhibit 4. The report reflects that a Social Media Investigation was requested on Petitioner, and that it was also requested that they conduct surveillance and a background investigation. (RX4).

The Parcel Ownership Identification Documentation was entered into evidence at the time of arbitration as Respondent's Exhibit 5. The Payment Ledger was entered into evidence at the time of arbitration as Respondent's Exhibit 6.

CONCLUSIONS OF LAW

The parties stipulated at the time of hearing that on March 2, 2017, Petitioner sustained an accident that arose out of and in the course of his employment with Respondent. (AX1).

With respect to disputed issue (F) pertaining to causation, the Arbitrator finds that Petitioner has failed to prove that his current condition of ill-being in the right-sided low back and right lower extremity is causally related to the accident of March 2, 2017, but that Petitioner has proven that his condition of ill-being in the left-sided low back and left lower extremity is causally related to the accident of March 2, 2017.

At the outset, the Arbitrator notes that, based on his testimony at the time of arbitration, Petitioner is alleging a current condition of ill-being of right-sided low back pain and right lower extremity pain. The Arbitrator further notes that the medical evidence reveals that Petitioner's initial complaints and treatment after the work incident on March 2, 2017, however, was that of left-sided lower back and left lower extremity pain.

As to Petitioner's initial left-sided low back pain and left lower extremity pain, the Arbitrator notes that both Respondent's Section 12 IME physician, Dr. Butler, and Petitioner's treating physician, Dr. Jhee, both agreed that the left-sided low back pain and left lower extremity pain was causally related to the March 2, 2017 incident. (PX1; RX2). While Dr. Jhee provided a favorable causation opinion to Petitioner regarding his left-sided low back and left lower extremity pain, the Arbitrator notes that Dr. Jhee could not definitively testify that Petitioner's subsequent development of right-sided low back pain and right lower extremity pain was causally related to the work accident at issue. For example, Dr. Jhee testified that when he saw Petitioner on January 18, 2018 his symptoms remained unchanged, that he noted that Petitioner felt the left leg was still weak, and that he noted mild tenderness in the right sacroiliac joint. When asked whether he had any indication on this date whether that was related to Petitioner's original work injury, Dr. Jhee responded that he was not so sure and that he did have this type of finding from the beginning, so there might have been some relationship between this condition and his work injury. (PX1). Similarly, on cross examination Dr. Jhee testified that for the right-sided problem he noted that at the time of the original consultation on August 10, 2017 he noticed some tenderness on both sides of the sacroiliac joint, and that as time went by Petitioner had some gradual worsening of right sacroiliac join inflammation or dysfunction that caused some right-side leg pain and radicular symptoms. When asked whether he would say that he was not sure whether it would have been related to the original injury, Dr. Jhee responded that his answer should be that it "could be yes or could be no." (PX1).

The Arbitrator notes that Dr. Butler testified that, per his records review report dated November 20, 2018, he reviewed the post-operative imaging from Petitioner's post lumbar disk herniation with discectomy at L5-S1, and that he believed that Petitioner did not require any additional medical treatment. Dr. Butler further testified that he did not believe that Petitioner was an appropriate candidate for a sacroiliac joint fusion based on the imaging studies that he had seen. Furthermore, Dr. Butler testified that he did not believe that Petitioner needed work restrictions as it related to the work injury that caused his lumbar disk herniation, that he believed that Petitioner had reached maximum medical improvement, and that he could return to work full duty with no restrictions based upon this injury. (RX2). Having

placed greater reliance upon the opinions of Dr. Butler in this matter, the Arbitrator hereby finds that Petitioner achieved maximum medical improvement for his left-sided low back and left lower extremity condition as of the date of Dr. Butler's report, which was that of November 20, 2018.

Having considered and reviewed the entirety of the medical evidence in this matter, the Arbitrator finds that Petitioner has failed to prove that his current condition of ill-being in the right-sided low back and right lower extremity is causally related to the accident of March 2, 2017, but that Petitioner has proven that his condition of ill-being in the left-sided low back and left lower extremity is causally related to the accident of March 2, 2017.

With respect to disputed issue (G) pertaining to Petitioner's earnings, the Arbitrator finds that Petitioner earned $45,097.06 in the year preceding the injury, and that the average weekly wage was that of $867.25 based on the documentation as contained in Respondent's Exhibit 1. (RX1).

With respect to disputed issue (J) pertaining to reasonable and necessary medical services, the Arbitrator finds that Petitioner's care and treatment up to and including November 20, 2018 was reasonable, necessary and causally related to the work accident of March 2, 2017. As a result thereof, Respondent shall pay all reasonable and necessary medical services as contained in Petitioner's Exhibit 12 **for medical services rendered up to and including November 20, 2018** as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit for all medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

With respect to disputed issue (K) pertaining to prospective medical treatment, in light of the Arbitrator's finding that Petitioner has failed to prove that his current condition of ill-being in the right-sided low back and right lower extremity is causally related to the accident of March 2, 2017, Petitioner's request for prospective medical treatment to the right-sided low back and right lower extremity as recommended by Dr. Seibly is hereby denied.

With respect to disputed issue (L) pertaining to temporary total disability, the Arbitrator notes that Petitioner claims that he is entitled to temporary total disability benefits for the timeframe of February 28, 2019 through October 24, 2019. (AX1).

In light of the Arbitrator's findings that Petitioner has failed to prove that his current condition of ill-being in the right-sided low back and right lower extremity is causally related to the accident of March 2, 2017 and that Petitioner achieved maximum medical improvement for his left-sided low back and left lower extremity condition as of November 20, 2018, Petitioner's request for temporary total disability benefits for the timeframe of February 28, 2019 through October 24, 2019 is hereby denied.

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

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	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Anne Mbuthia,

Petitioner,

vs. NO: 19 WC 3170

Shapiro Developmental Center,

Respondent.

20IWCC0383

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses and temporary total disability, and being advised of the facts and law, reverses the Decision of the Arbitrator as stated below.

I. FINDINGS OF FACT

Petitioner was employed by Respondent as a Licensed LPN 2 (Nurse). Her job duties included administering medication to patients and taking care of them medically. This required her to move around different buildings at Shapiro.

On December 27, 2018, Petitioner was working the morning shift. She had to retrieve keys to the medication cabinet from Building 514B before going to another building to distribute it. At 6:40 a.m. she was walking from Building 514B to Building 502A with keys in her pocket and a pen in hand to pass out medication. The route between the buildings required her to traverse an indoor staircase before exiting a door and walking outside to get to Building 502A.

While walking down the staircase in building 514B, a staircase that is not open to the general public, Petitioner fell. She testified that she did not know what caused her to fall, but reiterated that this was the route she had to take as part of her job. The stairs were made of wood and had a metal slab on the front edge of each stair. After falling, Petitioner crawled back up the

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stairs, unlocked the door with her keys and called for help, while experiencing pain in her left ankle. Petitioner indicated that she did not observe any defects on the staircase.

Petitioner reported her incident to her supervisor, Veronica Makhoka, who called for an ambulance to take Petitioner to St. Mary's Hospital. At St. Mary's Petitioner indicated that she fell down a flight of stairs. She underwent x-rays and was diagnosed with a trimalleolar fracture of the left ankle with widening of the medial joint space. Petitioner was also referred to an orthopedist.

Petitioner began treatment with orthopedist, Dr. Choy, who eventually performed an open reduction and internal fixation on the displaced lateral malleolar fracture and medial malleolar avulsion on January 10, 2019. She testified that she continues treating with Dr. Choy and undergoes physical therapy. Petitioner has not returned to work since the accident and has no indication from Dr. Choy as to when she will be able to return to work.

II. CONCLUSIONS OF LAW

The Arbitrator found that Petitioner met her burden of proving an accident arising out of and occurring in the course of her employment with Respondent on December 27, 2018. In so doing, the Arbitrator noted that Petitioner's daily job duties required her to use a particular route and the specific staircase on which she fell, which was not accessible by the general public.

To obtain compensation under the Act, a claimant must show, by a preponderance of the evidence, that she suffered a disabling injury that arose out of and in the course of her employment. *Baggett v. Industrial Comm'n*, 201 Ill. 2d 187, 194 (2002). An injury "arises out of" one's employment if it originated from a risk connected with, or incidental to, the employment and involved a causal connection between the employment and the accidental injury. *Id.* "In the course of" refers to the time, place, and circumstances of the accident. *Illinois Bell Telephone Co. v. Industrial Comm'n*, 131 Ill. 2d 478, 483 (1989). Both elements must be present at the time of the claimant's injury to justify compensation under the Act. *Id.*

There is no dispute between the parties that Petitioner was in the course of her employment when she was using the staircase. However, in order to determine the "arising out of" element of an accident, the risk must first be categorized. The risks to which an employee may be exposed are categorized into three groups: 1) risks distinctly associated with employment; 2) risks personal to the employee, such as idiopathic falls; and 3) neutral risks that have no particular employment or personal characteristics. *First Cash Financial Services v. Industrial Comm'n*, 367 Ill. App. 3d 102, 105 (2006). The Commission finds that Petitioner fails to satisfy any of the three categories.

"Risks are distinctly associated with employment when, at the time of injury, 'the employee was performing acts he was instructed to perform by his employer, acts which he had a common law or statutory duty to perform, or acts which the employee might reasonably be expected to perform incident to his assigned duties.'" *Steak 'n Shake v. Illinois Workers' Compensation*

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Comm'n, 2016 IL App (3d) 150500WC, ¶ 35 (quoting *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill. 2d 52, 58 (1989)). However, "[f]or an injury caused by an unexplained fall to arise out of the employment, a claimant must present evidence which supports a reasonable inference that the fall stemmed from a risk related to the employment." *Baldwin v. Illinois Workers' Compensation Comm'n*, 409 Ill. App. 3d 472, 478 (2011) (quoting *Builders Square, Inc. v. Industrial Comm'n*, 339 Ill. App. 3d 1006, 1010 (2003)). Petitioner testified that the route she took traversing the particular staircase on which she fell was the one that she had to take as part of her job. However, almost identically to the claimant in *Baldwin,* Petitioner slipped and fell as she was descending a staircase, she did not know what caused her to slip, and she saw no defect in the stairs. *Id.* That the stairs were made of wood and had a metal slab on the front edge of each stair does not establish that the stairs, composed of such materials, were defective.

Petitioner also fails to satisfy the second category. An injury stemming from an idiopathic fall arises out of employment only where the employment conditions significantly contributed to the injury by increasing the risk of falling or the effects of the fall. *First Cash*, 367 Ill. App. 3d at 105. In the case at bar, just as in *First Cash*, Petitioner testified that she "just fell" for an unknown reason, and offered no evidence suggesting that a physical condition caused her fall.

Petitioner further fails to satisfy category three. A neutral risk, one to which the general public is equally exposed, does not arise out of employment. *Baldwin*, 409 Ill. App. 3d at 478. By itself, the act of walking up a staircase does not expose an employee to a risk greater than that faced by the general public. *Id.* (citing *Elliot v. Industrial Comm'n*, 153 Ill. App. 3d 238, 244 (1987); see also *Illinois Consolidated Telephone Co. v. Industrial Comm'n*, 314 Ill. App. 3d 347, 353 (2000) (Rakowski, J., specially concurring)). Like the claimant in *Baldwin*, there is no evidence that the risk faced by Petitioner in descending a staircase at her employer's place of business was any greater than that faced by the general public. *Id.*

Ultimately, Petitioner sustained an unexplained fall. She testified that she did not know why she fell, and she was simply walking down the stairs at the time of her fall. There is no evidence of any defective condition on the stairs, or of any increased risk incidental to her job duties to which she was exposed to a greater extent than the general public. The record does not reflect any evidence that Petitioner was rushing at the time or that she was holding anything of any significance in her hands.

Accordingly, the Commission finds that Petitioner has failed to meet her burden of proving the "arising out of" element necessary to establish a compensable accident. Thus, the Commission hereby reverses the Arbitrator's decision and vacates all benefits awarded.

IT IS THEREFORE FOUND BY THE COMMISSION that Petitioner has failed to meet her burden of proof regarding accident in relation to the incident in question.

IT IS FURTHER ORDERED BY THE COMMISSION that all benefits awarded to Petitioner by the Arbitrator are hereby vacated.

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

Pursuant to section 19(f)(1) of the Act, claims against the State of Illinois are not subject to judicial review. Therefore, no appeal bond is set in this case.

DATED: JUL - 7 2020
O: 5/7/20
BNF/wde
45

Barbara N. Flores

Deborah L. Simpson

Deborah L. Simpson

Marc Parker

Marc Parker

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

MBUTHIA, ANNE
Employee/Petitioner

Case# **19WC003170**

SHAPIRO DEVELOPMENTAL CENTER
Employer/Respondent

20IWCC0383

On 6/19/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.13% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

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

JUN 19 2019

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

STATE OF ILLINOIS)
)SS.
COUNTY OF KANKAKEE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Anne Mbuthia
Employee/Petitioner
v.
Shapiro Developmental Center
Employer/Respondent

Case # **19** WC **3170**

20IWCC0383

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Anthony C. Erbacci**, Arbitrator of the Commission, in the city of **Kankakee**, on **May 17, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **December 27, 2018**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, the average weekly wage was $**997.32**.

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

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

ORDER

Respondent shall pay reasonable and necessary medical services of $**19,623.30**, as provided by Section 8(a) and 8.2 of the Act.

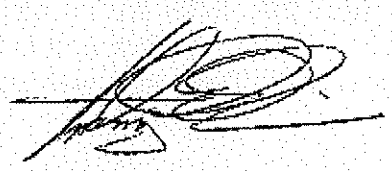
Respondent shall hold Petitioner harmless for all related medical bills paid by Petitioner, and any other third-party insurer or payor. Respondent shall pay any outstanding medical bills related to treatment of Petitioner's left ankle injury incurred from the date of the accidental injury through the date of this award.

Respondent shall pay Petitioner temporary total disability benefits of $**664.22** / week for **20** weeks, totaling $13,284.40, commencing **December 27, 2018** through **May 17, 2018** and for each week thereafter through present and until the Petitioner has been released to return to work, 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.



Arbitrator Anthony C. Erbacci

June 14, 2019
Date

JUN 19 2019

FACTS:

The parties stipulated that Petitioner, Anne Mbuthia, was a state employee working for the Respondent, Shapiro Developmental Center, on December 27, 2018.

Petitioner testified that on December 27, 2018, she was employed as an LPN II at Shapiro Developmental Center and her job duties involved administering medication to residents and taking care of them medically. She testified that her job requires her to move around to different buildings at Shapiro to distribute medication. Petitioner testified that on December 27, 2018, she was working the morning shift from 6:15 a.m. to 2:30 p.m. Petitioner testified that her injury occurred at approximately 6:40 a.m., while she was preparing to exit one building and go to another building to distributed medication to residents. Petitioner testified that she had to pick up keys to the medication cabinets in building 514B before going to distribute medication to the residents in building 502A.

Petitioner testified that after she picked up the keys to the medication cabinets in building 514B, she had to take a staircase inside the building before she could exit to walk to the 502A building. She testified the staircase was made of wood with a slide of metal on the very front edge. Petitioner testified that stairway is the route she has to take from where she gets keys for medication cabinets and to get to the next building. Petitioner was carrying the medication keys and a pen. Petitioner testified she was going down a staircase that is only used by staff at Shapiro, and is not accessible to the general public, when she fell.

Petitioner testified that the doors to the stairway are locked and when she fell there was no way should could communicate with anybody. She had to crawl up the staircase because she could not walk. She then opened the door with keys and called for help. Petitioner was feeling pain in her left ankle.

Petitioner reported her injury to Veronica Makhoka, the supervisor on duty that morning. The supervisor called an ambulance and Petitioner was taken to St. Mary's Hospital.

Medical Records regarding treatment of Petitioner's fractured left ankle, including surgery, physical therapy and subsequent follow up with her orthopedic surgeon were admitted by Petitioner as Petitioner's Exhibits ("PX") B and C.

Petitioner testified that x-rays were taken at St. Mary's Hospital and she learned she had two broken bones in her left ankle and she was referred to see an orthopedic doctor. Petitioner next saw Dr. Choy at OAK Orthopedics, who ordered another x-ray of her left ankle, and told her the swelling would need to subside before he could do surgery.

Petitioner had surgery on her left ankle on January 10, 2019, and continues to treat with Dr. Choy following her surgery. Petitioner last saw Dr. Choy on April 29, 2019 and is also receiving physical therapy from Presence Heath. Petitioner testified that she is still off work and Dr. Choy has not given her any indication of when she might be able to return to work. Petitioner was scheduled to see Dr. Choy next on May 28, 2019.

At the hearing Petition was using a cane, which she had been using since her last appointment on April 29, 2019. She had been using crutches before that. She was also wearing a brace on her left ankle at the time of the hearing.

The Petitioner's medical records reflect the nature and extent of Petitioner's injury and treatment, which include an open reduction and internal fixation surgery to repair the displaced lateral malleolar and medial malleolar ankle fractures to her left ankle.

Petitioner testified that she did not have any prior problems with her left ankle and had not been treating with a doctor for her left ankle before December 27, 2018.

Petitioner testified she has learned some of her medical bills have been paid by insurance but she does not know if they have been paid by workers' comp insurance or her own health insurance. She is not sure if all of her medical have been paid up to date. The medical bills admitted into evidence as Petitioner's Exhibits E and F evidence that the payments made have been made to Presence St. Mary's Hospital and OAK Orthopedics by Petitioner's personal health insurance through Aetna HMO. Respondent offered no evidence of it having paid any of Petitioner's medical expenses.

Petitioner testified she has not received any sort of disability payment while she has been off for work due to her injury.

CONCLUSIONS:

In Support of the Arbitrator's Decision relating to (C.), Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds and concludes as follows:

Petitioner testified she is required to pick up the keys to the medication cabinets in one building and use a particular staircase in order to exit that building before distributing medication to residents in other buildings. Petitioner testified that stairway is the route she has to take from where she gets the keys to where she has to exit the building Petitioner testified the staircase she is required to use is only used by staff at Shapiro, and is not accessible to the general public. Petitioner testified the stairs were wooden stairs with a "slide of metal" on the front edge. She testified that she did not know if there were cracks or anything wrong with the stairs, but she was in a lot of pain after she fell and didn't think to check the stairs. The records from Petitioner's emergency room treatment by Dr. Alexander Wang at Presence St. Mary's Hospital indicate she described work injury as happening when she slipped on the subject stairway on December 27, 2018.

Petitioner testified that she was not aware that there were any cracks or defects on the staircase and that she "just fell". Regardless, the Petitioner's daily job duties required her to use those stairs, which were only used by staff and were not accessible by the general public. Petitioner was in a place she was reasonably expected to be and was engaged in conduct that arose out of her daily job responsibilities. Her required use of that stairway to exit the building and carry on her job responsibilities on a daily basis increased her risk of injury beyond that to which the general public is exposed, particularly considering the general public does not have access to that stairway at the

Shapiro Developmental Health Center. Therefore, the Arbitrator finds Petitioner suffered an accident arising out of and in the course of her employment.

In Support of the Arbitrator's Decision relating to (F.), Is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds and concludes as follows:

In addition to Petitioner's credible testimony regarding her injury and current condition of ill being, Petitioner offered her medical records related to treatment of the subject injury into evidence and without objection from Respondent. There was no evidence that Petitioner did anything outside of work prior or subsequent to the December 27, 2018 injury that caused or otherwise contributed to her injury.

The Petitioner also testified that her left ankle injury has caused her pain and discomfort and physical limitations, which have required the assistance of crutches and a cane and which continue to the present time. Both Petitioner's testimony and the medical records of Petitioner's treatment subsequent to the December 27, 2018 work injury indicate that her condition of ill being is causally connected to the December 27, 2018 injury.

In Support of the Arbitrator's Decision relating to (J.), Were the medical services that were provided to Petitioner reasonable and necessary/Has Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds and concludes as follows:

Based on Petitioner's credible testimony and the medical records offered into evidence without objection, the medical services provided to Petitioner are found to have been reasonable and necessary given the nature and extent of Petitioner's injury and treatment. The evidence presented by Petitioner, including her testimony and the medical bills entered into evidence as Petitioner's Exhibits E and F, establish that Respondent has not paid any of the medical charges incurred for the reasonable and necessary medical services provided to Petitioner.

Respondent shall pay any outstanding medical bills related to treatment of Petitioner's left ankle injury incurred from the date of the accidental injury through the date of this award, and continuing until such time as the Petitioner has been declared to have reached maximum medical improvement, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall hold Petitioner harmless for any related medical bills paid by Petitioner and/or any third-party insurer or payor.

In Support of the Arbitrator's Decision relating to (L.), What temporary benefits are due, the Arbitrator finds and concludes as follows:

Petitioner's testimony and the medical records presented support the legal conclusion that she is entitled to Temporary Total Disability benefits from December 27, 2018 through present, which amounts to 20 weeks at a Temporary Total Disability rate of $664.22/wk. for a total Temporary Total Disability benefit in the amount of $13,384.40, as provided in Section B(b) of the Illinois Workers' Compensation 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 Down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

EVANGELINA BEDOY,

Petitioner,

vs.

Nos: 12 WC 035704,
12 WC 036659

McDONALD'S,

Respondent.

20IWCC0384

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, notice, causal connection, average weekly wage, medical expenses, permanent disability, penalties, and attorney fees, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

I. Causal Connection

The Commission affirms and adopts the Decision of the Arbitrator finding Petitioner's current condition of ill-being was causally connected to the October 3, 2012 accident. However, regarding Petitioner's right shoulder, Respondent correctly observes that the Arbitrator mistakenly placed the date of first complaint to Dr. Louis at October 6, 2012 instead of October 16, 2012. As there are no records of any October 6, 2012 medical visit, this would appear to be a scrivener's error in the Decision. Moreover, the erroneous clause merely introduced the Arbitrator's finding that Dr. Phillips, Respondent's Section 12 examiner, conceded a causal connection. Dr. Phillips's report reflects that he reviewed the October 16, 2012 records, further suggesting that the Arbitrator's reference to October 6 was a mere typographical error. Accordingly, the Commission corrects the Decision to reflect the date of first complaint to Dr. Louis at October 16, 2012.

20 IWCC0384

II. Average Weekly Wage

Respondent argues that the Arbitrator erred in calculating Petitioner's average weekly wage (AWW), noting that the wage earnings statement in Respondent's Exhibit 7 included 54, not 52, weeks of earnings. Respondent states that Petitioner's gross earnings in the 52 weeks preceding the accident were $14,727.61, resulting in an AWW of $283.22 instead of $296.52. Petitioner concedes that Respondent is correct in its calculation. Accordingly, the Commission modifies the Decision to reflect an AWW of $283.22.

III. Medical Expenses

The Arbitrator ruled that Respondent was liable to pay $120,850.22 of Petitioner's medical expenses related to services rendered by ATI Physical Therapy, Rehab Dynamix, Injured Worker Pharmacy, Dr. Markarian, Prescription Partners, Preferred Open MRI, Chicago Pain and Orthopedic Institute, Milwaukee Anesthesia, and Accredited Ambulatory Care. The Arbitrator also found Respondent was entitled to a credit for amounts paid on account as reflected in Respondent's Exhibit 4.

The Commission affirms the Decision's award of medical expenses, with one exception. Respondent challenges the amount awarded to ATI Physical Therapy for transportation expenses. Travel expenses may be awarded under a reasonableness standard. *General Tire & Rubber Co. v. Industrial Comm'n*, 221 Ill. App. 3d 641, 651 (1991). In this case, Petitioner produced no evidence that transportation to or from ATI was necessary or reasonable. The Commission disallows 28 charges of $109.60 apiece from July 2, 2014 through September 12, 2014, resulting in a reduction of the award to ATI Physical Therapy in the amount of $3,068.80.

In all other respects, the Commission affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE FOUND BY THE COMMISSION that Petitioner proved she sustained an accident arising out of and in the course of her employment with Respondent on October 3, 2012.

IT IS FURTHER FOUND BY THE COMMISSION that timely notice of this accident was given to Respondent.

IT IS FURTHER FOUND BY THE COMMISSION that Petitioner proved her current condition of ill-being is causally connected to the accident in this case.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay Petitioner's reasonable and necessary medical bills of: ATI Physical Therapy, Rehab Dynamix, Injured Worker Pharmacy, Dr. Markarian, Prescription Partners, Preferred Open MRI, Chicago Pain and Orthopedic Institute, Milwaukee Anesthesia, and Accredited Ambulatory Care, if previously unpaid and not written off, as listed in Petitioner's Exhibit No. 5, pursuant to the fee schedule and §§8(a) and 8.2 of the Act, deducting $3,068.80 in transportation charges from the amount awarded to ATI Physical Therapy for transportation expenses. Respondent is additionally entitled to a credit for amounts paid on account as reflected in Respondent's Exhibit

4. 20IWCC0384

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $253.00 per week for a period of 87.5 weeks, as provided in §8(d)(2) of the Act, for the reason that the injuries sustained caused a 17.5% loss of use of the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner penalties representing 50% of the amount of unpaid medical expenses pursuant to the fee schedule as provided by §19(k) of the Act, as well as attorney's fees representing 20% of the unpaid awarded medical expenses, pursuant to §16 of the Act.

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: JUL - 7 2020
d: 6/18/20
BNF/kcb
045

Barbara N. Flores

Deborah L. Simpson

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BEDOY, EVANGELINA
Employee/Petitioner

Case# **12WC036659**

12WC035704

McDONALD'S
Employer/Respondent

20IWCC0384

On 1/7/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.50% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0147 CULLEN HASKINS NICHOLSON ET AL
JOSE RIVERO
10 S LASALLE ST SUITE 1250
CHICAGO, IL 60603

5074 QUINTAIROS PRIETO WOOD & BOYER
DANA T BENEDETTI
180 N STETSON AVE SUITE 4525
CHICAGO, IL 60601

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Evangelina Bedoy,
Employee/Petitioner

Case # **12WC036659**

v.

Consolidated cases: **12WC035704**

McDonald's,
Employer/Respondent

20IWCC0384

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul-Eric Seal**, Arbitrator of the Commission, in the city of **Chicago**, on **October 16, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **10/03/2012**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**15,418.89**; the average weekly wage was $**296.52**.

On the date of accident, Petitioner was **51** years of age, ***single*** with **0** dependent children.

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

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

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

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

ORDER

Respondent shall pay reasonable and necessary medical services of $120,850.22 as enumerated in Petitioner's Exhibit Number 5, but subject to the fee schedule in Section 8.2 of the Act.

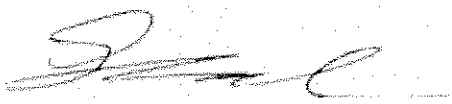
Respondent is entitled to a credit for amounts paid on account as enumerated in its Exhibit number 4.

Respondent shall pay Petitioner permanent partial disability benefits of $253.00/week for 87.5 weeks, because the injuries sustained caused the 17.5% loss of the person as a whole, as provided in Section 8(d) (2) of the Act.

Respondent shall pay to Petitioner penalties of 50% of the amount of unpaid medical expenses payable pursuant to the fee schedule as provided in Section 19(k) and an additional 20% of the amount payable under 19(k) consisting of the attorneys' fees in Section 16.

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 5th, 2019
Date

JAN 7 - 2019

Findings of Fact:

During October of 2012, Petitioner, Evangelina Bedoy, worked in the kitchen for Respondent, McDonald's. (T. 13) She has worked for Respondent for approximately 21 years. (T. 13) Her job duties included making hamburgers, bringing food supplies from the refrigerator, cleaning. (T. 13) Petitioner testified at hearing that on October 3, 2012, she went to the refrigerator to get meat. (T. 14) In the refrigerator, there were four or five boxes of meat stacked higher than her height, so she grabbed the top box and placed it on her left shoulder. (T. 14-15) As she did so, she twisted her lower back. (T. 15) She tried to pull the box with her right arm and noticed pain in her right shoulder as well. (T. 15) Despite the pain in her back and shoulder, Petitioner took the box of meat to the kitchen and told her managers, Elida and Esmena, what had just occurred. (T. 15) Petitioner continued to work the remainder of the day until the store manager, Maricela, arrived and told her to stop working. (T. 17)

A Form 45 was filed out by Luis Rivadeneyra, Petitioner's supervisor, on October 3, 2012 for an accident involving Petitioners' lower back on October 3, 2012 when "she was dropping a box of meat." (PX. 10)

She sought medical treatment with Trinity Hospital that day. (T. 17) At Trinity Hospital, a history was taken of "patient to ed with c/o lower medical back pain after lifting boxes at work today…" (PX. 7) There, she was given pain medication and told to follow up with her doctor in one to two days. (PX. 7)

On October 8, 2012, Petitioner received a letter from CCMSI, the insurer for Respondent, indicating it had received notice of Petitioner's work injury. (PX. 6)

Petitioner testified that two days later she returned to work in her same position despite continued pain. (T.17)

She eventually sought medical treatment with Demetrios Louis, M.D. of the Chicago Pain and Orthopedic Institute on October 16, 2012. (T. 18, PX. 1, pg. 2) He diagnosed her with lumbar strain, and right shoulder pain, placed her off work, ordered physical therapy and discussed the possibility of ordering an MRI of the right shoulder and lower back. (PX1, pg. 4-6)

On October 23, 2012, Petitioner filed an Application for Adjustment of Claim with the Illinois Workers' Compensation Commission, of which there is a proof of service to Respondent on October 22, 2018.

Petitioner followed up with Dr. Paul Marsiglia of Chicago Pain and Orthopedic Institute on November 8, 2012 with continued pain complaints in her lumbar spine and right shoulder. Dr. Marsiglia ordered an MRI of Petitioner's lumbar spine and right shoulder. (PX. 1, pg. 7-8)

On November 26, 2012, Petitioner was examined by Dr. Neeraj Jain of Chicago Pain and Orthopedic Institute. Dr. Jain reviewed an MRI of Petitioner's lumbar spine which revealed disk hernaitions at L4-5 and L5-S1 with spinal stenosis. (PX. 1, pg. 11, PX. 3, pg 4) The MRI of the right shoulder demonstrated bicep tenosynovitis and bursitis. (PX. 1, pg. 11, PX. 3, pg. 7) Dr.

Jain recommended epidural injections for her lumbar spine and a referral to an orthopedic surgeon for her shoulder. (PX.1, pg. 12)

Petitioner returned to work for Respondent in a light duty capacity on December 28, 2012. (T. 23)

Dr. Greg Markarian, and orthopedic surgeon with Chicago Pain and Orthopedic Institute, evaluated Petitioner on January 3, 2013 and upon review of the right shoulder MRI recommended physical therapy and possible injection after a few weeks. (PX. 1, pg. 17) On January 31, 2013, Dr. Markarian noted Petitioner was improving with physical therapy and suggested holding off on any injection. (PX. 1, pg. 22)

Petitioner underwent a course of physical therapy at Rehab Dynamics beginning on February 25, 2013 for her right shoulder. (PX. 2, pg. 78).

Petitioner underwent a bilateral L4-5, L5-S1 transforaminal steroid injection with selective nerve block by Dr. Jain on April 20, 2013. (PX. 1, pg. 27) In follow up on May 3, 2013, Dr. Jain noted 30-40% improvement post-injection. (PX. 1, pg. 29) He went on to recommend a second such injection. (PX. 1, pg. 29)

On June 6, 2013, Petitioner saw Dr. Markarian with regard to her shoulder. Dr. Markarian performed a three and three injection. (PX. 1, pg. 34) On July 18, 2013, Dr. Markarian ordered continued physical therapy for her shoulder. (PX. 1, pg. 37)

On June 23, 2013, Dr. Axel Vargas of Chicago Pain and Orthopedic Institute recommended a diagnostic intra-articular L4-5 and L5-S1 bilateral facet joint injection as well as an FCE to determine her work capacity. (PX. 1, pg. 35)

Petitioner was discharged from physical therapy at Rehab Dynamics on August 19, 2013. (PX. 2, pg. 5)

Petitioner underwent an FCE at ATI Physical Therapy on September 3, 2013 which placed Petitioner at sedentary to light physical demand level. (PX. 1, pg. 90)

By October 10, 2013, Dr. Markarian recommended Petitioner resume physical therapy for her shoulder and discussed the possibility of a tenodesis and decompression, should she fail to improve. (PX. 1, pg. 42)

On November 12, 2013, Dr. Vargas performed bilateral L4-5 and L5-S1 facet joint injections. (PX.1, pg. 43) In follow up on December 6, 2013, Dr. Vargas noted a 70% improvement in Petitioner's lower back pain following the injection but back to baseline on December 3, 2013. Dr. Vargas recommended bilateral medical branch blocks, one with long lasting anesthetic and steroid, and one with short acting anesthetic with steroid. (PX. 49)

On November 27, 2013, Dr. Markarian noted no improvement in Petitioner's right shoulder and formally recommended surgery consisting of an arthroscopy, biceps tenotomy, subpectoral tenodesis, and subacromial decompression with possible rotator cuff repair. (PX. 1, pg. 47)

On March 18, 2014, Dr. Vargas performed a bilateral L3, L4, L5 and dorsal root of L5 medical branch nerve block with steroids. (PX. 1. Pg. 60) Dr. Vargas performed the second block with Lidocaine only on April 1, 2014. (PX. 1, pg. 62) In follow up on May 9, 2014, Dr. Vargas was able to confirm that the source of Petitioner's pain was in the facets. (PX. 1, pg. 66). Accordingly, he went on to recommend that she undergo L3, L4, L5 and dorsal root of L5 radiofrequency ablation. (PX. 1, pg. 66)

Pending approval for both procedures, both Dr. Markarian and Dr. Vargas ordered physical therapy which was conducted at ATI Physical therapy. (PX. 4) By the last physical therapy session on September 12, 2014 from ATI, it was noted that Petitioner had overall improvement with some limitations with reaching away from her body or behind her back. (PX. 4, pg. 6-7)

Petitioner did not undergo the surgery recommended by Dr. Markarian and the radiofrequency ablation recommended by Dr. Vargas.

Throughout the course of her treatment, Petitioner was prescribed Tramadol, Omeprazole, Meloxicam, Zolpidem, Pantoprazole, Carisoprodol, Cyclobenzaprine, Naproxen, Dendracin, and Gabapentin. These medications were prescribed by the doctors at Chicago Pain and Orthopedic Institute and dispensed by Injured Worker Pharmacy and Prescription Partners. (PX. 5, pg. 40, 54-64)

Petitioner continues to work for Respondent in a light duty capacity cleaning tables as opposed to her prior position of working in the kitchen. (T. 25) However, since July of 2018, she is only working 10 hours per week, whereas before the accident, she normally worked 38 hours per week. (T. 25) She claims that she still notices pain while she works. (T. 31) She takes ibuprofen to alleviate this pain. (T. 32)

On cross-examination, Petitioner stated that she recalled Maria Torres being present on the date she was injured – but, she was not sure whether Hortencia Pulido was there. (T. 33, 50) Petitioner clarified that she is working light duty and reduced hours as prescribed by her treating doctors. (T. 45) She stated that Elida, the manager to whom she reported the injury, still works at McDonald's. (T. 51)

Respondent offered the testimony of Luis Rivadeneyra, supervisor for Respondent. (T. 6) He testified that the petitioner currently works as a crew person and he is not charged with setting her schedule. (T. 11) However, Mr. Rivadeneyra stated that Petitioner approached him about only working on two weekdays because she needed to take care of her grandchildren. (T.15) However, on cross-examination, Mr. Rivadeneyra clarified that Petitioner approached him about the reduction in hours in the context of her medical restrictions. (T. 28-29) He moved her to maintenance in the lobby where she works currently. (T. 30) Mr. Rivadeneyra testified that he filled out the entire Form 45 except for the portion dealing with wages. (T. 7) He believed someone filled in the wage information after he signed the form. (T. 37) He testified that he sent the form to the main office for the Respondent via fax, right away, as is custom. (T. 39) Mr. Rivadeneyra testified that it is policy at the Respondent's restaurant that anybody can work whatever hours they want. (T. 44)

Oscar Perretta, owner of McDonald's, testified at hearing as well for the Respondent. He testified that never spoke to Petitioner about reducing her hours at work. (T. 51) On cross-examination, when asked whether Petitioner sustained an accident while working at McDonald's on October 3, 2012, he stated "Yes." (T. 51) He testified that he was never contacted by any insurance company regarding Petitioner's accident. (T. 53)

Wendy Nunez, office administrator for the Respondent, testified at hearing for Respondent. Ms. Nunez identified Respondent's Exhibit 6, the employee time punch for October 3, 2012. (T. 60) She testified that according to the punch, Hortencia Pulido and Esmenia were not working on October 3, 2012. However, Elida was. (T. 65-66) On cross examination, Ms. Nunez testified that Elida still works for Respondent. She does not know whether anyone else that worked alongside Petitioner on October 3, 2012 still works for Respondent. (T. 71) Ms. Nunez received the Form 45 via fax from the Respondent's store. (T. 81) Ms. Nunez testified that prior to hearing, no one has ever asked her about Petitioner's accident and notice thereof. (T.80)

Steven Mather, M.D. performed a records review for Respondent on March 7, 2018, and he concluded that Petitioner suffered a lumbar sprain and should have resolved within 2 to 4 weeks. He believed the MRI was essentially normal for someone of Ms. Bedoy's age. He stated that her subjective complaints are out of proportion to the findings by physicians. He believed no injections were necessary because she had conflicting pain complaints. He concluded that the FCE was invalid because she claims to not be able to lift 6 pounds floor to chair but can lift more overhead and desk to chair. He believes that it was "bizarre" to not mention her initial visit to the ER to her treating doctors. He critiqued Dr. Vargas's diagnosis of facet syndrome because flexion should relieve facet syndrome and Dr. Vargas noted pain with flexion. He opined that the Erocin patches are "pricey" and provide no benefit. He believed she requires no further treatment and should be working full duty. He opined that no treatment beyond two weeks was reasonable and that she reached MMI on November 8, 2012. (RX. 1)

On cross-examination he stated he saw no instance of positive straight leg raise in the medical records. He admitted that the examiners at ATI regarded the FCE to be valid. He does not perform injections himself. He recognized that Petitioner was working full duty prior to his accident, experienced an immediate onset of pain following her injury. Dr. Mather believed that Petitioner's doctors deviated from the ODG guidelines but did not necessarily deviate from the standard of care. (RX. 1)

Dr. Craig Phillips testified for Respondent as well. On April 15, 2013, he examined Petitioner pursuant Section 12 of the Act for Petitioner's right arm condition. He diagnosed Petitioner with bicep tendonitis and subdeltoid bursitis as well as myofascial pain syndrome. (RX. 2) He believed that the diagnosis was causally related to the accident. He believed that the physical therapy and treatment she had received thus far was reasonable and necessary. He placed her with restrictions of 10 pounds with no overhead activities and recommended three months of physical therapy, Medrol dosepak and an injection. Dr. Phillips reevaluated Ms. Bedoy on September 9, 2013 and opined that Petitioner's pain complaints were purely subjective and not supported by the physical findings. He gave her an impairment rating of 4% of the upper

extremity. Dr. Phillips acknowledged that he could have obtained an impairment rating with Petitioner's decreased range of motion but did not do so. He felt that the medication provided to Petitioner for her shoulder was reasonable and necessary, except for the topical creams. (RX. 2)

Respondent offered into evidence Petitioner's Application for Adjustment of Claim filed on October 15, 2012 as Exhibit 5. It also offered the wage statement as Exhibit 7.

Conclusions of Law:

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

Petitioner credibly testified as to the accident she sustained while lifting a box of meat in the refrigerator causing her pain in her lumbar spine and right shoulder. He account is supported by the histories in the medical records. The owner of the Respondent's store admitted at hearing that Petitioner suffered an accident while at work. Respondent offered no witness testimony or documentary evidence to the contrary. Accordingly, the Arbitrator finds that Petitioner sustained an injury that arose out of and in the course of her employment with Respondent.

With respect to issue (E), whether Petitioner gave timely notice of her accident to Respondent, the Arbitrator finds as follows:

Petitioner credibly testified that she gave notice of her accident to her manager, Elida, immediately following the accident. Respondent did not present Elida to testify to the contrary. Petitioner's account is supported by the Form 45 that was filled out by Respondent on the same day of the accident. Furthermore, Respondent's insurance carrier sent a letter to Petitioner on October 8, 2012 acknowledging receipt of notice of the accident of October 3, 2012. Accordingly, the Arbitrator finds that Petitioner gave adequate notice of her accident to Respondent.

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

The chain of events supports a causal link between Petitioner's lower back pain and the accident sustained on October 3, 2012. Petitioner noticed immediate onset of lumbar pain following her accident. That account is supported by the emergency room records from Trinity Hospital. Petitioner's back pain continued throughout her medical care and through the present as she goes about her work activities. Moreover, even Respondent's Section 12 examiner opined that a causal link exists between Petitioner's back condition and the accident of October 3, 2012.

While Dr. Mather opined that Petitioner suffered a mere strain with no evidence of radiculopathy, the Arbitrator notes that Petitioner was working fully duty for Respondent for 21 years without incident until the onset of lumbar pain on October 3, 2012.

While Dr. Mather regarded the MRI findings as "normal," the treating doctors disagreed, and diagnosed Petitioner with disc herniations at L4-5 and L5-S1. The treating doctors'

diagnosis is consistent with that of the radiologist. Dr. Mather stated that there was no instance in the medical records where there existed a finding of positive straight leg raise. However, the Arbitrator notes instances of positive straight leg raise from the initial visit with Dr. Louis on October 16, 2012, thus diagnosing Petitioner with lumbar radiculitis. It is further noted by Dr. Marsiglia on November 8, 2012 (PX. 1, pg. 8)

While Dr. Mather critiques Dr. Vargas' diagnosis of facet syndrome for having noted pain with flexion, the Arbitrator notes that Dr. Vargas was able to confirm the diagnosis of facet pain by having performed two branch blocks, one with a steroid and another without.

With regard to Petitioner's right shoulder, the Arbitrator notes that, while Petitioner did not initially make complaints involving her arm until October 6, 2012 when she was examined by Dr. Louis, Respondent's own Section 12 examiner, Dr. Phillips, conceded a causal connection between Petitioner's right arm condition and the accident of October 3, 2012.

Accordingly, the Arbitrator finds that Petitioner's lumbar spine condition and right shoulder condition is causally related to the accident of October 3, 2012.

With respect to issue (G), what are Petitioner's earnings, the Arbitrator finds as follows:

Respondent offered into evidence a wage statement which demonstrates that Petitioner earned $15,418.89 in the year preceding her accident. Accordingly, the Arbitrator finds that the average weekly wage is $296.52. (RX. 7)

With respect to issue (J), whether the treatment provided to Petitioner was reasonable and necessary, the Arbitrator finds as follows:

With regard to the lumbar spine, the medical records support that the treatment rendered to Petitioner, consisting of the therapy, injections, medication and FCE were providing her with relief from her back pain through September 12, 2014 when she completed her last session of physical therapy. Despite Dr. Mather's insistence that Petitioner should have been pain free by 2-4 weeks post-injury, the testimony and medical records support that Petitioner's pain did not actually subside by that date. In fact, her pain continued but was gradually alleviated by the treatment she received from her doctors. That was illustrated with Petitioner's ability to continue working for Respondent.

With respect to Petitioner's shoulder, according to Dr. Phillips, the treatment she received was reasonable and necessary, save the topical creams. Petitioner continued to receive therapy for her shoulder beyond Dr. Phillips' Section 12 examination and he was unable to render any opinion on that medical care. Nevertheless, the records demonstrate that the therapy provided through September 12, 2014 increased functionality and range of motion in her arm. While Petitioner exhibited problems with reaching outward, she continues to work for respondent cleaning.

The Arbitrator notes that Respondent offered no utilization review pursuant to Section 8.7(i)(2) which states:

> An employer may only deny payment of or refuse to authorize payment of medical services rendered or proposed to be rendered on the grounds that the extent and scope of medical treatment is excessive and unnecessary in compliance with an accredited utilization review program under this Section.

305 ILCS 820/8.7(7)(i)(2).

Once a Petitioner meets its burden of proof and establishes causal connection, if Respondent fails to offer a utilization review opinion into evidence denying treatment, then all treatment is therefore deemed reasonable and necessary. Escobar v. Meyer, 16IWCC234

Accordingly, the Respondent is liable to the Petitioner for medical expenses related to services rendered by ATI Physical Therapy, Rehab Dynamix, Injured Worker Pharmacy, Dr. Markarian, Prescription Partners, Preferred Open MRI, Chicago Pain and Orthopedic Institute, Milwaukee Anesthesia, and Accredited Ambulatory Care. (PX. 5)

Respondent is entitled to credit for amounts paid on account pursuant to Respondent's Exhibit Number 4.

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

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that the record contains an impairment rating of 4% of upper extremity as determined by Dr. Phillips, pursuant to the most current edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment. The Arbitrator notes that this level of impairment does not necessarily equate to permanent partial disability under the Workers' Compensation Act, but instead is a factor to be considered in making such a disability evaluation. The Arbitrator notes that the FCE was not considered by the AMA rating doctor and provides a more appropriate insight into Petitioner's disability. Therefore, with respect to Petitioner's shoulder, the Arbitrator gives this factor some weight.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed in the kitchen at the time of the accident and that she is not able to return to work in his prior capacity as a result of said injury due to her permanent restrictions. The Respondent is accommodating Petitioner's restrictions at the present time. The Arbitrator therefore gives greater weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 51 years old at the time of the accident. Because of her age she still has some work life ahead of her during which she is limited to the restrictions put forth by the FCE. The Arbitrator, therefore, gives greater weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes according to Petitioner she is working only ten hours per week, whereas previously she worked 36 or 8. The Respondent claims that Ms. Bedoy sought those reduced hours unrelated to her injury, but rather because she needed to take care of her grandchildren.

However, on cross examination, Mr. Rivadeneyra, admitted that Petitioner requested a reduction in hours as she presented her medical work restrictions. The Arbitrator, therefore, gives greater weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that Petitioner states she notices pain about 20% of the time she is working. She uses Ibuprofen to alleviate her pain. The final notes form ATI Physical Therapy support Petitioner's account. The Arbitrator, therefore, gives greater weight to this factor.

Accordingly, the Arbitrator finds that Petitioner sustained 17.5% loss of use of the person as a whole pursuant to Section 8(d)(2) of the Act.

With respect to issue (M), whether the Petitioner should be awarded penalties, the Arbitrator finds as follows:

At hearing, Respondent placed into dispute the issues of accident and notice. Yet, Respondent offered no evidence rebutting Petitioner's testimony regarding her accident and the notice she gave thereof. It presented no occurrence witnesses even though it possessed a list of workers that it knew worked on the same day petitioner was injured. In fact, Petitioner offered documentary evidence supporting her account with the Respondent's own Form 45 filled out the day of the accident as well as a letter she received from the respondent's insurance carrier acknowledging that it received notice of her accident.

Moreover, the owner of McDonald's, Mr. Perretta, on cross examination readily acknowledged that an accident occurred and that he received notice of the same. Respondent's additional witnesses, Luis Rivadeneyra and Wendy Nunez, both acknowledged having received notice of Petitioner's accident. It is clear from Mr. Perretta's testimony as well as that of Ms. Nunez, that CCMSI never contacted either of these induvial to investigate whether an accident occurred or whether they received notice thereof.

At hearing in response to Petitioner's request for penalties, Respondent stated that it is entitled to dispute all matters. Yet, the Act compels respondent to act reasonably in doing so. Respondent's dispute of accident and notice presented no real controversy and was merely vexatious. Accordingly, the Arbitrator finds that Respondent is liable to Petitioner for additional compensation pursuant to Section 19(k) consisting of 50% of the unpaid medical bills awarded herein subject to the fee schedule. In addition, the Respondent is liable to Petitioner for an additional 20% of the awarded unpaid medical pursuant to the fee schedule representing attorneys' fees pursuant to Section 16 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF MC LEAN)

☒ 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

Yevgeniya Malcome,

Petitioner,

vs. NO: 14 WC 35206

Heritage Health,

20IWCC0385

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 25, 2019, is hereby affirmed and adopted.

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

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

20IWCC0385

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: JUL -8 2020
TJT:yl
o 6/9/20
51

Thomas J. Tyrrell

Maria E. Portela

Kathryn A. Doerries

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MALCOME, YEVGENIYA
Employee/Petitioner

Case# **14WC035206**

HERITAGE HEALTH
Employer/Respondent

20IWCC0385

On 1/25/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.45% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1824 STRONG LAW OFFICES
SEAN D OSWALD
3100 N KNOXVILLE AVE
PEORIA, IL 61603

4234 RIPES NELSON BAGGOT KALOBRATSO
PETER A DONAHUE
650 E DEVON AVE SUITE 110
ITASCA, IL 60143

STATE OF ILLINOIS)
)SS.
COUNTY OF McLEAN)

20 IWCC0385

☐ 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

YEVGENIYA MALCOME
Employee/Petitioner

v.

HERITAGE HEALTH
Employer/Respondent

Case # **14** WC **35206**

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 **11/30/18**. 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

20 IWCC0385

On **8/31/14**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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 $**20,800.00**; the average weekly wage was $**400.00**.

On the date of accident, Petitioner was **30** years of age, ***married*** with **3** dependent children.

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

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

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

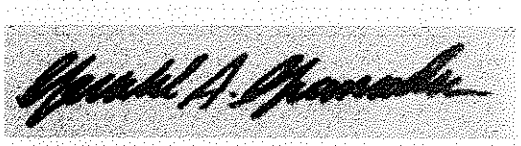
Respondent is entitled to a credit of $**0** under Section 8(j) of the Act.

ORDER

Petitioner failed to meet her burden of proof on the issues of accident and causation. 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

1/24/19
Date

JAN 25 2019

FINDINGS OF FACT

This case involves a Petitioner alleging injuries she sustained while working for the Respondent on August 31, 2014. Respondent disputes Petitioner's claims and the issues in dispute are: 1) accident; 2) causation; 3) medical expenses; 4) TTD; and 5) nature and extent.

The Petitioner testified that on August 16, 2014 she was working as a Certified Nurse's Assistant (CNA) for Respondent - a nursing home – when she injured her left shoulder at work. Petitioner filed a claim for workers compensation benefits stemming from that accident and that claim has since settled. The Petitioner further testified that on August 31, 2014, while working light duty from the shoulder injury, she injured her low back while transferring a resident from a toilet. She described that while putting the resident into bed, she had severe pain to her mid and low back.

Petitioner testified that she was aware of the Respondent's reporting policy that all accidents must be reported immediately. She testified that when she injured her shoulder on August 16, 2014, she reported the injury to the Respondent the same day. However, for the alleged accident on August 31, 2014, the Petitioner did not make a report to the Respondent until September 5, 2014. When asked why she did not report her alleged August 31, 2014 accident in the days following the incident, she stated that she thought her back pain was the same as before – in reference to her prior back problems - and would resolve within a couple of days.

Prior Medical Records

The Petitioner's previous medical records reveal that on December 10, 2004, the Petitioner injured her low back washing a resident. On December 13, 2004, the Petitioner had a strain of her mid-thoracic spine for which she treated through the end of the year. On September 9, 2005, the Petitioner had a mid-thoracic spine and trapezius strain, which she treated for through September 2005. On November 9, 2007, she had radiculopathy of both hands and had complained of pain for two years. On February 25, 2008, she was diagnosed with left wrist arthralgia/myalgia versus neuralgia with possible early carpal tunnel syndrome. On March 11, 2008, she complained of pain in her left shoulder, arm and neck with numbness in her left hand, and was diagnosed with left arm neuralgia.

On July 31, 2008, a myelogram of her lumbar spine and cervical spine with CT scan showed mild spasm in her cervical spine and L4-L5 and L5-S1 disk bulges with some impingement of the thecal sac as and the traversing nerve roots. The Petitioner testified that this was a result of a trauma. On August 8, 2008, she was referred to Dr. Couri for pain all over and was noted to be seeing Dr. Carmichael, pain specialist for possible fibromyalgia. On December 31, 2008, Dr. Couri indicated complaints in the neck and shoulders, upper back, low back, legs, calves, and feet. The Petitioner was diagnosed with fibromyalgia and obesity for which the doctor recommended pain medication, physical therapy and weight loss. On October 24, 2011, she was treated for obesity and fibromyalgia. She continued to treat for obesity and fibromyalgia through March of 2013. On March 10, 2014, she was treated for obesity adjustment disorder and fibromyalgia.

On August 11, 2014, the Petitioner noted that she had a motorcycle burn from a week ago, and that her fibromyalgia had been a little worse. She stated that both knees were bothering her, especially with stairs. She was diagnosed with arthritis of the knee, obesity, and fibromyalgia. She was strongly encouraged to lose weight and exercise.

On August 17, 2014, she was treated at AMG Occupational Immediate Care in Bloomington for her left shoulder. She stated that both the pain in her shoulder blade and neck started one hour after pushing a lady up in her chair. She had a significant prior medical history of fibromyalgia and some transient numbness. The Petitioner also had a long list of current health issues, including arthritis, chronic pain, arthralgia of the head/neck/trunk, fibromyalgia, obesity, thoracic strain and tension headaches. On August 25, 2014, she returned to IWIN for the left trapezius muscle strain. She told her doctor that the numbness and tingling was related to her fibromyalgia and that she was tolerating light duty.

Post Accident Medical Records

On September 2, 2014, Petitioner returned to IWIN with improved symptoms to her left shoulder. At that time, she was recommended to return to regular duty and she indicated that she was able to self-modify her work to avoid aggravating activities. She continued on over-the-counter medication and was advised to continue physical therapy. There is no indication of a history of a work injury or low back or mid back injury in the treatment record.

On September 5, 2014, she was again seen at IWIN but for low back pain. She gave a history that on August 31, 2014 she was helping a resident off the toilet into a wheelchair when she felt pain in her low back. Her gait was noted to be slow and hesitant. She was able to walk on heels and tiptoes without difficulty. She complained of pain with straight leg raise on the left at 45 degrees. Straight leg raise was negative on distractions. She was diagnosed with a lumbar muscle strain, but was witnessed walking in the parking lot with a normal gait. She was also noted to be able to enter her personal vehicle without difficulty. She was put on light duty with restrictions of 20 pounds lifting and minimal bending or twisting of the back.

On September 9, 2014, she returned to IWIN for treatment of the left shoulder and her low back. She stated that her symptoms remain the same in that she had constant pain in her low back, increased pain with walking, pain shooting into her tailbone and down her leg. She stated that while she was sitting, her right leg went numb and complained that she felt worse and had difficulty doing her home exercise program. On examination she was noted to have an "extreme pain show present," and was diagnosed with a lumbar muscle strain. However, there was noted hyper-exaggeration and symptom magnification, which could not be explained by her objective findings. She was referred to her primary care physician with a differential diagnosis of this hyper-exaggeration. The doctor suggested a clinical follow-up for possible shingles, diabetes or a thyroid disorder, psychogenic pain or pain for secondary gain. He stated that none of these causes would be work-related. The Petitioner was recommended to continue medication, heat and physical therapy with light duty restrictions of 20 pounds lifting, and minimal bending or twisting of the back.

On September 17, 2014, Petitioner was seen at IWIN and noted to have a resolved left trapezius muscle strain - which was likely due to her chronic fibromyalgia and could not be explained from her accident of August 16, 2014. She was released without restrictions at baseline and advised to follow-up with her primary care physician for her chronic pain and fibromyalgia. She was also referred to Dr. Dru Hauter for an impairment rating based on the AMA guidelines. On the same day but in a different note, she was seen at IWIN for her low back, which she stated had improved. She complained of increased pain when walking and described her pain as 4 out of 10 and constant. Although she stated that her condition was better, she complained of pain all over with walking or moving her legs. She was diagnosed with lumbar muscle strain and symptom magnification. The doctor stated that her current symptoms do not correlate with her mechanism of injury. She was referred to Dr. Couri for treatment of chronic pain from fibromyalgia. She was released from care at IWIN without

restrictions and at baseline with a recommendation to follow-up with her primary care physician for her chronic pain. In that final note, the doctor stated that any work restrictions from this chronic pain would not be due to her work-related problem.

On September 18, 2014, she was diagnosed with a resolved left trapezius muscle strain. The doctor stated that her continued complaints of pain were likely due to chronic fibromyalgia and could not be explained from her original date of accident. She was given a 0% impairment rating and discharged from care. On that day, she also treated at Advocate medical Group (AMG). At that time, she gave a history of her low back injury. She had a long list of active problems. X-rays of her low back on September 18, 2014 showed degenerative changes.

On September 25, 2014, she followed up at AMG, stating that she had gone to a chiropractor who did x-rays of her entire spine and told her that her hips were off and her L1 was in bad shape. The chiropractor recommended treatment three times a week for four weeks. The Petitioner stated that she had not started physical therapy yet. She was diagnosed with back pain and recommended a trial of physical therapy and return to light duty with no lifting more than 20 pounds, limited bending, and twisting.

On October 10, 2014, the Petitioner was seen by Dr. Carmichael at McClean County Orthopedics complaining of thoracic pain radiating to her shoulder blades and low back into both hips and down the legs. She gave a history of her injuries. She complained of pain from approximately T10 down to the lumbosacral junction. She was diagnosed with thoracic pain and lumbago. She was recommended to obtain a lumbar MRI, which showed a small central disk protrusion at L4-L5 and an anterior and posterior diffuse disk bulge at L5-S1. Dr. Carmichael diagnosed the Petitioner with low back pain and recommended a thoracic MRI to evaluate the scapula pain. He noted that the Petitioner had a lot of obtuse questions such as whether scoliosis was caused by her recent injury and whether her pelvis was out of alignment. He deferred on these questions to the chiropractor and therapists. Petitioner subsequently underwent a thoracic MRI on October 14, 2014, which was normal except for small disk herniations in the mid-thoracic spine without cord compression

On October 30, 2014, the Petitioner saw Dr. Kube. She gave a history of a new injury two months earlier when she was moving patients as a CNA. One month later she started to notice a difference in pain down the leg to the lateral thigh and into the dorsal aspect of her foot. She complained of occasional numbness and tingling down her leg. She stated that her back pain was approximately 90% of her pain and 10% of her pain was from the leg. She tried physical therapy, TENS unit, chiropractor and epidural steroid injections. X-rays at that time were negative for any fractures. The doctor reviewed an MRI which showed a disc herniation at L5-S1, mild in the central distribution. She was diagnosed with an aggravation of her prior low back injury and recommended to have physical therapy as well as medication. At that point she was put on light duty of no lifting greater than 10 pounds frequently and 35 pounds occasionally, and to avoid overhead and floor to waist lifting, bending and twisting.

The Petitioner underwent chiropractic treatment from October 31, 2014 to April 22, 2015. The Petitioner underwent physical therapy from August 25, 2014 through September 17, 2014 at IWIN. She also underwent physical therapy from September 10, 2014 through April 17, 2015 at Prairie Spine and Pain Institute.

On December 2, 2014, Petitioner saw Dr. Kube after one month of physical therapy. Most of her low back symptoms had resolved by that time, but she still complained of pain in the mid-back and thoracic spine up to the right scapular region and the right trapezius. On physical examination, she had mild tenderness in the left SI

joint, and tenderness in the central thoracic, left scapular and trapezius. She was noted to be making progress in physical therapy as well as with her chiropractic treatments and the doctor recommended exhaustion of these conservative forms of treatment. He kept her on light duty of 10 pounds lifting, frequently rare lifting of 35 pounds, no lifting overhead or floor to waist, and limited bending and twisting, sitting or standing.

On January 21, 2015, she followed up with Dr. Kube and indicated she did not want the SI joint injection because the chiropractor recently popped her hip and much of her low back pain and buttock pain subsided. She still complained of radicular type symptoms into her leg but the majority of her complaints were in her back. The doctor explained that he wanted the SI joint injection for diagnostic purposes and he noted her disk protrusions and degenerative disks at L5-S1, L4-L5, and L3-L4. The doctor noted that he believed the conservative treatment had failed and that injections should be the next step. The Petitioner was very apprehensive about the SI joint injection, which was cancelled. She was referred to Dr. Kube for pain management. The SI joint had not been ruled out as the cause of her pain. He believed that she had discogenic pain pattern versus facet arthropathy. He was also suspicious of the SI joint being the generator of her pain.

On February 17, 2015, the Petitioner returned to Dr. Kube. At that time, he recommended a conditioning program followed by a functional capacity evaluation to see if she could move forward. He recommended that she be off of work completely while she went through therapy and rehab, and then have her return to work after that.

On March 10, 2015, she had an evaluation for work conditioning. She complained of pain throughout her entire spine. Apparently she stated she was originally diagnosed with a pulled muscle and told to continue light duty. The functional assessment noted that the Petitioner was walking with a mildly apprehensive gait. She was able to perform sit to stand without the use of her arms, and had minor difficulties with bed mobility. She was able to perform a bilateral squat utilizing the catcher's position, and able to perform a single leg stance equally bilaterally as well as negotiate four steps using a step over step gait pattern and no upper extremity assist. She was ultimately recommended to undergo work conditioning.

On April 27, 2015, the Petitioner underwent a functional capacity evaluation. The Petitioner's effort was seen as valid and she was indicated to be working in the light work load category of lifting 20 pounds occasionally and up to 10 pounds frequently. The Petitioner continued to see Dr. Kube who provided additional injections. He recommended permanent restrictions consistent with the FCE.

Petitioner testified that in April 2016 she returned to work full duty as a home health CNA. She testified that her current job requires that she drive 40 minutes each way to the home of her patient. She currently works eight hours per day, four to five days each week and earns as much or more than she was earning with Respondent. Her current job duties require that she cooks, cleans, does laundry and helps administer medicine. She testifies that she is able to walk around the house without limitation.

Dr. Kube testified via evidence deposition on November 9, 2017. He is a board certified spine and orthopedic surgeon. Based on a hypothetical question assuming that Petitioner had not had treatment following her 2007 incident within two years of August 31, 2014, and based on the Petitioner's symptoms, Dr. Kube opined that Petitioner's low back condition was causally related to August 31, 2014 incident and that her medical treatment after that time was reasonable, necessary and causally related. Dr. Kube testified that he did not review the medical records prior to August 31, 2014 or any of the prior diagnostic studies. He stated that he could not tell if the Petitioner's herniated disks seen on the 2014 MRI were acute, degenerative or a long standing

condition. He based his opinions on the history and symptoms as given by the Petitioner. Dr. Kube stated that if the Petitioner's low back pain was disk related, he would have expected immediate complaints of leg pain. Dr. Kube admitted that evidence of a pre-existing fibromyalgia or positive prior diagnostic studies could change his causation opinion. Dr. Kube stated that if the Petitioner had ongoing symptoms in regard to her low back and SI joint region in the weeks prior to her date of accident, it would be hard to delineate the cause of her fibromyalgia pain complaints versus the work incident.

On March 2, 2018, Dr. Kevin Walsh testified pursuant to deposition. He is a board certified orthopedic surgeon who conducted an Independent Medical Examination of Petitioner on December 8, 2015 regarding left shoulder and low back. Dr. Walsh noted that Petitioner gave a history of injuring her low back while lifting a resident, but refused to discuss her prior low back injuries. Notwithstanding the Petitioner's reluctance to discuss her prior medical history, Dr. Walsh was able to review a significant amount of her prior medical records. Dr. Walsh testified that at the onset of the IME, the Petitioner filled out a pain diagram indicating pain across her thoracic spine, lumbar spine, both buttocks, left scapula, neck and thigh. She gave a pain rating at that time of 6-8/10. Dr. Walsh diagnosed the Petitioner with muscular strains. He stated that the extreme pain ratings were not consistent with the diagnostic objective tests. He interpreted the 2014 lumbar MRI to show a small protrusion at L4/5 with no central stenosis or neuro-foraminal narrowing and L5/S1 loss of disc height with mild diffuse disc bulge without central canal stenosis. He stated that these findings did not explain the Petitioner's significant complaints of pain and disability. He did not believe there was evidence of nerve root impingement, consistent with Dr. Kube. Dr. Walsh believed the MRI findings were very similar to the Myelogram findings from 2008. Dr. Walsh testified that the findings on the Thoracic MRI in 2014 were mild and degenerative in nature, unrelated to any work accident. He also noted the multi-level degenerative findings on her spine x-rays in September 2014 and stated they were not related to any work accident.

Dr. Walsh indicated that the Petitioner had evidence of significant symptom magnification. In addition to the Petitioner's high pain rating over a year after her alleged injury, he noted the symptom magnification indicated in the original records of IWIN. He also noted that in March/April 2015, in therapy the Petitioner stated that she could not walk faster than .7 miles per hour, only 25% of normal walking speed. He felt this extreme limitation could not be explained by any objective findings, but only symptom magnification. He stated that a person with such a history of symptom magnification was not a good candidate for an FCE, due to its large subjective component. The Petitioner had a positive Waddell's sign during his examination for symptom magnification.

Dr. Walsh further testified that the Petitioner's low back and leg conditions were not causally related to any work accident on August 31, 014. He noted the Petitioner's failure to even mention a work injury or back complaints at IWIN on September 2, 2014, which he stated was completely inconsistent with her later extreme complaints of pain and injury. Dr. Walsh noted the Petitioner's significant prior medical history as indicated in her medical records. He testified that the Petitioner was at maximum medical improvement when she was discharged from IWIN in September 2014 and that any treatment after that time was not reasonable, necessary or causally related to any work injury. He stated that she did not need any work restrictions as of his IME and that any restrictions would not be related to any work accident. He stated that the chiropractic treatment and physical therapy were duplicative and redundant treatments. He testified that the Petitioner was not a surgical candidate. Finally, he testified that the 2014 MRIs, the treatment by Dr. Kube, Dr. Carmichael, and the work conditioning was not necessary, especially in light of the Petitioner's significant symptom magnification.

CONCLUSIONS OF LAW

1. With regard to the issues of accident and causation, the Arbitrator finds that the Petitioner has failed to meet her burden of proof. In support of this finding, the Arbitrator relies on the medical evidence and the Petitioner's testimony. Both the medical evidence and the live testimony cast doubt on the credibility of Petitioner's claims. Petitioner testified that she sustained a severe back injury on August 31, 2014 that led to years of treatment and was unlike any pain she previously experienced. Petitioner also testified that she was aware of the Respondent's policy of reporting work accidents soon after they occur, as she did for a prior accident on August 16, 2014. However, she did not report her alleged accident of August 31, 2014 until September 5, 2014. Moreover, Petitioner did not indicate any work accident when she saw a medical provider on September 2, 2014 – two days after the alleged incident. The failure to report the incident immediately or even at her medical visit soon after the alleged accident date is clearly at odds with Petitioner's testimony of sustaining a severe back injury. The Arbitrator also notes the inconsistency of the Petitioner's testimony regarding injuring her thoracic spine when compared to the accident reports and medical records. The credibility of Petitioner's claims is further eroded by the indications of symptom magnification noted at IWIN and by Dr. Walsh, as well as extreme complaints of pain without corresponding objective diagnostic findings. For example, the IWIN records indicate that although the Petitioner presented with a limp and severe pain, she was noted walking to her car without a limp or limitation. Also, Petitioner testified to having to use a wheelchair at home to get from one place to another – which is inconsistent with her medical diagnosis and her testimony of working full time as a home health CNA. The Arbitrator notes the various areas of pain indicated in the Petitioner's testimony and medical records - from her shoulder, scapula, neck, thoracic spine and lumbar spine - are more consistent with the Petitioner's pre-existing condition of fibromyalgia than any structural back pathology. On several occasions she testified that the pain in her back was noticeably different than her prior fibromyalgia. However, when asked why, in the days following the alleged incident, she made no report of accident, she stated that she thought her back pain was the same as before and would resolve within a couple of days.

In weighing the opinions of the medical experts in this case, the Arbitrator finds that the preponderance of the evidence supports those opinions of Dr. Walsh – i.e. that Petitioner's complaints are due to her pre-existing conditions. Although Petitioner's treating physician, Dr. Kube gave Petitioner a favorable opinion on the question of causation, he admitted that he did not review Petitioner's prior medical records or history and that such information could change his opinions of causation.

Given the facts above, the Arbitrator concludes that due to the lack of credibility of Petitioner's claims, she failed to prove that she sustained an accident on August 31, 2014 or that her current condition of ill-being is causally related to the alleged accident.

2. Based on the Arbitrator's findings above, all other issues are rendered moot.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Michelle Cansino,

Petitioner,

vs. NO: 15 WC 1681

20IWCC0386

Denny's,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causation, medical expenses and temporary total disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, with corrections noted below, said decision being attached hereto and made a part hereof.

The Commission corrects the following clerical errors and/or inconsistencies contained in the Arbitrator's decision. At page 2 of the Form decision, under "Findings", the Commission corrects the decision to show that Petitioner did not sustain an accident that arose out of her employment but that Petitioner was in the course of her employment at the time of the alleged accident, so as to conform to the Arbitrator's finding at page 7 of 7 of the Addendum.

In addition, the Commission clarifies the Arbitrator's decision to show that Petitioner failed to prove that her current condition of ill-being is causally related to the alleged accident on 12/21/14 per the opinion of Dr. Verma. The Commission notes that while the Arbitrator found no causation in the "Findings" section of the Form decision (page 2), she also indicated in the Addendum portion (page 7 of 7) that all other issues were moot, including causation, in light of her finding as to accident (arising out of).

Finally, the Commission strikes language in the "Order" section of the Form decision (page 2) to the effect that the "… case is dismissed." Instead, the claim is simply denied.

20IWCC0386

All else otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision dated 1/3/19 is affirmed and adopted with changes as stated herein, and Petitioner's claim for compensation is 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: JUL - 8 2020
o:5/19/20
TJT/pmo
51

Thomas J. Tyrrell

Maria E. Portela

Kathryn A. Doerries

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

CANSINO, MICHELLE
Employee/Petitioner

Case# **15WC001681**

DENNY'S
Employer/Respondent

20IWCC0386

On 1/3/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.50% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5122 PORRO NIERMANN LAW GROUP LLC
CHRIS M WILLIAMS
821 W GALENA BLVD
AURORA, IL 60506

0507 RUSIN & MACIOROWSKI LTD
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CHICAGO, IL 60606

20IWCC0386

STATE OF ILLINOIS)
) SS
COUNTY OF KANE)

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

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

Michelle Cansino
Employee/Petitioner

v.

Denny's
Employer/Respondent

Case # 15 WC 1681

An *Application for Adjustment 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 **Geneva**, on **March 14, 2018; proofs reopened and closed again on December 7, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

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

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

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

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

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

G. [ ] What were Petitioner's earnings?

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

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

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

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

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

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

N. [ ] Is Respondent due any credit?

O. [ ] Other _____

FINDINGS

On the date of accident **December 21, 2014**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did 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 **$22,052.16**; the average weekly wage was **$424.08**

On the date of accident, Petitioner was **45** years of age, **single** with **2** dependent children.

Respondent ***does not owe for*** any medical services.

Respondent shall be given a credit of **$1,102.76** for TTD, **$0** for TPD, **$0** for maintenance, and **$991.01** for medical benefits, for a total credit of **$2,093.77**

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

ORDER

Petitioner failed to prove she was injured in an accident on December 21, 2014, that arose out of and in the course of her employment with respondent.

Petitioner's claim is hereby denied and case is dismissed.

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

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

Christine MOuy

Signature of Arbitrator

December 27, 2018

Date

IC ArbDec19(b) p. 2

JAN 3 - 2019

20IWCC0386

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Michelle Cansino	)	
Petitioner,	)	
vs.	)	**No. 15 WC 1681**
Denny's	)	
Respondent.	)	
	)	

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

This matter proceeded to hearing under the provisions of §19b/§8a in Geneva on March 14, 2018 (Proofs reopened and closed on December 7, 2018). The parties agree that on December 21, 2014, 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 $22,052.16 and his average weekly wage calculated pursuant to §10 was $424.08.

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 petitioner is entitled to payment for prospective medical treatment.
4. Whether petitioner is due TTD.
5. Whether penalties and attorneys' fees should be imposed upon respondent.
6. Is respondent due any credit?

FINDINGS OF FACTS

Petitioner testified she began her employment with respondent as a server in November, 2014. As a server, she seated customers, took orders, served, swept and cashed out drawer. Her previous employment was that of a caregiver for a 92-year-old man.

Her uniform included black pants, an apron and non-slip shoes. Petitioner was not wearing the non-slip shoes as they had to be reordered.

Petitioner testified that on December 21, 2014, she slipped and fell on the grouted tile floor. Petitioner alleged the area was greasy, slippery and wet. She fell in the kitchen where there was coffee, water and other liquids present. Petitioner twisted her right knee and struck her right elbow.

She went to Rush Copley emergency room. Dr. Joyce at Rush referred petitioner to Dr. Lombardi. Dr. Lombardi order surgery for her right knee. She admitted she can't afford the surgery and Public Aid won't cover treatment with Dr. Lombardi.

She has not returned to work since the claimed accident. Her activity is limited due to injury. Her knee gives out. She has constant pain. She goes to the emergency for pain medication.

She confirmed she had prior knee problem due to arthritis from breaking her knee on both sides and that she would go to the hospital emergency room in order to get pain medication.

On cross examination, petitioner testified she was not sure what substance she slipped on. She couldn't recall what, if anything, she was carrying.

She testified her right foot slipped a little. She then twisted to the side. She hit her right elbow.

She wasn't quite sure what prior treatment and when she received it for her right knee; she thought maybe two months prior. She agreed she had received treatment for her right elbow in the six months prior to her claimed accident.

She could not remember if she told the doctors she had no prior problems with knee.

She claimed that the first time surgery for her right knee was discussed was on January 27, 2015 with Dr. Lombardi.

Rush Copley Medical Center Records (PX.1)

She presented to the ER on December 21, 2014 with right knee pain after a mechanical fall at work. She reportedly slipped and fell on a wet floor and fell predominantly on her right knee. She admitted she had chronic right knee pain. The diagnosis was knee contusion. X-rays showed no acute injury. (216-236)

Petitioner was seen again in the ER on December 24, 2014 in follow up to her fall of December 21, 2014. She reported right knee and right elbow pain. She had failed to mention her right elbow at the time of the initial treatment. She was not able to fill the prescription or see the orthopedic surgeon for financial reason. (195-215)

She was seen in Occupational Health on January 2, 2015 with history of being seen on December 21, 2014 and December 24, 2104. She stated she slipped after stepping on something wet on the floor. She alleged she fell on her right knee and right elbow. She indicated she was initially seen on December 21, 2014 with complaints of right knee pain after slipping and falling. She returned to the ER on December 24, 2014 as her left elbow was not addressed in the initial ER visit. She was given a script for Norco at the first ER visit, but did not fill it as she was already taking Norco for her degenerative back condition. She was requesting more pain medication claiming she ran out of the pain medication, did not know where the script from the first ER visit was and she could not see her PCP until January 19, 2015 for a new script.

Petitioner admitted to having a history of degenerative joint disease in the right knee for which she had injections. She had recurrent pain with yard work, carrying child and wore a sleeve when at work. She could not state how often she had pain prior to her accident. She had a history of right knee tibia fibula fracture.

An MRI was ordered and she was referred to an orthopedic surgeon. Review of the ILPMP by the ER doctor revealed petitioner has been on 50 Vicodin 325/5 mg every 25 days. Therefore, she was advised to either have the ER script filled or contact her PCP for medication before she sees the orthopedic surgeon. Alternative therapies besides narcotics were discussed. (179-193)

Petitioner was seen on January 8, 2015 for right knee and elbow pain after a fall at work on December 21, 2014. She reportedly was on chronic pain medication with she uses for arthritis. She has increased the use of pain medication since the work accident. Her PCP fills the

prescription on a fixed schedule; occupation health does not prescribe medication for chronic pain. She was prescribed Hydrocodone. (162-178)

Petitioner presented to the emergency room on January 9, 2015 due to right knee pain after she slipped and fell at work on December 21, 2014 and landed on her right knee and struck her right elbow on steel shelving. She had been seen the day before after running out of Norco for her arthritis. She was discharged with a short course of Vicodin. Petitioner was prescribed Hydromorphone. (141-161)

The January 12, 2015 MRI showed a Grade II-III chondromalacia along the medial and lateral patellar articulating facets with high-grade chondromalacia along the medial femoral condyle at the patellofemoral articulation; posterior horn medial meniscus tear; medial greater than lateral tibiofemoral joint space narrowing as well as high-grade chondromalacia along the medial femoral condyle at the tibiofemoral articulation. (194)

On September 13, 2015 she was seen for a rash, right foot infection and chest congestion. On August 11, 2015, she was seen for a foot rash and pain that began after being nicked a month prior during a pedicure. (106-140).

Petitioner presented to the emergency room on September 20, 2015, with a history of slipping on grease stain developing left and right knee pain. She reported her left leg went out and she fell on her right knee. She was prescribed Norco. (86-105)

Petitioner was seen on October 8, 2015 due to bilateral knee pain. Petitioner reported she had a work injury in December, 2014 and fell a second time at a restaurant in September, 2015 and reinjured her right knee, as well as injuring her left knee. She requested pain medication and was prescribed Hydrocodone. (68-105)

On November 4, 2015 petitioner presented to the emergency room with a rash and bilateral knee pain. Diagnosis was bilateral chronic knee pain and scabies. She was prescribed Hydrocodone. (49-67)

On October 19, 2016, petitioner was seen in the emergency room after stubbing her toe when her knee gave out. X-rays of foot where negative. (31-48)

On January 29, 2017, petitioner presented to the emergency room after being sexually assaulted by her ex-husband with a glass bottle and being struck in the face. Her past medical history included a torn meniscus. (2-30)

Rush Copley Occupational Health & MRI Records (PX.2)

These records where included in Petitioner's Exhibit 1.

Rush Copley Medical Center Bills (PX.3)

$2,181.00 - 12/21/2014
$200.00 - 12/22/2014
$3,567.00 - 12/24/2014
$275.000 - 1/02/2015
$640.00 - 01/08/2015
$2,505.00 - 01/09/2015
$610.00 - 08/11/2015
$3,780.00 - 09/13/2015
$4,163.00 - 09/20/2015
$640.00 - 10/08/2015
$1,677.00 - 11/04/2015

$2,318.00 - 10/19/2016
$12,993.00 - 01/28/2017

DuPage Medical Group Records and Bills (PX.4)

She was seen by Dr. Lombardi on January 13, 2015; a Kenalog injection was administered, physical therapy was recommended and prednisone and Norco were prescribed.

Petitioner was seen by Dr. Lombardi on January 27, 2015 due to knee and elbow pain. Arthroscopic right knee surgery was discussed. Petitioner reported no relief from the Kenalog injection or physical therapy. Norco was prescribed.

Petitioner was seen by Dr. Lombardi on March 10, 2015. Dr. Lombardi reported petitioner was using too much of the narcotic Norco. Dr. Lombardi prescribed prednisone, meloxicam and Norco. Dr. Lombardi noted if there was further delay for surgery, he would refer petitioner for pain med management.

She was seen on March 30, 2015 by PA-C Jennifer Bren by Dr. Lombardi for pain med management. Dr. Lombardi wants to do surgery, but awaiting approval. Petitioner testified positive for cocaine, benzo and opiates. She was given 60 tablets of Norco.

On April 14, 2015 petitioner was seen by PA Ryan Enger for a med check. She was reportedly stable on four Norco a day. She was negative for cocaine use; although she was positive for cocaine at the last visit. She was prescribed a fifteen-day supply.

Dr. John Anthony Lombardi January 22, 2018 Deposition (PX.5)

Dr. Lombardi, board certified orthopedic surgeon, testified via deposition in behalf of petitioner. Dr. Lombardi testified consistent with his records (6-14).

Dr. Lombardi did not believe petitioner was capable of working as of the last day he had seen petitioner (14). Dr. Lombardi reviewed the 2013 MRI with the 2015 MRI and concluded petitioner clearly had a torn meniscus according to the 2015 MRI and on the 2013 there was some changes of the meniscus but not an obvious tear (16-17). Dr. Lombardi believed petitioner's fall on December 21, 2014 is a competent mechanism for the injury [as found on the 2015 MRI] (17).

Petitioner did not report to Dr. Lombardi that she had treated from 2013 and up to two days prior to the claimed work accident (30-34).

Dr. Lombardi agreed petitioner's meniscus tear could have been degenerative (38).

Respondent's Video of Petitioner's fall (RX.1)

Camera 2 video depicts petitioner stepping into the kitchen and going down on her right knee with her hands outstretched reaching for the counter to apparently stop her fall. The area was red tile floor with grout. The video failed to show any substance on the floor where petitioner went down. There had been various people who had crossed the area without difficulties. Someone came to her aid. Neither the person who came to her aid or the petitioner looked back at the floor where petitioner had gone down. No one cleaned the area after petitioner fell.

Respondent's Payment Screen (RX.2)

Respondent paid $1,102.76 in temporary total disability payments and $2,241.01 in medical treatment; including $1,250.00 for an independent medical exam.

Dr. Nikhil N. Verma January 18, 2017 Deposition (RX.3)

Dr. Verma, board certified orthopedic surgeon who focuses on sports medicine primarily treating knees, shoulders and elbows, testified in behalf of respondent. Dr. Verma examined the petitioner on April 8, 2015 at respondent's request (6). Petitioner reported to Dr. Verma that she had underlying arthritis with mild discomfort for which she received injections two to three years prior but denied active medical treatment of the right knee before the accident (7).

Dr. Verma diagnosed underlying degenerative changes of petitioner knee associated with arthritis and degenerative meniscal tear (14).

Dr. Verma viewed the video tape of petitioner's fall and provided his own opinion as to how petitioner fell (14).

Dr. Nikhil Verma April 10, 2017 Report (RX.4)

Dr. Verma authored an addendum report after reviewing a January 12, 2015 right knee MRI scan, a September 18, 2013 right knee MRI scan and additional records treatment and X-rays subsequent to his exam [of April 8, 2015]. Dr. Verma determined petitioner's condition was degenerative in nature, including the medial meniscus identified on the January 12, 2015 MRI.

Copley Memorial Hospital Records (RX.5)

Duplicates of Petitioner's Exhibit 1.

Presence Mercy Medical Center Records (RX.6)

Petitioner presented to the emergency room with left foot pain on June 1, 2016 from a fall at a restaurant on September. She was waiting to have an MRI, but unable to do so. She reportedly took her last Norco that day; additional Norco were prescribed.

On January 19, 2016 reported injured right arm when throwing garbage into dumpster on January 14, 2016. She left without being seen.

On January 22, 2015 petitioner arrived at the emergency room due to right knee pain from prior work injury, but left without being seen.

Edward Hospital Records (RX.7)

On January 22, 2015, petitioner was evaluated for physical therapy for her right knee.

Delnor Hospital Records (RX.8)

Petitioner was seen on February 11, 2016 due to right shoulder and trapezius pain after throwing trash into garbage can. She was prescribed Norco and Valium.

Petitioner was seen on January 26, 2016 due to shoulder complaints. She was prescribed Norco, along with tramadol, orphenadrine and prednisone.

Petitioner was seen on January 19, 2016 due to right shoulder pain. She was prescribed Norco and Valium.

Petitioner was seen for right knee pain on January 22, 2015 and evaluated for right knee pain. DVT was ruled out. No prescriptions were given.

Loyola Hospital Records (RX.9)

Petitioner was seen November 5, 2014 by Steven Stakenas, APN for right knee and right elbow pain. Petitioner's arthritic right knee was discussed. Petitioner advised the injections

previously administered to the right knee did not help. Stakenas recommended petitioner discuss joint reconstruction. Petitioner was given a brace and prescribed Norco.

Petitioner was seen on November 6, 2013 for her right knee and given an injection. She received one on September 27, 2013. The MRI of September 25, 2013 showed tricompartmental articular cartilage degeneration; greatest at the medial compartment.

She was seen on September 11, 2013 with history of an eight-year history of knee injury from accident and a twisting injury two weeks' prior while carrying grandchild. She was prescribed Norco.

On September 18, 2013, petitioner was seen for right knee pain. She reported she had suffered a knee injury eight years before; two weeks before she was carrying her grandchild upstairs, noticed a twisting in her knee and fell. According to the form completed by petitioner on September 18, 2013, she was being seen for extreme knee pain.

Dr. Akil Moinuddin/Aurora Medical Center Records (RX. 10)

Petitioner was seen on January 19, 2015 for right knee pain and prescribed 50 Norco. She was seen on July 23, 2013, August 16, 2013, January 21, 2015 and December 23, 2016 for weight control.

On November 25, 2013, petitioner she was seen for weight control and right knee pain. She was prescribed Norco. On December 20, 2013, she was seen for weight control and right knee pain. She was looking for an increase in her prescription of Norco; 50 Norco were prescribed.

On January 8, 2014 she was seen for weight control and refill on Norco due right knee pain, which she rated at 10 out of 10. She was prescribed 50 Norco, to be taken every 12 hours.

On February 3, 2014 she was given 45 Norco due to right arm and right knee pain. On February 26, 2014 she was seeking refills of Norco due to surgery of right arm pain. 45 Norco were prescribed.

On March 12, 2014, petitioner returned for refill on Norco due to severe right knee pain rated 9 out of 10. 45 Norco were prescribed and Dr. Moinuddin discussed addiction potential with Norco.

On March 18, 2014 petitioner was seen for weight control.

On April 14, 2014 petitioner was seen for referral to Loyola orthopedics for left arm, as well as refill for Norco. She complained of left arm pain after slipped and falling on ice. She was prescribed 45 Norco.

She was seen on May 12, 2014 due to poison ivy. She was prescribed 55 Norco. On June 3, 2014, 55 Norco were prescribed due to multitude of complaints. Another 55 Norco were prescribed on July 8, 2014, August 5, 2014 and September 3, 2014. On October 1, 2014, October 29, 2014 and November 25, 2014, 50 Norco were prescribed.

On November 25, 2014 she was seen by Dr. Moinuddin for right elbow and knee pain. She asked to be seen by an orthopedic surgeon.

On December 19, 2014, petitioner was seen for weight control, refills on Norco and a note for probation that she is unable to work due to knee, elbow, wrist and right index finger. She was prescribed 50 Norco.

On January 19, 2015 she obtained refill of 50 Norco for right knee and right elbow pain.

CONCLUSIONS OF LAW

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

The Arbitrator questions petitioner's credibility as she hesitated when responding to questions; specifically, in response to cross examination by respondent's attorney on her earlier treatment of her right knee and elbow, as well as her seeking of pain medication immediately preceding her claimed work accident.

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

There is no question petitioner was in the course of her employment with respondent when she fell on her right knee. The question is whether her fall arose out of her employment with respondent.

The Arbitrator, repeatedly reviewed the video tape of petitioner's fall to determine if petitioner "slipped" as claimed. The Arbitrator failed to find petitioner actually slipping prior to going down on her right knee. The video failed to show any sign of substance on the floor. Individuals repeatedly walked over the area where petitioner fell without problems. After the fall, petitioner, and the person who came to her aid, did not look back to the floor where petitioner claims contained substance that caused her to slip and fall. Petitioner also claimed she struck her right elbow. However, the video does not show her striking the elbow, but rather reaching out for the counter as she was going down on her right knee.

(It should be noted that the Arbitrator did not consider Dr. Verma's opinion regarding how the accident occurred based upon his view of the video tape as it usurps the Arbitrator's function in determining whether petitioner's sustained an accident that arose out of and in the course of her employment with respondent.)

The Arbitrator noted petitioner was seeking a disability slip for her pre-existing right-knee condition, and elbow pain two days before the claimed accident. One month before the claimed accident, the nurse practitioner at Loyola suggested petitioner discuss total knee replacement with a specialist due to petitioner's right knee pre-existing arthritis. Furthermore, the only body parts petitioner claimed she hurt in the alleged work accident was the right knee and right elbow. Coincidentally, these were the same two body parts for which she sought treatment from Dr. Moinuddin less than a month before, on November 25, 2014.

Regardless of whether petitioner's right foot actually slipped, or her right leg gave out, there was no evidence that she slipped on any substance and thus was not exposed to an increase than that of the general public.

For all these factors, the Arbitrator finds petitioner failed to prove that she was exposed to a greater risk than that of the general; thus her injury did not arise out of her employment with respondent.

As the Arbitrator determined petitioner was not injured in an accident that arose out of his employment with respondent, the claim is denied and all other issues are moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Gabino Gutierrez,

Petitioner,

vs.

NO: 13 WC 13987

20IWCC0387

Hondo Ranch dba FJK Enterprises and Illinois Insurance Guaranty Fund,

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 jurisdiction and employment relationship, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, with changes as stated herein, said decision being attached hereto and made a part hereof.

The Commission strikes the Arbitrator's reference on page 4 of his analysis wherein he states that "[j]udicial notice is taken that horses are notoriously unpredictable animals, especially thoroughbreds." (Arb.Dec.[Addendum], p.4). The Commission notes that such a statement is not so indisputable or well-known so as to forego the need for the formal presentation of evidence and allow for the taking of judicial notice. As such, said language is hereby stricken.

All else otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision dated 3/1/19 is affirmed and adopted with changes as stated herein.

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

20 IWCC0387

DATED: JUL - 8 2020
o: 5/19/20
TJT: pmo
51

Kathryn A. Doerries

Kathryn A. Doerries

Maria Elena Portela

Maria E. Portela

DISSENT

I believe the record shows that an employment relationship existed between Petitioner and Respondent on the date of the accident. As a result, I respectfully dissent from the majority opinion.

To assist in determining whether a person is an employee, the supreme court has identified a number of factors. Among the factors cited by the supreme court are: (1) whether the employer may control the manner in which the person performs the work; (2) whether the employer dictates the person's schedule; (3) whether the employer compensates the person on an hourly basis; (4) whether the employer withholds income and social security taxes from the person's compensation; (5) whether the employer may discharge the person at will; and (6) whether the employer supplies the person with materials and equipment. *Roberson v. Industrial Comm'n*, 225 Ill. 2d 159, 175, 866 N.E.2d 191, 310 Ill. Dec. 380 (2007).

Another relevant factor is the nature of the work performed by the alleged employee in relation to the general business of the employer. *Roberson*, 225 Ill. 2d at 175; *Ware*, 318 Ill. App. 3d at 1122. Along these lines, our supreme court has noted "... because the theory of workmen's compensation legislation is that the cost of industrial accidents should be borne by the consumer as part of the cost of the product, this court has held that a worker whose services form a regular part of the cost of the product, and whose work does not constitute a separate business which allows a distinct channel through which the cost of an accident may flow, is presumptively within the area of intended protection of the compensation act." *Steel & Mach. Transp. Inc. v. Ill. Workers' Comp. Comm'n*, 33 N.E.3d 674, 392 Ill. Dec. 873 (1st. Dist. 2015); citing *Ware*, 318 Ill. App. 3d at 1124 (quoting *Ragler Motor Sales v. Industrial Comm'n*, 93 Ill. 2d 66, 71, 442 N.E.2d 903, 66 Ill. Dec. 342 (1982)).

The label the parties place on their relationship is also a consideration, although it is a factor of "lesser weight." *Ware*, 318 Ill. App. 3d at 1122. The significance of these factors rests on the totality of the circumstances, and no single factor is determinative. *Roberson*, 225 Ill. 2d at 175. Nevertheless, the right to control the work and the nature of the work are the two most important considerations. *Kirkwood*, 84 Ill. 2d at 21; *Ware*, 318 Ill. App. 3d at 1122.

Finally, for purposes of the Act, the term "employee" should be broadly construed. *Ware v. Industrial Comm'n*, 318 Ill. App. 3d 1117, 1122, 743 N.E.2d 579, 252 Ill. Dec. 711 (2000); see also *Skzubel v. Illinois Workers' Compensation Comm'n*, 401 Ill. App. 3d 263, 267, 927 N.E.2d 1247, 340 Ill. Dec. 236 (2010).

In this case, Respondent's business was caring for, training and racing thoroughbred racehorses. Although Petitioner testified that he was a "horse trainer", the Arbitrator found that Mr. Gutierrez's job was actually that of a horse exerciser or "hot walker." That being the case, one would think there would be even more reason to view Petitioner as an employee given the apparent lack of specialized training and expertise required in such a job. Regardless, Petitioner's services did not represent a separate business but instead formed a regular part of Respondent's commercial enterprise. Petitioner did not own or operate any separate companies or set up multiple corporate entities, unlike Mr. Kirby who was still writing checks under the name of a corporation (Hondo Ranch, Inc.) which had been dissolved a year prior to the accident only to register another (FJK Stables, LLC) less than a month after the accident. Petitioner also did not hold himself out to be an independent horse exerciser, although he did sometimes take on extra work with other trainers at the racetrack when he had finished his work for Respondent. But even then he could only do so with the permission of Mr. Kirby.

In addition, Petitioner claimed that he was paid a weekly salary that varied from $400.00 to $650.00, depending on how much work there was. However, he testified that his normal working salary was $650.00 per week. The Arbitrator found that Petitioner was a seasonal worker who was "probably paid in cash" and that "[t]he custom and practice [was] to pay exercisers on a project basis or per ride." However, absolutely no evidence was submitted by the parties, either testimonial or documentary, that would support such a finding. More to the point, there is no evidence whatsoever that would lead one to believe that Petitioner was paid on a project or per ride basis, lending further credence to his claim that he was an employee and not an independent contractor.

Furthermore, while it appears Petitioner was paid in either cash or by personal check, and that Respondent did not withhold income and/or social security taxes, this arrangement would seem to be more of function of Mr. Kirby's questionable business practices, and his possible desire to avoid paying and withholding employment taxes, than any true reflection of the parties' business relationship, especially since Petitioner was asked to fill out such tax forms by the other trainers for whom he did occasional work. Such a situation would be indicative of the superior bargaining power of Mr. Kirby and the fact that Petitioner had little choice but to accept the terms, and the method of payment, if he wanted to work there.

It also would appear that Respondent provided Petitioner with the supplies and equipment needed to perform his job duties and dictated his schedule in terms of which horses were to be exercised and when. And while there was no direct testimony on the subject, one could safely assume that Petitioner could be terminated from his job for any reason and at any time. As such, Petitioner would be considered an at-will employee, which itself is suggestive of an employment relationship. (See *Ware*, 318 Ill. App. 3d at 1125-26).

20IWCC0387

Finally, and most importantly, the evidence shows that Respondent exercised a degree of control sufficient to warrant a finding that an employment relationship existed between the parties. Mr. Kirby controlled the manner in which Petitioner performed his duties to the extent that he told Mr. Gutierrez what horse to work with and what to do with that horse, such as galloping or else preparing the horse for a race. I do not believe, as the Arbitrator noted, that these job duties somehow entail some sort of "special skill", nor do I believe that Mr. Kirby provided only "general supervision" – as if any further instruction was even necessary. The fact that Petitioner could not work for any other trainer without the permission of Mr. Kirby is further proof of the control Respondent exercised over Petitioner, and further evidence that Petitioner did not have the type of freedom one would normally associate with an independent contractor. Indeed, Petitioner was not so much a "free-lancer", as the Arbitrator noted, as he was an employee who was allowed to work for other trainers when he had finished his duties for Respondent.

Thus, based on these factors – most notably the shared nature of their business and the degree of control exercised by Mr. Kirby in terms of the work Mr. Gutierrez was to perform for Respondent and whether he could do side jobs for other trainers -- Petitioner was for all practical purposes an employee of Respondent, especially if one construes the term broadly in order to effectuate the purpose of the Act.

Therefore, I would reverse the Arbitrator's finding to the contrary and award benefits accordingly.

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GUTIERREZ, GABINO
Employee/Petitioner

Case# **13WC013987**

HONDO RANCH DBA FJK ENTERPRISES AND ILLINOIS INSURANCE GUARANTY FUND
Employer/Respondent

20IWCC0387

On 9/5/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.11% 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:

4069 JONATHAN SCHLACK
200 N LASALLE ST
SUITE 2830
CHICAGO, IL 60601

1872 SPIEGEL & CAHILL PC
MILES P CAHILL
15 SPINNING WHEEL RD SUITE 107
HINSDALE, IL 60521

20 IWCC0387

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

Gabino Gutierrez
Employee/Petitioner

v.

Hondo Ranch dba FJK Enterprise and The Illinois Insurance Guaranty Fund
Employer/Respondent

Case # **13** WC **13987**

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 **Kurt Carlson**, Arbitrator of the Commission, in the city of **Chicago**, on **07/13/2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **April 23, 2013**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**17,160.00**; the average weekly wage was $**330.00**.

On the date of accident, Petitioner was **37** years of age, ***single*** with **4** dependent children.

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

Respondent shall be given a credit of $**7,674.37** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**7,674.37**.

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

ORDER

Respondents were operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act.

An Employer/Employee relationship did not exist between Petitioner and Respondents.

Petitioner's current state of ill-being is causally related to the work-related injury.

Petitioner's AWW was $330.00, in the year proceeding the injury Petitioner earned $17,160.00.

Medical services provided to Petitioner were reasonable and necessary.

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

09-01-17
Date

ICArbDec19(b)

SEP - 5 2017

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

GABINO GUTIERREZ,	)	
	)	
Petitioner,	)	
	)	
	)	
vs.	)	**13 WC 13987**
	)	
	)	
HONDO RANCH D/B/A FJK ENTERPRISES INC. AND ILLINOIS INSURANCE GUARANTY FUND,	)	
	)	
Respondents.	)	

FINDINGS OF FACT AND CONCLUSIONS OF LAW

This case was heard by Honorable Kurt Carlson, Arbitrator of the Workers' Compensation Commission, in the city of Chicago, Illinois, on July 13, 2017. After hearing the testimony and reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues below and includes those findings in this document.

I. STATEMENT OF FACTS

Petitioner testified that on April 23, 2013 he was hired by Frank Kirby and Hondo Ranch, as a horse trainer for thoroughbred races (T. 8-11). Petitioner testified that he was working for Respondent on April 23, 2013 in his usual and normal position (T -15). On this day, he was riding a horse when it rose on its hind legs throwing Petitioner to the ground (T. 15-16). The horse then fell to the ground, landing on Petitioner's right foot and ankle (T. 17). Petitioner was unable to stand up (Id.). Petitioner noticed that his foot was crooked, and he was told to stay down (Id.). Petitioner testified that there were always two ambulances at the horse track, and one took Petitioner to MacNeal Hospital (Id. at 17-18).

Petitioner testified and the medical records reflect that Petitioner initially treated at the emergency department at McNeal Hospital on April 23, 2013 (PX # 2, p.7). It was noted that Petitioner sustained a work-related injury to his right ankle (Id.). Petitioner was assessed with a displaced fracture of the lower tibia and fibula (Id. p.9) Petitioner underwent an x-ray of the ankle that reveled an avulsion fracture of the medial malleolus with lateral displacement of the distal fragment by 10 mm (Id. p. 16).

Subsequently, Petitioner came under the care of Dr. Scott A. Seymour at Orthopedic Associates of Riverside on May 6, 2013 (PX #5, p.4). Dr. Seymour recommended that Petitioner undergo surgery to repair his right ankle fracture and dislocation, which was causally connected to his work injury (Id.).

On May 8, 2013, Petitioner underwent a surgical intervention including an open reduction internal fixation bimalleolar ankle fracture with repair of syndesmosis with Arthrex tightrope (Id., p.6).

On September 12, 2013, Dr. Seymour noted that Petitioner would benefit from a bone stimulator for the fibular fracture partial delayed union (Id. p.16). Petitioner was to be off-work (Id. p.17). On March 3, 2014, Petitioner went to his follow up appointment with Dr. Seymour, who noted that Petitioner's fractures were healed (Id. at 26). Petitioner was to return to work in a light duty capacity (Id.).

On February 6, 2014, Petitioner underwent an IME with Dr. Simon Lee (PX #6, p.1). Dr. Lee noted that Petitioner's status was directly caused by the original injury on April 23, 2013 (Id., p.2). Dr. Lee also noted that Petitioner's treatment had been reasonable, necessary and appropriate based on Petitioner's injury (Id.).

At trial, Petitioner testified that he is currently working for Jose Esquivel in Louisville, Kentucky (T. p.8). Petitioner's position with his current employer is a stable cleaner (T. p.23). Petitioner testified that in his new job he works more and gets paid less because he is no longer able to be a horse trainer (T. p.22). Petitioner testified that he is no longer able to be a horse trainer because of the fracture sustained to his right ankle (Id.). Following his fracture, Petitioner gained weight and suffered from anxiety and frustration (T. p.22-23). Due to his weight gain, he cannot train the horses because horse trainers must be light-weight like jockeys (Id.). Petitioner testified that he attempted to return to work for Frank Kirby, but he was no longer able to give him a job because he thought that Petitioner would no longer be able to do his job duties because of his right ankle (Id., p. 25-26). Prior to his position in Kentucky, Petitioner looked for work and procured a factory position through Elite Staffing, but only worked at the factory for three months because he was unable to carry heavy things due to his foot (Id. p.27).

In his personal life, Petitioner testified that due to his work-related injury he is no longer able to run, play soccer or basketball with his children, nor carry objects heavier than 30-40 pounds (T. p.24). Petitioner testified that he suffers from pain in his ankle daily, and his ankle swells up at night (Id.). He is no longer able to move his right ankle the way he can move his left ankle (Id. p.24-25).

II. FINDINGS OF LAW

a. In support of the Arbitrator's decision relating to (B), whether an employer-employee relationship existed, the Arbitrator finds the following facts:

Under the Act, an employee is one who is compensated for services provided to the State, municipal corporation, or business (820 ILCS 305/1(b)(1)). An employer is defined as anyone

who has another in its employment and has either elected to be covered by the Act or is engaged in an activity which is defined to be extra-hazardous and thereby is automatically covered by the Act (820 ILCS 305/1(a)(2), (3), (4)). The Arbitrator finds that exercising horses, especially horse riding, is an extra hazardous activity, despite not being specifically listed as such in the Act. Judicial notice is taken that horses are notoriously unpredictable animals, especially thoroughbreds.

Determining whether an employer/employee relationship exists is a factual question based upon a number of considerations (*see* Bauer v. Industrial Commission, 51 Ill.2d 169, 282 N.E.2d 448 (1972)). Under the Act, the following factors have been considered to determine if an employment relationship existed at the time of the alleged injury: 1) The right to control the manner in which the work is being performed; 2) The method of payment; 3) The right to discharge; 4) The skills required to perform the work; 5) The ownership of tools, materials, and equipment used in the work; 6) The relationship of the work performed to the employers purpose; 7) The deduction of withholding taxes. Courts have consistently held that the employer's right to control the manner of the employee's work is the single most important determinative factor, even where the other factors may conflict (*see* Bauer v. Industrial Commission, 51 Ill.2d 169, 282 N.E.2d 448 (1972)).

Determining the whether the Petitioner was an employer or independent contractor in this case was made difficult for several reasons, principally Petitioner's choosing to mischaracterize his job title. The record shows he was a horse exerciser, not a trainer. Petitioner's motivation to mislead the court about the very nature of his employment could only be motivated by his desire to characterize himself as a full-time, salaried employee, eligible for workers' compensation coverage. However, there are key facts that suggest the Petitioner was an independent contractor.

First, Petitioner did not ride exclusively for Frank Kirby or Hondo Ranch. He was free to ride for other trainers and did so. It appears the Petitioner was paid on a cash basis, as no check stubs, banking or tax records were produced to corroborate his testimony of being paid by check. While it is true that Petitioner submitted checks into evidence indicating Hondo Ranch as the payor (T. p.29) (RX #5), those checks were created after the accident. Petitioner did not produce any documentation proving he was paid by check prior to the occurrence. Thus, it is likely that the parties had a mutually beneficial cash arrangement. Petitioner finally admitted on cross-examination that he requested to be paid in cash. (T. p.55) Petitioner never received tax documentation from Kirby, nor was any income claimed on his taxes, even though he incorrectly stated that he claimed $5,200 in 2013. (T. p. 51) Therefore, the method of payment would indicate that Petitioner was independent contractor and not an employee.

While it is true that Petitioner received TTD checks listing FJK Enterprises, Inc. as the insured from the TPA Sedgwick (T. p.37) (PX #9) and an IME report lists FJK Enterprises, Inc. as the employer (PX #6), those documents do not prove that Petitioner was an employee. It appears to the Arbitrator that Petitioner attempted to solidify the employment relationship based upon an unarticulated estoppal argument, but this would have been more effective if Petitioner had Frank Kirby testify on Petitioner's behalf. It should be noted that Petitioner's counsel was in contact with Kirby on the eve of trial, but he failed testify on Petitioner's behalf and no estoppal argument was made at trial. (PX #7)

Based on the record, it appears that Frank Kirby hired the Petitioner, paid him cash and instructed the Petitioner as to which horse had to be exercised that day (T. p.12, 15-16). No tax paperwork was ever filled out. (T. p.12) However, it should be noted that Petitioner is not a horse trainer, despite Petitioner repeatedly stating so. Instead, he was a horse exerciser or "hotwalker,"

which is a less skilled occupation. Petitioner told his medical care providers he was an "exerciser." (PX #2) Additionally, the Incident Report from Hawthorne Race Course shows the proper job title listed as "exerciser." (PX #1) He told his tax preparer that he was a "hotwalker." (RX #1) By examining similar cases in other jurisdictions and another recent case in Chicago, the custom and practice of the horse racing industry is to hire hot walkers per "ride," usually $10.00 per horse. (See, Don Gogel v. John Hancock (2013 Ky. Unpub. Lexis 1 (Ky., Feb. 21, 2013) and Illinois arbitration decision captioned, Eleazar Villasaldo v. Michael Reavis Racing Stables – 13 WC 09006). The jobs are seasonal and are often dependent on many factors, which include the local weather and/or health of the horses. Id. They are not salaried positions and the riders work for different stables. Id. (T. p.13) Sometimes they are hired out by different stables on the same day. Id. Petitioner's tax records from 2011 to 2016 show that the Petitioner and/or his spouse were employed in Illinois, Kentucky, Louisiana and Arkansas. (RX #1) Petitioner currently works in Kentucky. (T. p.21). Those thoroughbred racing states are evidence that Petitioner led a peripatetic or nomadic lifestyle, indicia of freewheeling independence and free lancing employment. Petitioner was not an employee tied down to a 9 to 5 job. He even had more than one social security number as evidenced by comparing his out of state tax statements with his federal tax records. (RX #1)

In Lang v. Silva, 306 Ill.App.3d 960, 240 Ill.Dec.21 (1st Dist. 1999) citing Clark v. Industrial Comm'n, 54 Ill.2d311, 297 Ill2d 311, 297 NE2d 154 (1973), the Illinois Supreme Court noted that racing a professional thoroughbred race horse requires specialized skills. Similarly, exercising or "hotwalking" a thoroughbred racer would require specialized skills.

Petitioner testified that Kirby gave the Petitioner instructions about how "to train them as to how to gallop" and "how to train them for the races." (T. 10) But it is clear from the record,

Petitioner is not a trainer. And even when given some generalized instructions, such a "gallop" or "trot," it is up the rider to use his skills to bring about that result. Once upon a racing thoroughbred, "anything can happen." (Clark v. Industrial Comm'n. @ 157). The court noted that it is obviously impossible for an owner to discharge the jockey when he racing and it is similarly impossible to discharge an exerciser while he is galloping a steed. There was no evidence that Kirby ever supervised the Petitioner's work. There is no evidence about whether Petitioner used his own saddle or tack.

Petitioner was a free-lancer who work for different owners and was paid as such with no deductions for income, social security and unemployment compensation taxes. Additionally, Petitioner had special skills and appeared to be under general supervision of Kirby, but not direct supervision. The weight of the evidence leads to the conclusion that Petitioner was an independent contractor and not an employee.

b. In support of the Arbitrator's decision relating to (C), whether an accident occurred that arose out of and in the course of Petitioner's employment with Respondent, the arbitrator finds as follows:

The Hawthorne Race Course Incident Report states that on April 23, 2013, the Petitioner injured his right ankle when the thoroughbred racehorse, "River" (whose trainer was Kirby) pinned him against the wall while exercising. The record does not state that the Petitioner was thrown or that the animal fell on its rider. P(PX #1) In fact, no other injury was reported.

The Petitioner was taken to the emergency room at McNeal Hospital in Berwyn, where he told them that "while exercising, the horse moved too close to the wall and his right foot got bent back." The ankle was shattered. (PX #2) Later that day, the medical record was updated to reflect that the Petitioner was thrown from the horse. There is no record of the horse falling on the Petitioner.

However, at trial, the Petitioner stated that he was thrown from the horse and then the horse fell on him (T. p.15-16). While there are some discrepancies in the record about the accident, it is clear the Petitioner's right ankle was broken at the race course that morning.

If the horse had fallen on the Petitioner, as stated under oath, it probably would have been recorded at the race course or in the emergency room. It doesn't seem likely that the Petitioner would have omitted that fact in the past and then suddenly remembered it at trial. Such unnecessary exaggeration had the effect of damaging the Petitioner's overall credibility.

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

The causal connection between Petitioner's current ill-being and April 23, 2013 work accident has been corroborated by medical evidence and witness testimony. Petitioner's injury to his right ankle is causally related to his work-related injury on April 23, 2013.

Further, Respondent's IME Dr. Simon Lee opined that Petitioner suffered from a right bimalleolar ankle fracture and syndesmotic disruption status post open reduction internal fixation with mild posttraumatic arthrosis (PX #6). Dr. Lee further opined that Petitioner's "current status as well as the subsequent diagnosis and treatment to date are in direct causality with the original injury and condition" of April 23, 2013 (Id.). Furthermore, Respondent did not offer any witnesses to contradict Petitioner version of events.

Therefore, this Arbitrator finds that Petitioner sustained injury to right ankle arising out of and in the course of his employment with Respondent. Furthermore, given the temporal relationship between the accident and the onset of pain, this Arbitrator finds that Petitioner's

right ankle condition was caused or aggravated by his work duties as shown through the direct credible medical evidence and testimony presented at the hearing.

d. In support of the Arbitrator's decision relating to (G), Petitioner's average weekly wage, the Arbitrator finds the following facts:

Petitioner's occupation with Kirby was seasonal and probably on a cash basis. Kirby was not the Petitioner's only employer. Thus, there is no way to corroborate Gutierrez's earnings or how he was paid. The custom and practice to pay exercisers on a project basis or per ride. Too much of the Petitioner's testimony was contradicted by the rest of the record which would include his job title, terms and conditions of his employment, taxes, the accident and his current disability and job status. The Petitioner did not have much credibility at trial. Even his testimony about his average weekly wage was imprecise. As a result, the Arbitrator could have only awarded the statutory minimum rates with four dependents effective on April 23, 2013. ($330.00).

e. In support of the Arbitrator's decision relating to (J), whether medical treatment rendered was reasonable and necessary, this Arbitrator finds the following:

Section 8 (a) of the Workers' Compensation Act states that an employer shall provide and pay… all necessary medical, surgical and hospital services thereafter incurred, limited, however to that which is reasonably required to cure or relieve the affects of the accidental injury…

However, as the Petitioner was independent contractor, Respondent has no liability for the outstanding medical bills under The Illinois Workers' Compensation Act.

k. In support of the Arbitrator's decision relating to (K), what temporary benefits are in dispute?

No temporary total disability benefits are awarded as Petitioner was an independent contractor and not an employee.

f. In support of the Arbitrator's decision relating to (L), the nature and extent of Petitioner's permanent partial disability caused by to the April 10, 2013 accident, the Arbitrator finds as follows:

In determining the level of permanent partial disability, the Commission shall base its determination on the following factors: (i) the reported level of impairment pursuant to subsection (a); (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order. 820 ILCS 305/8.1(b)

No compensation is awarded in this case as the Petitioner was an independent contractor and not an employee. Nevertheless, the Petitioner's credibility was damaged further when testifying to the following:

Petitioner claimed to have permanent lifting restrictions of 25 pounds, but this is untrue. Petitioner failed to return to his doctor, who anticipated returning his patient to work with no restrictions.

Petitioner testified he was unable to return to work as a horse trainer, but he is not a horse trainer, he was a "hot walker" or exerciser. After his employment with Respondent, Petitioner worked at a factory (Elite Staffing) but stated he could not work at the factory for long because

of his inability to lift heavy things (ostensibly it was fine to stand on his feet for eight hours). His testimony about when he worked in the factory and for how long was vague.

Petitioner currently stated that he cleans horse stables in Kentucky because he is not capable of returning as a horse trainer in Illinois, but it is difficult to believe that he cannot find more suitable work in Chicago where he has four children to support.

With respect to subsection (iv) of Section 8.1b(b), Petitioner's future earning capacity, the Arbitrator notes Petitioner testified that he is currently working more but earning less than he was with Respondent. However, none of this could be corroborated with any documentation. Whatever employment he has found in Kentucky, it agrees with him.

g. In support of the Arbitrator's decision relating to (O), Respondent's motion to dismiss the Illinois Insurance Guaranty Fund, the arbitrator makes no decision as the matter is moot.

As the Petitioner was not employee, this issue was not addressed by the Arbitrator.

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 Choose reason	☐ Second Injury Fund (§8(e)18)
X Correction of scrivener's error	☐ PTD/Fatal denied
☐ Modify Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MARY STEWART,

Petitioner,

20IWCC0388

vs. NO: 12 WC 41562

KAY & ASSOCIATES,

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 temporary total disability and permanent partial disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission, herein, corrects a scrivener's error in the Arbitrator's decision, heading labeled as, (2) Petitioner's work accident of May 2, 2012; the correct accident date should be noted as May 3, 2012.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 12, 2018 is, otherwise, 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.

20IWCC0388

Bond for 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: JUL - 8 2020
o-6/30/20
KAD/jsf

Kathryn A. Doerries

Maria E. Portela

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

STEWART, MARY
Employee/Petitioner

Case# **12WC041562**

20IWCC0388

KAY & ASSOCIATES
Employer/Respondent

On 10/12/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.38% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4103 MICHAEL J GRAVLIN LAW OFFICE
134 N LASALLE ST
SUITE 2020
CHICAGO, IL 60602

1680 CASSANO & ASSOCIATES
LAWRENCE CASSANO
1240IROQUOIS AVE
NAPERVILLE, IL 60563

20 IWCC0388

STATE OF ILLINOIS)
)SS.
COUNTY OF McHenry)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

MARY STEWART
Employee/Petitioner

v.

KAY & ASSOCIATES
Employer/Respondent

Case # **12** WC **41562**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael Glaub**, Arbitrator of the Commission, in the city of **Woodstock**, on **July 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. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [ ] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [x] Is Respondent due any credit?
O. [x] Other **Chain of Referral**

FINDINGS

On **05/03/2012**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$16,640.00**; the average weekly wage was **$320.00**.

On the date of accident, Petitioner was **49** years of age, ***single*** with **0** dependent children.

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

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

Respondent shall be given a credit of **$57,465.17** for TTD, **$NA** for TPD, **$NA** for maintenance, and **$NA** for other benefits, for a total credit of **$57,465.17**.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $220.00/week for 130 1/7 weeks, commencing 05/08/2012 through 11/05/2014, minus one day during that period on which Petitioner worked for Respondent, as provided in Section 8(b) of the Act.

Petitioner failed to prove that she is entitled to maintenance benefits after she reached MMI on November 5, 2014. Benefits are hereby denied after November 5, 2014.

Respondent shall be given a credit of $57,465.17 for TTD, $NA for TPD, and $NA for maintenance benefits, for a total credit of $57,465.17.

Petitioner's condition of ill-being is causally related to her work accident of May 3, 2012.

Respondent shall pay the petitioner permanent partial disability benefits of $220.00 per week for a period of 125 weeks because the injuries sustained caused a 25% loss of use of the person as a whole under Section 8(d)2 of the Act

Respondent shall pay any compensation accrued from November 5, 2014 through July 12, 2018 and pay the remainder of the award, if any, in weekly payments.

Petitioner's treatment with Aunt Martha's Clinic, Dr. Qadir, Dr. Aranas, and Dr. Said was outside the chain of referral and is not compensable under the Act.

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

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

Signature of Arbitrator

10/11/18
Date

OCT 12 2018

Mary Stewart v Kay & Associates
12 WC 41562

20IWCC0388

DECISION OF ARBITRATOR

An Application for Adjustment of Claim was filed in this matter and notice of hearing mailed to each party. This matter was heard on July 12, 2018 by an Arbitrator designated by the Commission in the City of Woodstock, County of McHenry, and State of Illinois. After hearing the proofs and allegations of the parties and having made careful inquiry into this matter, the Arbitrator concludes as follows:

SUMMARY OF THE ISSUES:

The parties stipulated and agree that on May 3, 2012, Respondent, KAY & ASSOCIATES ("Respondent"), was operating under and subject to the provisions of the Illinois Workers' Compensation Act ("the Act"); the relationship of employer and employee existed between Petitioner, MARY STEWART ("Petitioner"), and Respondent; Petitioner sustained an accident that arose out of and in the course of employment; Respondent was given timely notice of the accident within the time limits stated in the Act; at the time of the injury Petitioner was 49 years of age, single, with 0 dependent children under 18 years of age; and that Petitioner's average weekly wage calculated pursuant to Section 10 of the Act was $320. The Parties also stipulated that all medical bills have been paid (Arbitrator's Exhibit 1). Finally, the parties agree that Respondent has paid benefits in the sum of $57,465.17 in temporary total disability benefits.

The parties dispute the issues causal relationship, chain of referral, TTD, and the nature and extent of the injury.

THE ARBITRATOR HEREBY MAKES THE FOLLOWING CONCLUSIONS OF FACT:

A. Petitioner's Trial Testimony

On May 3, 2012 Petitioner, Mary Stewart, was employed by Respondent Kay & Associates. She sustained an injury at work that day while doing inventory. She was putting boxes away on top of a shelf, a box fell on top of her head and to her right, between her neck and shoulder. (T. 12) She reported the incident to her supervisor (Joe) same day.

Petitioner testified she felt "a little bit" of pain. (T. 12) She denied having any pain in her neck, back or leg prior to May 2012. She completed her shift and went to work the next day.

Roughly two or three days later she sought treatment at Concentra, the company clinic. (T. 13) on referral of the Respondent. Petitioner was diagnosed with a probable pulled muscle after an exam and x-rays. Physical therapy was prescribed.

Petitioner testified she had approximately three weeks of physical therapy at Concentra but therapy did not resolve her symptoms. (T. 15) Petitioner then chose to treat with her own personal physician, Dr. Ross. Dr. Ross referred her to Dr. Kelly. (T., 15)

Dr. Kelly reportedly recommended injections. Petitioner had two injections on the left shoulder, two on the right side, and one in the low back. Petitioner testified the injections helped only temporarily, *i.e.*, for about four weeks, and then her pain returned. (T. 16) She claimed she had numbness and pain down her left leg and the low back and neck. She returned to Dr. Kelly once or twice after the injections. Petitioner testified she was referred to Dr. Singh, but he didn't want to see her because she thought she had an allergic reaction to the shots. (T. 17)

Petitioner then sought treatment from Dr. Nash or Mash, and then was referred to Dr. Singh for surgery.

She contends she still has issues with her skin, side effects of the injections. (T. 18)

Petitioner could not recall who referred her to Dr. Singh, but testified she was referred to him. Dr. Singh prescribed lumbar spine surgery. (T. 19)

As below, Dr. Singh's records do not reflect any referral from another medical provider.

Petitioner underwent lumbar spine surgery under Dr. Singh. It helped "for a little while." (T. 20) Her relief was only temporary. She followed up with Dr. Singh post operatively, and treated with physical therapy and medications. Dr. Singh then discharged her from his care. (T. 20)

Since her discharge by Dr. Singh, Petitioner testified she's seen other doctors including Dr. Qadir, Dr. Aranas and Dr. Said. She was not referred to those doctors by Dr. Singh. She was going to Dr. Qadir, and Dr. Qadir referred her to Dr. Aranas, and Dr. Aransa referred her to Dr. Said. She found and went to Dr. Qadir through her health insurance. (T. 22)

Following her work accident, Petitioner returned to work for three days, and then was taken off work by the doctors at Concentra. Since May 8, 20112 she went back to work for one other hour. She testified she was not able to work longer due to radiating pain. (T. 23-25) She testified she has not been able to return to work anyplace else. Petitioner testified that her injuries from May 2012 have still not resolved and she is unable to work. (T. 26)

Petitioner is not sure who referred her to Dr. Singh, except to say it was one of the doctors at Concentra. (T. 28)

Petitioner was hired by Respondent on April 6, 2012. (T. 28) She worked as a production associate for a little less than a month before the alleged work injury.

Petitioner testified the job duties of a production associate included the following tasks – assembler, performing visual inspections, performing testing, packaging assemblies and

mechanical units, and visually inspecting items to ensure they're assembled correctly. (RX 10) (T. 29-30)

Before her May 2012 work injury, Petitioner had three prior back injuries and workers' compensation claims. (RX 13) (T. 30-31)

Prior to the accident date in this case, she suffered a low back injury on July 21, 2000 while working for Shaped Wire. She was packing reels of wire spools and running a machine and doing a forklift, she testified, when she injured her back. (T. 32)

Prior to the accident date in this case, she suffered a low back injury on March 29, 2001 while working for Shaped Wire. (T. 32-33)

Prior to the accident date in this case, she suffered a low back injury on October 6, 2003 while working for R & O Specialists. (T. 33-34)

As a result of one or more of those prior back injuries, Petitioner underwent back surgery on October 27, 2000, described as a left L3-4 lumbar hemilaminotomy and microdiskectomy under Dr. Ross. (T. 33-34) She treated post-operatively under Dr. Ross and ultimately had a functional capacities evaluation ("FCE") test on November 19, 2001. The FCE results indicated Petitioner's physical demand level capacity was at the light/medium level. (RX 1) (T. 35-36) Petitioner's surgery of October 2000 and FCE were related to her work accident and back injury of 2000. (T. 36)

When Petitioner saw Dr. Ross in December 2001, her physical capabilities were found to be as in the FCE, at the light to medium physical demand level. When she saw Dr. Ross on December 13, 2001 she still had complaints of pain in her back. And she was restricted in terms of her ability to work. And she was taking medications at the request of Dr. Ross due to her symptoms of pain and back surgery, including Vioxx, Neurontin and/or Darvocet for pain control. Petitioner continued to see Dr. Ross into 2002. (T. 37-38)

In 2005 Petitioner returned to Dr. Ross for a new back injury related to her operation of a forklift as an employee of R & O. (T. 38)

In connection with Petitioner's prior workers' compensation case from 2000, she had a Section 12 medical examination by Dr. Francisco Espinosa on October 29, 2001. She gave a history of numbness and tingling and weakness, and that her symptoms were aggravated by walking, bending, standing, and laying on her left side. Dr. Espinosa didn't share his opinions with Petitioner, she testified. (T. 39-40)

Petitioner was on light duty at that time in October 2001. (T. 40) Dr. Espinosa agreed with Petitioner's treating physician in October 2001 that she should remain on light duty. (T. 40-41) Dr. Espinosa expressed the opinion he didn't think Petitioner would ever be able to return to her previous occupation. (T. 41)

In January 2003, Petitioner applied for Social Security disability benefits. She claimed benefits from July 2000 to present (*i.e.*, January 2003). (T. 41-42)

When Petitioner presented to Dr. Ross in December 2001, Dr. Ross found her to be at MMI with ongoing future work restrictions. (T. 42-43)

In December 2001 Petitioner was still experiencing left leg pain and numbness that fluctuated in severity, especially with prolonged sitting. Dr. Ross instructed her to continue taking medication for pain control. He found her to be at MMI and released her to return to work on a restricted basis in December 2001, with lifting up to 10 pounds frequently and 25 pounds occasionally, and the ability to vary her position from sitting to standing as needed. (T. 43-44)

When Petitioner presented to Dr. Ross in January 2005 she still had symptoms and felt pain in her back and left leg. This was following the work-related forklift accident. Dr. Ross prescribed a repeat MRI. Petitioner did not recall whether she ever had it, and the records do not indicate another MRI was done at that time. (T. 44-45)

Petitioner saw Dr. Singh for the last time on November 5, 2014. She and her doctor had a lengthy conversation. Dr. Singh described her as "confrontational" but Petitioner denied that was accurate. (T. 47) Petitioner testified she told Dr. Singh she still had pain in her low back and left leg and neck. Dr. Singh told her it could not be from anything he did for her because the pins and screws he put in her back were still in place. She still had lower leg pain running down her left leg and low back pain. She testified that Dr. Singh told her there was nothing else he could do for her, and refused to see her after that. (T. 47-48)

Petitioner testified Dr. Singh told her the MRI that was done post-operatively showed no significant spinal canal stenosis and that the fusion at L3-4 was solidly incorporated. She testified the radiologist who read the MRI also found the fusion to be solidly incorporated. (T. 48)

Petitioner had an FCE on July 11, 2014 at Athletico. (RX 9) (T. 50) She had a prior FCE on May 20, 2014. (RX 8) (T. 51)

The FCE from July 11, 2014 showed Petitioner was capable of work at the MEDIUM physical demand level. (T. 51-52)

Dr. Singh found Petitioner to be at MMI when he saw her on November 5, 2014, for both the cervical and lumbar spine. And he released her to return to work with permanent restrictions based upon her last FCE which placed here at the MEDIUM physical demand level. He did not refer her to any other doctors or medical providers. He discharged her from care. (T. 49-50)

Petitioner was examined in behalf of Respondent by Dr. Jay Levin on October 24, 2012 (RX 4 and RX 5), and Dr. Steven Mash in April 2015 (RX 6 and RX 7).

After being discharged by Dr. Singh, Petitioner sought medical treatment at "Aunt Martha's," a clinic in Aurora, Illinois. (T. 54) She was also seen at Rush Copley Hospital. (T. 55)

Petitioner admitted meeting with a vocational rehabilitation counselor from Genex in April 2017. She and the counselor discussed her education, work experience, physical limitations, etc. She was asked whether she had given any thought to returning to work. She testified that she said she was willing to do light duty. That testimony was not consistent with the Genex Vocational Case Management Initial Report. Petitioner testified she reported that she was in a lot of pain, and that she did not feel she was at MMI. She also told the vocational rehab counselor that she didn't think any employer would hire her because of the need to alternate between siting, standing and lying down. (T. 55-58)

Petitioner testified that she submitted job applications at "different places," but could only recall Kmart and temporary services. She denied working, saying only that she just applied for work. (T. 58)

When Petitioner met with the Genex voc rehab counselor, she denied saying she had not looked for work. If the Genex counsel testified Petitioner told her she had not looked for work, "It would be her word against mine," Petitioner testified. (T. 58-59)

B. Summary of the Documentary Evidence

The vocational rehabilitation Genex report dated April 7, 2017 contradicts Petitioner's testimony - it indicates she stated that had not given any thought to returning to work. (RX 15) The Genex report shows that, "When asked if Ms. Stewart has given any thought to return to work, she responded 'no.' She reportedly was in a lot of pain and did not feel she is at maximum medical improvement. She explained that she doesn't know that employer would hire her based off of needing to alternate sitting, standing, and even laying down." (RX 15)

According to the May 20, 2014 FCE, "the target job as a warehouse worker were identified as 'Medium' physical demand level work by consulting the Dictionary of Occupational Titles for the job title." (RX 8) According to the FCE dated July 11, 2014, and final record from the treating physician Dr. Singh dated November 5, 2014, Petitioner is capable of work at the "Medium" physical demand level. (RX 9; RX 11; PX 4)

A description of Petitioner's job duties for Respondent was admitted in evidence. (RX 10) Petitioner's job duties as a Production Associate for Respondent included: (i) assembling components and housing units in accordance with layout instructions and prints; (ii) performing visual inspection of units for proper assembly, solder problems, missing, reversed, or damaged components, test function verification, silk screen and packaging to ensure workmanship standards are met. May also perform lot sample inspections of finished products; (iii) modifying new and repaired units to the current revision per modification instructions; (iv) performing manual and automated tests on printed circuit boards and units to determine conformance to product specification per test procedures; (v) wire-wrap wire cable to electronic terminals; (vi) maintain product documentation and related logs as required; (vii) pack finished products including any required literature; (viii) check pick lists to verify component and quantity

accuracy; (ix) be responsible for general utility tasks including product movement; (x) follow safety rules and keep work area in clean and orderly condition; (xi) perform other duties as assigned by supervisor. She may use the following equipment/tools at work: hand, air, and power tools, wire-strip, lead cutting and forming machines, exacto knives, calipers, scribes, electronic test equipment, test fixtures, hand press, hand trucks, rivet gun, foam packing machines, bar code scanner, tape machine and computer terminal. (RX 10, Job Description)

(1) Petitioner's Multiple Pre-Accident Work Accident and Injuries, and Surgery

Petitioner was seen for a Section 12 examination by Dr. Francisco Espinosa on October 29, 2001, following her work accidents at Shaped Wire, Inc. and back injuries for which she had surgery to her lumbar spine at the L3-4 level, an L3-4 microdiskectomy. In his medical report dated October 29, 2001, Dr. Espinosa diagnosed persistent L3 radiculopathy on the left side. He wrote, "Unfortunately, the prognosis is not very good as she does have epidural fibrosis, which is not treatable with surgery and will continue to have residual and recurrent symptoms due to scar tissue that developed post-operatively." Dr. Espinosa opined Petitioner's condition of ill-being was related to her work accident of July 21, 2000 and re-injury of March 29, 2001. He recommended further treatment including epidural injections. As for work, he opined Petitioner was restricted to light duties and modified activities. (RX 1, pp. 10037-10038)

He wrote, "I frankly do not think that she will be able to return to her full occupation as prior to her injury." (RX 1, pp. 10037-10038)

Petitioner had an FCE on November 19, 2001. She was found to be capable of work only at the LIGHT MEDIUM physical demand level. (RX 1, pp. 10344 – 10348)

(2) Petitioner's Work Accident of May 2, 2012

On May 3, 2012, Petitioner alleges she was putting a box of screws away on a top shelf when it fell on top of her head and left shoulder. She complained of neck, back and shoulder pain. Her past medical history showed she had an L3-L4 discectomy in 1999-2000.

Petitioner had multiple prior work accidents for other employers, and sustained two prior injuries to the low back. On October 27, 2000 she had surgery to her low back described as a left L3-L4 lumbar hemilaminotomy and microdiskectomy. (RX 1, Dr. Ross Records) That surgery was performed by Dr. Ross at Central DuPage Hospital. Petitioner's pre and post-operative diagnoses were L3-L4 lumbar disc herniation.

Medical records show Petitioner was seen initially on May 7, 2012 by Dr. Mahmuda S. Moshin of Concentra. She stated, "I was putting a box of screws on the top shelf and it fell on top of my head and left shoulder." The box reportedly weighed about 15-20 pounds and it fell on top of her head and left shoulder. The incident happened Wednesday and she continued to work and has been working since. Her pain is located on the left side of the back and her left upper extremity feels "numb." She rated her pain at 8/10 and described it as "moderate, severe, constant and pressure." Petitioner was in moderate distress secondary to pain. Lumbar ROM was decreased in all planes. Pain to palpation was noted on the left paraspinous area at L2, L3, L4 and L5. Reflex testing was normal and equal bilaterally to Achilles and Patellar. Straight leg

raising test was positive on the left in the supine position, which produced pain in the back but no sciatic pain and tight hamstrings noted. She was diagnosed with cervical and lumbar strain. She was given Torodol, Ibuprofen and Cyclobenzaprine. She was scheduled for physical therapy 3 times a week for 2 weeks. She could return to work with restrictions that included: (i) no lifting over 10#; (ii) no prolonged standing/walking longer than tolerated; (iii) no pushing/pulling over 15# of force; and (iv) should be sitting 50% of the time. She was to return 05/09/2012 for follow up. (RX 1)

Petitioner began a course of physical therapy with an initial evaluation on 05/07/2012 at Concentra. She reported the same history as at her prior office visit. She was to attend therapy 3 times a week for 1-2 weeks.

On May 9, 2012 Petitioner followed up with Dr. Julio Mancera of Concentra. She had been working within her duty restrictions. She has been taking her medications without improvement. She had attended 1 PT session and "does not feel better." The pain was located on the bilateral lower back and lumbosacral region. She rated her pain at 2/10. Examination showed negative straight leg raising. ROM was moderately decreased in the lumbar area. Waddell's were positive for overreaction. Palpation was positive for pain at L3, L4 and L5 bilaterally. Cervical and thoracic back exams revealed no abnormalities. She was diagnosed with low back strain. She was to remain on modified duty and continue therapy and her medications. She was to follow up in a week.

Petitioner followed up with Dr. Moshin on May 15, 2012. She reportedly felt "30% better." She has not been working because light duty work was not available, she said. Her pain was located "on the anterior aspect of the posterior aspect of the lateral aspect of the left shoulder and left trapezius muscle." She described the pain as moderate, atypical, constant, sharp and shooting. The pain radiated into the upper portion of the left arm with associated paresthesias. She complained of lower back lumbar region pain on the left side that radiated to the thigh post aspect. She rated her pain at 6/10. Examination of the left shoulder showed decreased ROM in all planes. Tenderness to palpation was noted at the "anterior area, posterior area, trapezius muscle." Lumbar examination showed straight leg raising test was positive bilaterally. Lumbar ROM was decreased. C-spine x-rays showed "degenerative findings, lumbar spine DJD changes noted." Petitioner was told she could resume regular activity at work, but at a "slower pace." She was to return in 1 week for follow up.

On May 21, 2012 Petitioner followed up with Dr. Moshin. She continued to have pain in the lumbar region with radiation into the left buttock, posterior aspect of the thigh, anterior aspect of the LLE and into the foot and toes. She also complained of pain and numbness in the LUE, along with weakness. Straight leg raise test was positive bilaterally. Lumbar ROM was decreased in all planes. The left shoulder exam revealed no physical abnormalities. Tenderness to palpation was noted at the posterior area, with decreased ROM in all planes. She was diagnosed with cervical and lumbar strain with radiculopathy. An MRI of the cervical spine was ordered. She could work regular duties. She was instructed to follow up after the MRI was completed.

On May 22, 2012 Petitioner had an MRI of the cervical spine at Fox Valley Imaging. Impressions were: (i) disc herniations at multiple levels, most prominent at C4-C5 and C5-C6.

On May 24, 2012 Petitioner followed up with Dr. Moshin. She felt her "pattern of symptoms is no better." She reported she "has not RTW as there are no parts in the CO." She continued to complain of pain in the shoulder region radiating to the LUE in the lower back with radiation of pain to the post aspect of the thigh. She also had pain in the neck, arm, forearm, shoulder, back and lower back. Pain was rated at 6/10 and radiated into the upper portion of the extremities, including the left arm and leg. Cervical examination revealed Petitioner was in moderate distress secondary to pain. ROM was decreased. Tenderness to palpation was noted in C4, C5, C6 and C7. Lumbar examination revealed she was in moderate distress due to pain. ROM was limited in all directions. Straight leg raise test was positive on the left. She was diagnosed with: (i) DJD C spine, cervical stenosis ("see MRI report"); (ii) lumbar strain with DJD. She was allowed to return to modified duty at work which consisted of; (i) no pulling/pushing over 15# of force; (ii) no lifting over 10#. She was to return after the MRI of the lumbar spine was completed. (RX 1)

Petitioner had an MRI of the lumbar spine at Fox Valley Imaging on 05/24/2012. Impressions were: (i) left side lateral disc herniation at L3-L4; (ii) defect in the left lamina possibly representing a previous surgery or developmental change.

She was then referred to a neurosurgeon. On June 7, 2012 Petitioner was seen by Dr. Dmitry Ruban of Rush-Copley Neurosurgery. On exam she had give-away weakness in all muscle groups on the left side in both upper and lower extremities; otherwise she is 5/5 in strength. Her sensation "appeared to be equal throughout to light touch." Her deep tendon reflexes were 2+, with no signs of myelopathy. Dr. Ruban did not see "any structural causes on the cervical or lumbar MRI to explain all of the patient's symptoms." At this time, he said Petitioner did not require any surgical intervention and he would defer further treatment to her occupational health physician. He did not have any specific work restrictions to prove Petitioner. She was to follow up with her occupational health physician.

On June 11, 2012 Petitioner followed up with Dr. Moshin. Her symptoms were no better. She does not feel that PT was helping either. Her exam was essentially unchanged from the previous. Her work restrictions included: (i) no lifting over 15#; (ii) no prolonged standing/sitting longer than tolerated; (iii) no pushing/pulling over 20# of force. She was to continue therapy 3 times a week for 2 weeks.

Also on 06/18/2012 Petitioner followed up with Dr. Moshin. She was to continue working within her work restrictions that included: (i) no lifting over 10#; (ii) no prolonged standing or walking longer than tolerated; (iii) no bending greater than 4 times per hour; (iv) no pushing/pulling over 15# of force. (RX 1)

Petitioner followed up with Dr. Harmony Savage of Concentra on June 28, 2012 with complaints of cervical and lumbar pain that continued without improvement. She did not attend her PT session today due to car trouble. She stated she saw a neurosurgeon that referred her for injections but she has not set them up yet. She had completed PT and was to be released due to

the lack of improvement. Her diagnosis was lumbar and cervical strain. Her work restrictions remained the same. She was referred to a pain specialist and told to follow up in 2 weeks.

On June 21, 2012 Petitioner was seen by Dr. Matthew Ross of Midwest Neurosurgery and Spine Specialists. It was noted she was now almost 12 years post left L3-4 lumbar hemilaminotomy and microdiskectomy. She stated she was "doing well until last month when she had a new work injury." She said she was doing inventory at work and stocking boxes overhead when one of them fell onto her head. She estimated the box weighed 25-30 pounds. She noticed "some headache immediately." As she continued working, she started experiencing more pain in her neck extending into both shoulders. She also reported shooting pain down the left arm into her outer fingers. Lastly, she started noticing discomfort in her low back and down her left leg. She was referred to an occupational medicine clinic for treatment. She has not had any improvement with therapy, Flexeril or Ibuprofen. It was noted that she attempted some light duty work, but this "resulted in some provocation of her neck pain." Dr. Ross opined Petitioner's neck and upper back pain is most likely a strain injury. However, he stated that "the low back and left leg symptoms are more complicated. This may simply be a strain although she may have some radiculopathy from the L3-4 foraminal stenosis." He recommended Petitioner proceed with a left L3 selective root block and transforaminal cortisone injection. In the meantime, she was to continue with physical therapy for her neck and back. She was capable of returning to light duty work; she could "reasonably" lift 10 pounds and be allowed to very her position from sitting to standing. She was to return to this office after the injection.

Petitioner followed up with Dr. Savage on July 12, 2012. She was to continue working within her duty restrictions. Her care was transferred to her pain specialist on this date.

On July 24, 2012 Petitioner presented for evaluation to Dr. James Kelly of DuPage Pain Center. She was referred by Dr. Kelly for an L3 transforaminal nerve root block/steroid injection, as well as possible myofascial trigger point injections for the upper back, shoulder and cervical region. Examination showed she had increased lumbar pain with "even minimal lumbar extension." Left lateral rotation caused increased pain in the cervical region, upper back and shoulders. She had positive tension sign on the left in the sitting position. Straight leg raise was positive on the left at 45 degrees. Deep tendon reflexes were equal and active through with no pathologic reflexes, although she appeared to have mild weakness to quadriceps and hip flexors on the left. Dr. Kelly stated that "those maneuvers on testing strength seem to increase pain as well, so it is questionable as to whether the patient had diminished effort on account of this." Dr. Kelly assessed Petitioner with left L3-L4 radiculopathy and myofascial pain syndrome with active trigger point. He recommended transforaminal injections and trigger point injections.

On August 7, 2012 Petitioner had a left L3 transforminal epidural steroid injection and nerve root block, as well as 2 myofascial trigger point injections, performed by Dr. Kelly. Her diagnoses were left L3 radiculopathy and myofascial pain syndrome with active trigger points. She tolerated the injections "really well" and was then discharged in good condition.

Petitioner followed up with Dr. Kelly on August 14, 2012. She had "significant relief of the leg pain for about 3-4 days and has had insidious recurrence." She had less relief with the trigger point injections and was still having "quite a bit of pain" across the upper back and

shoulders, with secondary radiation into the upper extremities. She was having difficulty sleeping due to the pain. Dr. Kelly noted she has "radiculopathy confirmed with the result of the block and steroid injection and she has persistent myofascial pain." She was to follow up with Dr. Ross. Dr. Kelly thought that a series of trigger point injections in conjunction with restarting PT will provide long term benefit. Petitioner was agreeable to this plan. She was started on Ibuprofen 800 mg in the meantime.

On August 22, 2012 Petitioner followed up with Dr. Ross. She feels her pain is worse. She now had pain going into both legs. She continued to experience some pain and discomfort across her upper back and shoulders. Dr. Ross wrote that Petitioner's "response to the selective nerve root block suggests that the foraminal stenosis is responsible only for a component of her overall pain. It would certainly not explain her back and bilateral leg pain." He thought her pain may be facet mediated. He recommended she proceed with diagnostic facet blocks at L3-4, L4-5 and L5-S1. If she obtained good relief, she would be a candidate for radiofrequency ablation of the medial branch nerves to the involved joints. If she did not obtain goof relief, she would be a candidate for a discogram study. It was be "reasonable" for her to return to work in a sedentary capacity, lifting up to 10 pounds occasionally and varying her sitting/standing positions as tolerated. She was to return to this office upon completion of her diagnostic facet blocks.

Petitioner followed up with Dr. Kelly on September 20, 2012. It was noted she got "excellent relief of her low back and left leg pain with the lower back injection, which was done a number of weeks ago and she was greater than 50% relief for at least a week then the pain started to come back." The trigger point injections of the upper back and shoulders have provided "minimal relief if any." She is still not working. Her diagnosis was myofascial pain and lumbar radiculopathy. If she was not approved for any further injections then the doctor suggested increasing the ibuprofen and Flexeril. She was to follow up in one month.

On October 24, 2012 Petitioner had an IME with Dr. Jay Levin and gave a history of accident. She complained of low back pain, left leg pain to the 5th digit in the left foot, neck pain into her bilateral trapezius area and both arms down to the 5th digit in both. Dr. Levin stated Petitioner had significant degenerative disc changes at C4-5, C5-6 and C6-7. She did not bring her MRI films with her but stated she has them at home. They gave her a prepaid UPS mailing envelope and she was to mail the scans back Dr. Levin. Upon receipt, he would update his opinion and recommendations.

On November 6, 2012 Dr. Levin produced his updated recommendations and opinions. He wrote that Petitioner previously had surgery which was a left L4-L4 hemilaminotomy and microdiscectomy in 2000, followed by a second work related injury to the lumbar spine in 2003. He wrote that her diagnosis from the May 2012 accident was cervical contusion with a cervical and lumbar myofascial strain from that date of event. He stated that there was a causal relationship between the accident and this diagnosis. He wrote that Petitioner did have a herniated disc as a result of that occurrence, in either the cervical or lumbar spine. Her medical symptoms from the accident should have resolved by now, the doctor opined. No further treatment was necessary. Dr. Levin opined that Petitioner should have returned to full duty work within 7-10 days after the accident. PT for the cervical and lumbar spine of 10 visits over a period of up to 8 weeks would have been medically necessary. (He attached the ODG

Guidelines referable to this diagnosis to his report). It was his opinion Petitioner had reached MMI.

On November 28, 2012 Petitioner went to Rush-Copley Medical Center. It was noted she had a history of chronic back pain, who was seen in the emergency department 2 days ago by Dr. Marco Rodriguez with complaints of diffuse desquamating rash for which she was transferred to Loyola University for concern of possible TEN; she was then evaluated extensively and discharged earlier today with the diagnosis of "drug reaction" and was prescribed Norco, Colace, as well as hydrocortisone cream. She presented today with complaints of persistent rash as well as a "burning sensation like I am on fire." Norco has not helped. Examination of the skin showed diffused erythema noted throughout about 95% of the body, sparing the palms of the hands, soles of the feet and mucous membranes with circular lesions with central clearing consistent with erythema multiform noted sporadically throughout bilateral upper and lower extremities.

Dr. Narayana admitted Petitioner to the hospital for observation and pain control.

Petitioner had a hospital admission in November/December 2012 at Loyola University Medical Center for a reaction to drugs.

Petitioner was seen by Dr. Singh for the first time on February 27, 2013.

On March 11, 2013 Petitioner followed up with Dr. Amit Mehta of Instant Care Medical Group, S.C for her low back pain. She stated her symptoms were across the low back with radiation into the legs. She was scheduled for an MRI next week. She stated she has no new issues, complaints or other new changes. It was recommended they hold off on any injections since the previous injections have caused her to have a reaction. She was to follow up after her MRI.

On March 13, 2013 Petitioner had an MRI of the cervical and lumbar spines at Instant Care Medical Group. The impressions of the cervical spine were: (i) some straightening and reversal of the usual cervical curvature, probably representing muscular spasm; (ii) at the C4-C5 and C5-C6 levels, subligamentous posterior disc herniations measuring 2-3mm at both, these levels were noted to indent the central surfaces of the thecal sac without significant spinal stenosis—there was mild right lateral recess narrowing seen at the C5-C6 level; (iii) the rest of the cervical spine appeared unremarkable.

Impressions of the lumbar spine were: (i) at the L3-L4 level, there is a soft tissue structure measuring 3-4 mm indenting the left side of the thecal sac with narrowing of the left lateral recess—furthermore, there appears to be a left laminectomy, suspected to be postsurgical epidural scarring with granulation tissue changes, although disc reherniation or herniation cannot be excluded; (ii) rest of the lumbar spine appeared unremarkable.

On March 15, 2013 Petitioner presented to Stroger Hospital, "seen as an inpatient dermatology consult for erythroderma, 2/2 to psoriasis." She was to get some blood work done and follow up on March 20, 2013.

On March 20, 2013 Petitioner had some blood work done at Stroger Hospital.

On March 28, 2013 Petitioner was seen by Dr. Kern Singh. She returns having complaints of neck pain and low back pain. She has had left lower extremity dysesthesias that radiates into the anterior aspect of her thigh and to the dorsum of her foot. She stated her symptoms have been "worsening" in nature. Her neck pain was rated at 7/10 and radiates into her upper extremity and to her index and thumb fingers. Her symptoms are worse through the day, with activity, bending forward, to brush her teeth, and riding in a car. She is able to sit, stand and walk for 10 minutes at a time. She previously had a L4-5 laminectomy and discectomy in 2009 by Dr. Matthew Ross.

Her diagnoses were: (i) C4-5 and C5-6 disc osteophyte with cord compression and spinal stenosis; (ii) recurrent herniated nucleus pulpous, L3-4; (iii) status post- L3-4 laminectomy. She had failed conservative PT and epidural injections. She was placed on the surgical scheduled for April 9, 2013. Conservative treatment was recommended for her cervical spine at this time, to see how her symptoms improve after her lumbar surgical intervention. Petitioner was unable to work at this time.

On April 25, 2013 Petitioner was seen by Dr. Singh. She continued to have complaints of low back pain and left lower extremity dysesthesias that radiate into the anterior aspect of her thigh and dorsum of her foot. She stated her pain has been "worsening" in nature. It was noted she was "not approved for her surgery on 04/09/2013" and had to be taken off the surgery schedule. She stated her symptoms are worse through the day, with activity, being forward to brush her teeth and riding in a car. She was able to sit, stand and walk for 10 minutes at a time.

Her diagnoses were: (i) C4-5 and C5-6 disc osteophyte with cord compression and spinal stenosis; (ii) recurrent herniated nucleus pulpous, L3-L4; (iii) status post an L3-L4 laminectomy. It was noted Petitioner has failed conservative treatment including PT and epidural injections.

Dr. Singh reiterated he thought she would benefit from an "L3-L4 spinal fusion done by an extreme lateral inter body approach at L3-L4, followed by a minimally invasive laminectomy and microdiskectomy and posterior spinal fusion with instrumentation. She has been placed on the surgery scheduled for 05/10/2013. Risks and benefits were discussed and Petitioner understood and wanted to proceed with surgery. With regard to the cervical spine, Dr. Singh recommended continuing conservative treatment, to see how her symptoms improve following her lumbar surgical intervention. She was unable to work at this time.

On June 13, 2013 Petitioner followed up with Dr. Singh. She continued to have complaints of axial low back and left lower extremity pain and dysthymias that are radiating into the dorsum aspect of her left foot." Her symptoms are "worsening." It was noted she was not approved for her surgery on 05/10/2013 and had to be taken off the schedule. She also is having continued axial neck pain radiating into bilateral upper extremities, with the left arm being worse than her right arm with a continued numbness into her left hand.

Her treatment has "only consisted of physical therapy and 1 epidural steroid injection for her lumbar spine in 08/2012 by Dr. Kelly, with no relief of her symptoms." She also had 4 trigger point injections in her cervical spine with no relief of symptoms. She is currently taking Gabapentin and Norco.

Examination showed 2+ reflexes bilaterally. Motor strength was rated "5" bilaterally in upper and lower extremities. Hoffman's sign, Inverted Brachioradialis and Spurling's signs were all negative. Her diagnoses remained: (i) C4-5 and C5-6 disc osteophyte with cord compression and spinal stenosis; (ii) recurrent herniated nucleus pulpous, L3-4; (iii) status post L3-4 laminectomy.

At this time, Dr. Singh noted Petitioner had exhausted conservative and non-operative measures. She would benefit from L3-4 spinal fusion done by an extreme lateral interbody approach at L3-4, followed by a minimally invasive laminectomy and microdiscectomy with posterior spinal fusion. He noted he would "continue to re-recommend her surgical intervention." With regard to her cervical spine, he recommended continuation of conservative treatment to see how her symptoms improve following her lumbar surgical intervention.

On August 28, 2013 Petitioner followed up with Dr. Singh with continued complaints of axial lower back pain and left lower extremity pain and dysesthesias that was radiating into the dorsal aspect of her left foot. Petitioner indicated her symptoms were worsening. Dr. Singh noted Petitioner was not approved for her foot surgery on 05/10/2013 and therefore, had to be taken off the surgical schedule. Dr. Singh noted Petitioner's treatment had only consisted of physical therapy, 1 epidural steroid injection for the lumbar spine on 08/2012 with no relief of her symptoms. Petitioner had 4 trigger point injections in her cervical spine with no relief of her symptoms. She was currently taking gabapentin and Norco.

The diagnoses were that of: 1) C4-C5 and C5-C6 disk osteophyte complex with cord compression and spinal stenosis; 2) recurrent herniated nucleus pulpous, L3-4; and 3) status post L3-L4 laminectomy. Dr. Singh opined that Petitioner had exhausted all conservative nonoperative treatment measures. As such, Dr. Singh opined Petitioner "would benefit from an L3-L4 spinal fusion done by extreme lateral interbody approach to L3-L$, followed by a minimally invasive laminectomy and microdiskectomy and posterior spinal fusion." She was placed on the surgical schedule for 09/27/2013.

On August 28, 2013, Petitioner returned to Dr. Singh with continued complaints of axial low back pain and left lower extremity pain and radiation into the left foot. Her symptoms reportedly were worsening. Surgery had not yet been approved. Her treatment had consisted of physical therapy, one epidural steroid injection for her lumbar spine in August 2012 by Dr. Kelly, and four trigger point injections in her cervical spine, with no relief. Petitioner having failed conservative treatment, Dr. Singh prescribed surgery. (RX 17)

On November 13, 2013, Petitioner was seen again by Dr. Singh who scheduled surgery for December 13, 2013. (RX 17)

Respondent approved the lumbar fusion surgery on November 21, 2013.

Petitioner had surgery on December 13, 2013, a revision L3-4 laminectomy and interbody fusion with posterior spine fusion.

She followed up with Dr. Singh on January 6, 2014 reporting no significant improvement. When seen again on February 5, 2014, Petitioner stated improvement since prior to fusion surgery, though still reported pain. She was taking tramadol and Flexeril for pain. Physical therapy was prescribed. (RX 17)

Petitioner continued to treat and follow up with Dr. Singh on March 3, 2014, and April 9, 2014. The April 9, 2014 record shows she "continues to improve, as she reports her low back pain today is a 4/10 to 5/10." (RX 17)

On May 20, 2014 Petitioner presented to Athletico Physical Therapy. She had completed a Functional Capacity Evaluation. The summary report states that "the physical demands of the target job as warehouse worker were identified as medium physical demand level work by consulting the Dictionary of Occupational Titles for the job title.

At the request of Dr. Singh, Petitioner had an FCE on July 11, 2014. The test was valid, though "variable levels of physical effort on Ms. Stewart's behalf were observed," and "minor inconsistency to the reliability and accuracy of Ms. Stewart's reports of pain and disability." It was found Ms. Stewart "demonstrated the ability to function within the "Medium" physical demand level. (RX 9)

On July 28, 2014, Dr. Singh allowed Petitioner to return to work with restrictions as in the FCE of July 11, 2014. (RX 17)

Petitioner was seen for the last time by her surgeon Dr. Singh on November 5, 2014. (RX 11) She reported complaints of neck and back pain. She was "extremely confrontational as she was threatening in her tone." She accused Dr. Singh of doing "something wrong with her surgical intervention, and that she wanted to seek another opinion." Dr. Singh informed her that he'd imaged her lumbar spine, that the interbody fusion at L3-4 appears to be solidly incorporated. The MRI following it, from my own interpretation as well as the MRI interpretation by the radiologist, showed that there was no significant spinal canal stenosis. Her pain complaints with regards to her cervical spine are not anatomic in nature." (RX 11)

Dr. Singh had a 45 minute discussion, after which the conversation was terminated when "she stored out of the room, stating that, 'fine,' she would seek her own treatment." (RX 11)

Dr. Singh opined Petitioner was at maximum medical improvement for both the cervical and lumbar spine. He allowed her to return to work with permanent restrictions based upon her last functional capacity evaluation, placing her at a medium physical demand level. (RX 11)

On April 2, 2015, Petitioner presented to Dr. Steven Mash, MD at DuPage Medical Group for an independent medical examination (IME). Petitioner told Dr. Mash that while putting away a box of screws on May 3, 2012, the box fell striking her on the head and shoulder.

Petitioner complained of pain "about the left arm radiating into the left hand and left leg numbness as well." Petitioner did admit prior difficulty with both her lumbar and cervical spine, which she was treated for in 2000. Petitioner stated she was able to work between 2005 and the DOA, and that she admitted experiencing neck and back discomfort during that period, although it was not as severe as it was at present. (RX 6)

Examination of the Petitioner revealed Petitioner demonstrated significant pain behavior throughout the exam, with difficulty demonstrating ROM about the neck and lower back. Examination of the cervical spine revealed complaints of pain at the root of the neck and of radicular symptomology into the left upper extremity. Petitioner demonstrated forward flexion and extension of about 5-10 degrees. Right and left rotation only 5 degrees. Right and left lateral flexion only 5 degrees. In a seated position, Petitioner was able to raise straight leg 30 degrees; more than 30 degrees resulted in Petitioner complaining of lower back pain. In a supine position, was able to raise straight leg 30 degrees; more than 30 degrees resulted in Petitioner complaining of pain. Knee and ankle reflexes were 2+. Neurocirculatory function was intact and hip exams were normal. Dr. Mash also reviewed Petitioner's medical history as part of the examination.

Dr. Mash's diagnosis of Petitioner was degenerative cervical spondylosis, status post L3, L4 posterior spinal fusion with instrumentation and interbody cage placement. Dr. Mash believed Petitioner was at MMI regarding the low back difficulty. He further believed that Petitioner was at MMI regarding the cervical spine. Dr. Mash's opinion was that the lumbar spine injury was causally related to the injury as alleged, but he opined that Petitioner's cervical condition was not causally related. Dr. Mash further opined that Petitioner had reached MMI when she was released by Dr. Singh in November 2014. He believed Petitioner was unable to perform her job based on the job description provided. He wrote that treatment to date for the lumbar spine problem was reasonable, necessary, and related to the work accident. He did not believe that it was reasonable, necessary and related to the work accident for the cervical spine problem. In Dr. Mash's opinion, "any treatment directed to the [Petitioner's] cervical spine after two months following the injury would not be related to the injury on the job." (RX 6)

The record contains an impairment rating of 13% of the whole person as determined by Dr. Steven Mash, pursuant to the most current edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment. (RX 7)

THE ARBITRATOR HEREBY MAKES THE FOLLOWING CONCLUSIONS OF LAW:

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

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

Based upon the testimony of the Petitioner and upon the medical records, the Arbitrator finds that Drs. Singh's, Ross's, Kelly's, and Mash's opinions are more persuasive than those of Dr. Levin, and that Petitioner's condition of ill-being is causally related to her accident while working for Respondent. Petitioner testified she was fully capable of working for Respondent,

pain free, prior to the May 3, 2012 occurrence. She testified that the incident caused her immediate pain, and that the pain did not resolve. Petitioner provided a consistent history of the incident and her pain to all of her medical providers and the IME doctors. Dr. Singh testified that all of the pain complaints Petitioner made were consistent with her diagnostic test results. Respondent's independent medical examiner, Dr. Mash, opined that Petitioner's lumbar complaints and disc herniation were directly related to the incident on May 3, 2012. Although Petitioner did have a prior back surgery, and prior back complaints, that treatment was nearly a decade prior to this accident, and Petitioner was able to function and work in her employment for Respondent.

Based on the all of the above, the Arbitrator concludes that Petitioner's condition of ill-being is causally related to the petitioner's accidental injuries on May 3, 2012.

K. What temporary benefits are in dispute?

The Arbitrator adopts the medical opinion of the treating surgeon, Dr. Singh that the Petitioner reached Maximum Medical Improvement by November 5, 2014.

After carefully considering all the evidence submitted, the Arbitrator finds that Petitioner's right to TTD benefits ended on November 5, 2014.

Respondent shall pay Petitioner temporary total disability benefits of $220.00/week for 130 1/7 weeks, commencing 05/08/2012 through 11/05/2014, minus one day during that period on which Petitioner worked for Respondent, as provided in Section 8(b) of the Act.

As above, Respondent shall be given credit for all TTD paid in the sum of $57,465.17.

As for any claim for maintenance or interim benefits after November 5, 2014, the Arbitrator finds that Petitioner did not perform any meaningful – or any – job search activities. Specifically, there was no evidence of any job search activities for employment within the medical restrictions of Dr. Singh and the Functional Capacity Evaluation.

The vocational rehabilitation Genex report dated April 7, 2017 contradicts Petitioner's testimony - it indicates she stated that had not given any thought to returning to work. (RX 15) The Genex report shows that, "When asked if Ms. Stewart has given any thought to return to work, she responded 'no.'" (RX 15)

Based on all of the above, the Arbitrator finds Petitioner failed to prove that she is entitled to temporary total disability benefits after November 5, 2014. The Arbitrator further finds that petitioner failed to prove she is entitled to maintenance benefits after she reached Maximum Medical Improvement on November 5, 2014. Benefits are hereby denied after that date.

L. Nature and Extent of the Injury

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that the record contains an impairment rating of 13% of the whole person as determined by Dr. Steven Mash, pursuant to the most current edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment. (RX 7) The Arbitrator notes that this level of impairment does not necessarily equate to permanent partial disability under the Workers' Compensation Act, but instead is a factor to be considered in making such a disability evaluation. Dr. Mash noted on April 2, 2015 that Petitioner was at MMI as to her back and cervical spine. He believed the current condition of the lumbar spine was causally related to the accident date, but the cervical spine condition was not causally related. Because Dr. Mash's AMA report is consistent with the treating physician Dr. Singh's records of November 5, 2014 and opinion that Petitioner had reached MMI and based on Dr. Singh's November 2014 opinion that Petitioner was capable of work at the "Medium" physical demand level. The Arbitrator gives the appropriate weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals Petitioner was employed as a production associate at the time of the accident and that she is able to return to work in her prior capacity as a result of said injury. The Arbitrator notes the FCE from July 11, 2014 showed Petitioner was capable of work at the "Medium" physical demand level. (RX 9) According to the May 20, 2014 FCE, "the target job as a warehouse worker were identified as 'Medium' physical demand level work by consulting the Dictionary of Occupational Titles for the job title." (RX 8) According to the FCE dated July 11, 2014, and final record from the treating physician Dr. Singh dated November 5, 2014, Petitioner is capable of work at the "Medium" physical demand level. (RX 9; RX 11; PX 4) A description of Petitioner's job duties for Respondent was admitted in evidence and the arbitrator the job duties listed appear to fall within the "Medium" physical demand level. (RX 10) The Arbitrator gives the appropriate weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 49 years old at the time of the accident and 55 years old at the time of the Arbitration Hearing. The Arbitrator notes the petitioner is nearing the end of one's customary work life. The Arbitrator gives the appropriate weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes Petitioner's AWW on the date of the accident was $320, and finds she is able to meet or even exceed those wages at a job in the "Medium" physical demand level. The Arbitrator gives the appropriate weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes Petitioner was restricted to the "Light/Medium" physical demand level due to a *prior* work accident and *prior* back surgery, and now is less restricted at the "Medium" physical demand level. The Arbitrator gives the appropriate weight to this factor.

Moreover, the records show that Petitioner recovered from surgery and reached MMI as of November 5, 2014, when she was last seen by her treating physician, Dr. Singh. She was found to be capable of work at the MEDIUM physical demand level.

Based on all of the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 25% loss of use of the person as a whole pursuant to §8(d)2 of the Act.

N. Credit

Respondent shall be given a credit of $57,465.17 for TTD, $NA for TPD, and $NA for maintenance benefits, for a total credit of $57,465.17.

O. Chain of Referral

The Arbitrator notes that all medical bills are paid. The Arbitrator finds that all Petitioner's treatment with Aunt Martha's Clinic, Dr. Qadir, Dr. Aranas, and Dr. Said was outside the chain of referral and is not compensable under the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF PEORIA)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Susan Pittman,

Petitioner,

vs.

NO: 15 WC 37116

20IWCC0389

Pella Windows,

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, notice, causation, medical expenses, temporary total disability and nature and extent, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, while correcting several clerical errors, said decision being attached hereto and made a part hereof.

The Commission corrects scrivener errors in the Arbitrator's decision at page 2 of the Form decision to show a claimed date of accident of 6/11/14 (not 10/22/14) and page 1 paragraph 2 of the Addendum to show Petitioner began working for Respondent on 10/9/06 (not 10/9/16).

All else otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision dated 5/1/19 is affirmed and adopted with changes as stated herein, and Petitioner's claim for compensation is denied.

20IWCC0389

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: JUL 10 2020
o:6/30/20
TJT/pmo
51

Thomas J. Tyrrell

Maria E. Portela

Kathryn A. Doerries

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

PITTMAN, SUSAN
Employee/Petitioner

Case# **15WC037116**

PELLA WINDOWS
Employer/Respondent

20IWCC0389

On 5/1/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.39% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2333 WOODRUFF JOHNSON & EVANS
JAY JOHNSON
4234 MERIDIAN PKWY SUITE 134
AURORA, IL 60504

0264 HEYL ROYSTER VOELKER & ALLEN
DANA HUGHES
300 HAMILTON BLVD
PEORIA, IL 61601

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

20 IWCC0389

- ☐ 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

Susan Pittman
Employee/Petitioner

v.

Pella Windows
Employer/Respondent

Case # **15** WC **37116**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gerald Granada**, Arbitrator of the Commission, in the city of **Peoria**, on **March 12, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **10/22/14**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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 $**33,103.70**; the average weekly wage was $**635.60**.

On the date of accident, Petitioner was **51** years of age, ***single*** with **0** dependent children.

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

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

Respondent shall be given a credit of $**0** for TTD, $**0** for TPD, $**0** for maintenance, and $**31,235.20** for other benefits, for a total credit of $**31,235.20**.

Respondent is entitled to a credit under Section 8(j) of the Act for amounts paid by the employer sponsored group health insurance plan.

ORDER

Petitioner failed to meet her burden of proof on the issues of accident and causation. Therefore 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 Gerald Granada

4/30/19
Date

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FINDINGS OF FACT

This case involves a Petitioner alleging injuries sustained while working for the Respondent on June 11, 2014. Respondent disputes Petitioner's claims and the issues in dispute are: 1) accident; 2) notice; 3) causation; 4) medical expenses; 5) TTD; and 6) nature and extent. As a procedural matter, the Petitioner originally alleged in her Application for Adjustment of Claim an accident date of October 22, 2014 and amended the accident date at the onset of this arbitration hearing. (AX 2)

Petitioner became an employee of Respondent on October 9, 2016. Petitioner testified that she worked for Respondent in the assembly of windows, in which she did a number of various activities at different work stations. She worked at three lines for Respondent, rotating every two hours. Respondent offered job duties videos that reflected these three lines. The videos were utilized during Petitioner's testimony. On the first job, the sash line, she would cut butyl, which is the hard substance that prevents leaks in a window. The window would go under a heating lamp to help soften the butyl for cutting. It was difficult to cut if it had not been heated. Petitioner said she would use her whole body to push the knife through the window, and she felt stress on her lower back while performing this activity. She would cut butyl two hours out of each eight hour shift. Workers on the sash line also did cladding and put the hardware on, but Petitioner rarely did those jobs. The sash line video fully depicted the jobs Petitioner did on that line. The Petitioner disagreed with the depiction of said job in the video, saying it would be unusual for the window to sit under that heat lamp as long as it did on the video. She also claimed the pace of the line was slow in the video, but confirmed that Respondent sounds a bell when a line is running too slow. Petitioner testified she could not hear the bell in the video with the sound turned up on the video.

Petitioner then described the jamb prep line and watched the Respondent's video depicting other employees perform the jobs at this station during her testimony. Respondent offered Ex. 2B as a depiction of the jamb prep line. Jamb prep was part of the three part rotation Petitioner performed daily, for two hours each time. The video depicted two people running the operation, but Petitioner testified that she would do this job alone. Petitioner also testified that the jamb prep video did not show one of the job requirements on the jamb line, which involved pressing metal into wood, using hands to shove it in. Petitioner would also use a hammer to do this job and she felt that motion in her lower back. The Petitioner did the first job depicted in the jamb prep video, but not the other two. All work on the jamb prep line was done at waist height.

The Petitioner then described a third job, which was called the stile rail press sash, as depicted in Respondent's Ex. No. 4. The video depicted two people working the job, but the Petitioner described working at this station alone. The video depicted a worker working at waist level or just slightly above. She did the glass layup job from 2006 to 2009. She would otherwise do the job as it was depicted in the video. Petitioner would work this job every two hours and rotate it with the other two jobs described in Respondent's Ex. No. 2b and 3b. Petitioner testified that she did not hear any bell on the video to signal the line was moving too slow.

The Petitioner testified that the machines never ran as smoothly as they did in the videos. She corrected the glass every day. They had to fix the butyl. She would adjust or fix windows ten to fifteen times per day. The largest glass was 45 x 76 inches but she did not know how much it weighed. She would lift the butyl on a big spool into the machine. The Petitioner prefaced several answers to questions about quantities or weight with "don't quote me on this." Petitioner testified that she had pain with bending and reaching into the machines. Cutting butyl and slamming the wood into the metal on the jamb prep line were the two most difficult tasks for her and neither task was depicted in any of the video footage.

Petitioner was asked about when she first noticed back pain. On this topic, the following question and answering session occurred. (T. 69)

Q. If the records show you did report back pain on June 11, 2014, would that be accurate?
A. I'm not certain.

Q. If the records from there show that, would you have any reason to disagree with that?
A. No.

Q. If the records reflect you requested FMLA days, does that sound familiar?
A. Yes.

Q. Did you have any specific injury on that date?
A. I'm not certain on that.

Q. If the records reflect that on June 11, 2014 that you went to the nurses' station, would you have any disagreement with that?
A. No.

Petitioner could not recall the details of any accident report or report of pain from June 11, 2014. She did not know the date. She did not know whether she walked up to the occupational health nurse at Pella or whether or not she reported back problems. She claims to have walked up with her coordinator. She did not prepare any accident or injury paperwork like she had done in the past for a prior worker's compensation claim involving her neck. Petitioner testified that she knew the procedure at Pella to report a work injury but that she did not do it on June 11, 2014.

Six months prior to her alleged accident date, Petitioner filed for FMLA in December of 2013. At that time, she was having pain in her legs. She was seeing Nurse Cornell at HSHS in Rushville. She thought it was varicose veins. Terrah Cornell, APN prepared Pella Corporation FMLA documentation on Petitioner's behalf for the leave commencing on December 17, 2013. Petitioner was also having low back pain. She described that her pain would come and go as part of her daily life. She would have flare ups. Nurse Cornell wrote "currently on prescription pain medications and muscle relaxers for chronic low back pain. Will need to be seen at least every three months for medication management." (RX 5) She was taking Tramadol and Vicodin as well as a muscle relaxer as needed on a daily basis for her pain. She had been doing so since November 2012. (RX 11)

Petitioner told Nurse Cornell what she did for a living but Nurse Cornell's records do not reflect a history of work-related symptoms. She did not go to the doctor on June 11, 2014. The first medical visit after the Petitioner's alleged date of accident is from August 6, 2014 and was primarily for leg pain and a refill of depression medications. (RX 11) The medical treatment record from that day notes a chronic history of lower back pain. The treatment plan did not include recommendations for the low back.

Petitioner could not recall the significance of October 22, 2014, the original date of accident as alleged on her Application for Adjustment of Claim. She did not recall whether she talked to the occupational nurse at Pella around that time. Her original Application for Adjustment of Claim alleged accidental injuries on October 22, 2014 and was filed November 17, 2015. (AX 2)

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On September 23, 2014, Petitioner reported leg pain to her primary care physician, Dr. Card with complaints of dragging her legs and tripping, which she thought was vascular. Dr. Card referred her to Dr. Mulconrey, who had treated Petitioner's neck in the past. On October 13, 2014, she saw Dr. Mulconrey with complaints of pain in her lower back with numbness in her buttocks, and pain running down her legs. She reported pain for the past year or so. She told them where she worked but his notes do not include a history of work injury. She wrote on the initial forms her complaints were due to work, and then she scratched it out. She said she was scared and wanted to make sure it was related to work.

Dr. Mulconrey recommended MRIs and ultimately performed surgery on November 25, 2014. (PX 3) She did not get better in the postoperative course. Petitioner underwent physical therapy and a home exercise program. In February of 2015, she continued to have pain down her legs and back pain while she was off work. Dr. Mulconrey referred Petitioner to Dr. Robbye Bell for injections – which Petitioner testified did not help, as she continued with low back pain after the injections.

Petitioner returned to Dr. Mulconrey after seeing Dr. Bell. Dr. Mulconrey recommended another MRI and ultimately another surgery. On December 15, 2015 Dr. Mulconrey performed a fusion at L4-5 and L5-S1. She continued with Dr. Mulconrey in postoperative until he released her from care without any work restrictions January 23, 2017. (PX 3) Petitioner did not return to work. She is currently on social security disability since 2016. Petitioner will be 55 on April 20, 2019.

Dr. Mulconrey testified via evidence deposition on June 18, 2018. (PX 1) He testified that Petitioner reported a 1-2 year history of low back pain worse over the past six months when he first saw her on October 13, 2014. She complained the pain was 7/10 with pain in the right buttocks, anterior portion of the thigh and calf and weakness in the right lower extremity. She did not report a history of work injury. (PX 1, p.9) He had a basic understanding of her work as a factory worker at "Pella Window Company." (PX 1, p.11) Dr. Mulconrey generated a letter for the Petitioner at her request on August 25, 2015. (PX 1, p.27) He opined the Petitioner had an underlying degenerative condition in her lumbar spine, and that the repetitive bending lifting and twisting and lifting of heavy weight may have led to further aggravation of the underlying disease.

On cross-examination, Dr. Mulconrey acknowledged a clinical phone call note from July 28, 2015 wherein the Petitioner requested that Dr. Mulconrey write a causation opinion. (PX 1, Dep. Exh. 5) In response to this request, Dr. Mulconrey agreed to write a letter for the Petitioner indicating her job may have "increased her lumbar pain." He would not go further to say her injury is work related since it had not been documented that way in the past. (PX 1, p.35) He acknowledged he had no specifics about her job at the time he wrote the note. Dr. Mulconrey further acknowledged that on Petitioner's new patient examination form, she indicated that she was not suffering from a work injury. (PX 1, Respondent Dep. Exh. 1) He initially believed Petitioner was capable of her regular work duties for Respondent based on his conversation with her about her work duties. (PX 1, p.41) When asked for disability paperwork purposes whether Petitioner's condition was work related, he indicated it was not. (PX 1, p.43) Dr. Mulconrey further went onto quantify his beliefs about Petitioner's work tasks. Specifically, he indicated repetitive bending meant "frequently working below waist level." (PX 1, p.44) He admitted no one was repetitively bending below waist level in the work video he reviewed. He believed the employees on the video were repetitively twisting and lifting. He admitted to not knowing the weights of the items lifted in the video. (PX 1, p.46) Petitioner told Dr. Mulconrey she was lifting heavy weight which he equates with repetitively lifting over 35lbs. He admitted his causation opinion could change if she were not required to lift that much. He admitted Petitioner's symptoms of pain in the low back and back down the legs

and into the buttocks were consistent with degenerative disc disease and the Petitioner's radiological findings. (PX 1, p.48) He opined that Petitioner's condition could naturally progress over time, regardless of activity. (PX 1, p.49)

Dr. Ryon Hennessy testified via evidence deposition on August 8, 2018. (RX 1) Dr. Hennessy is a spinal surgery, fellowship trained orthopedic surgeon, who was retained by Respondent to examine the Petitioner on January 6, 2017, review numerous medical records and studies, job duties descriptions, and prepare reports summarizing his findings and opinions. (RX 1, p.7) He identified degenerative changes in the Petitioner's lumbar spine dating back to 2001. X-rays obtained at Sarah Culbertson Memorial Hospital May 17, 2001 showed mild degenerative osteoarthritis with mild narrowing of the L5-S1 disc space. He noted that Petitioner complained of pain in her lower back and right buttocks. He found severe canal stenosis at L4-5 and moderate decreased disc space at L5-S1 causing stenosis in 2012. He opined the L5-S1 disc was collapsed in 2012 and identified disc protrusion facet arthropathy, severe central stenosis, and moderate foraminal stenosis at L4-5. He then reviewed the 2014 MRI obtained after the alleged work accident and found the findings were exactly the same as those identified in the 2012 MRI. The protrusion had gone further into the canal since 2012 due to natural progression of degenerative disc disease. The MRI of October 20, 2012 showed degenerative changes at L4 through S1 with moderate bilateral foraminal compromise at L5-S1, and significant canal stenosis at L4-5. (RX 11) Prior to that, on May 1, 2012, she presented to the emergency department at Culbertson Memorial Hospital with complaints of low back pain. (RX 11) She also complained of pain down the back of her right leg and was diagnosed with a right L5-S1 radiculopathy.

Dr. Hennessy took a history of Petitioner, one of repetitive trauma but also of a specific event on October 22, 2014, the originally alleged date of accident. On that specific date, she described to Dr. Hennessy lifting butyl that she dropped, and reported to the office that day. Respondent's occupational health nurse's notes from that time period do not reflect this. (PX 2) She filled out no forms and went home.

Dr. Hennessy also reviewed Respondent's job duties reports and video analyses. He reviewed the job duties with the Petitioner. Regarding the sash line, he noted no significant bending, frequent 10lb lifting, occasional 20lb lifting, and occasional 50lb lifting as described by Petitioner. Dr. Hennessy opined the jobs would not cause undo strain on the back.

Dr. Hennessy opined Petitioner's long-standing degenerative disc disease, facet arthropathy, spinal stenosis and lumbar radiculopathy dated back to 2001. He opined she suffered from degenerative processes but not a posttraumatic process. He found that none of the diagnoses were caused, aggravated or exacerbated by her work duties on or about the alleged accident date. He noted Petitioner reported no history of work event or work association in the medical treatment records, and none are noted by Dr. Mulconrey. Dr. Hennessy noted the first association of work is contained in records in 2015 after the first surgery.

Alisa Hammond was called by Respondent to testify at the hearing. Ms. Hammond works for Respondent as an occupational nurse and has been with Respondent in that position since November 30, 2009. She provides guidance on all workers compensation, short-term disability, long term disability, wellness programs, and FMLA. When an employee requests FMLA either on the phone or in her office, she guides them to the appropriate paperwork. Sometimes an employee can utilize FMLA over an extended period of time, if they have a chronic healthcare problem. An employee can utilize an extended 12-month FMLA with certain paperwork.

Ms. Hammond testified that Respondent's employees are aware of the procedure for reporting a work injury through orientation and through training with their department managers and coordinators. If an employee has a work injury, there is an incident report filled out with specific details about the work injury. Those practices and procedures were in place when the Petitioner had her prior neck claim as well as the current 2014 claim. Ms. Hammond described the Petitioner's December 2013 application for benefits under FMLA. (RX 5) Petitioner's healthcare provider described her as having chronic low back pain for which she would require intermittent leave and pain medications due to flare-up of back pain, which may prevent her from working. Once an employee requests an extended leave, they can call in or report to her in person their request to utilize FMLA time during that leave. The Petitioner called in for that type of leave request on June 11, 2014 as documented in Petitioner's Ex. No. 2. She did not work that day. She did not initiate any type of accident or injury paperwork for a work injury at that time, or any other. She did not report any back pain being related to work. She did not report that work duties were making her back feel worse or require treatment. At no point from June 11, 2014 until the time Petitioner no longer worked for Pella did she have a conversation about her back condition being related to work.

Ms. Hammond testified that she had numerous communications with the Petitioner over the course of her work history with Respondent. Ms. Hammond recalled conversations about Petitioner's veins in her legs. After June 11, 2014, the Petitioner did not miss work until she requested FMLA time for July 14, 2014. She did not miss any other time from work for FMLA reasons through August of 2014.

Ms. Hammond also watched the videos viewed by Petitioner during her testimony. She observed the Petitioner on the floor every day. She found no discrepancies with how Petitioner performed the work compared to the workers in the video and noted that the pace of work was the same. Ms. Hammond agreed that the task of pressing the wood into the metal was not depicted in the jamb press video and also agreed that Petitioner would be working alone in each station as opposed to the two workers depicted in the job videos. Ms. Hammond is not an ergonomist, though she is on the ergonomic team at Pella. She has never done the Petitioner's job for a full day. Ms. Hammond testified that Petitioner has had a prior workers' compensation claim, and therefore expected Petitioner to be familiar with the process to report an accident.

Respondent also called Donna Muehlbacher to testify. Ms. Muehlbacher is a certified occupational therapist and an ergonomic assessment specialist - working in those fields for the last 20-30 years. She has an associate's degree in occupational therapy and an ergonomic assessment specialist certificate. The certification allows her to look at different aspects of a work process to identify hazards and make recommendations. She has mostly worked in the realm of workers' compensation. Before performing job analyses, she had experience with work hardening. Ms. Muehlbacher has been self-employed in employers' services, consulting for the last five years of her practice.

Ms. Muehlbacher prepared the three job analysis reports Respondent offered at trial along with the accompanying DVDs marked Respondent's 2A-4B. In preparing her job analysis, she would do the following: contact the supervisor at the employer once that job analysis request had been made; schedule a time to meet with the supervisor at the employer and obtain information accordingly; take video of the job tasks; take measurements and view the job performed; collect information to develop and prepare a report utilizing all of that information; quantify the tasks and measure weights lifted throughout the job task; and conduct push-pull measurements using a chatillon gauge.

Ms. Muehlbacher identified the job analysis reports and job DVDs as those she prepared of the Petitioner's three job stations. Relative to the jamb prep job descriptions, offered as Respondent's 2A and B, Ms. Muehlbacher found it required no bending, no twisting, and 10lbs lifting maximum two to four times per shift, and frequent lift 3-5lbs ten plus times per hour up to 180 times per shift. She classified the job at the light level of physical demand based on the dictionary of occupational titles. T.152.

Ms. Muehlbacher identified Respondent's Ex. 3A and B as the sash line classic operator. She quantified there were no bending requirements, and lifting requirements were limited to 30lbs maximum one to ten times per day and then 10-15lbs ten plus times per day. The sash line classic required no twisting. She classified that job at the medium level of physical demand based on the full duty operator being required to lift up to 50lbs. However, the sash line job required no lifting greater than 30lbs.

Finally, Ms. Muehlbacher identified Respondent's 4A and B as the style rail press sash prep rotation. That job required occasionally bending, 4-6 ½ pounds lifting maximum ten plus times per hour and the same for frequent lifting, and no twisting. She classified that job in the light level of physical demand. She described the stations and rotations as having good recovery time. The recovery time allows the muscles to relax and take a break from the amount of time that the worker is performing a particular task, which Ms. Muehlbacher believed was good from an ergonomic standpoint.

Ms. Muehlbacher did not know the purpose for the job analyses. She had prepared a lot of job analysis reports for Respondent in the past. The jobs required frequent to continuous reaching at the waist level. She reviewed no medical records in connection with the case.

CONCLUSIONS OF LAW

1. Regarding the issues of accident and causation, the Arbitrator finds that the Petitioner has failed to meet her burden of proof. In support of this finding the Arbitrator relies on the testimony and evidence presented at trial – all of which cast doubt on the Petitioner's claims. Petitioner alleges to have sustained an accident while working for the Respondent on June 11, 2014, in which she injured her back, but the evidence does not support this claim. On the contrary, the evidence shows that the Petitioner had a noted history of back pain that culminated in her requesting FMLA leave for her back on June 11, 2014. Petitioner has had prior experience in reporting a work injury, yet she failed to report any work injury or exposure on June 11, 2014, or any date thereafter within 45 days. The Petitioner herself could not recall the details of any report of back pain to the Respondent on June 11, 2014. She did not seek any medical treatment for her low back until September, 2014 when she saw Dr. Card and even then, she did not report a work accident, nor make any mention of work activity having caused her back complaints. No medical records around the time of the alleged incident document any facts that might establish a causal relationship between Petitioner's work and her lumbar spine condition. On the contrary, the initial medical evidence described Petitioner's low back condition as chronic in nature, susceptible to flare ups.

Petitioner attempts to prove-up a repetitive trauma claim and relies on Dr. Mulconrey – who had treated Petitioner in her prior workers compensation case - to support such a claim. However, Dr. Mulconrey's support in this case is very tentative at best. Petitioner indicated that she was afraid to tell Dr. Mulconrey that she had a work injury – a claim the Arbitrator finds incredible, given that Petitioner has had at least one prior workers compensation claim, for which she received treatment from Dr. Mulconrey. Even more telling is the fact that Dr. Mulconrey agreed to write a letter for the Petitioner indicating her job may have increased her lumbar pain,

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but would not go further to say her injury is work related since it had not been documented that way in the past. It is significant that Dr. Mulconrey's records fail to document medical causation, especially given Dr. Mulconrey's prior professional relationship with the Petitioner. The facts show that the Petitioner failed to report a work injury or work association with her low back pain to Dr. Mulconrey, whom she had seen for her prior worker's compensation injury to her neck. Dr. Mulconrey's records are full of notations that the Petitioner was not reporting a work injury, as evidenced from the Petitioner's own paperwork, the doctors' dictation, the FMLA disability paperwork, and the clinical phone notes denying Petitioner's request to support that she had sustained a work injury based on lack of documentation in the records.

Given all these facts, the Arbitrator concludes that the Petitioner failed to prove that she sustained a work accident arising out of and in the course of her employment on June 11, 2014 or that her current condition of ill-being is causally related to her employment.

2. Based on the Arbitrator's findings above, all other issues are rendered moot.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Michael Anthony Hollinger,

Petitioner,

vs.

NO: 17 WC 34710

20IWCC0390

Spee-Dee Delivery Service,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 1, 2019, is hereby affirmed and adopted.

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

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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 $25,000.00. 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: JUL 10 2020
TJT:pmo
o 5/19/20
51

Thomas J. Tyrrell

Maria E. Portela

DISSENT

I respectfully dissent from the majority opinion awarding prospective medical treatment.

Petitioner, a delivery driver, sustained a work-related accident on October 11, 2017, while pulling a dolly, carrying a 160 pound package, up a flight of stairs. He sought medical attention on October 12, 2017, and received conservative care including physical therapy.

An MRI scan was performed on November 27, 2017, which revealed a right central to subarticular disc extrusion with causal migration at L3-L4 and narrowing of the right lateral recess and likely impingement of the right L4 nerve root. (PX4) Petitioner underwent a microdiscectomy at L3-L4, on May 2, 2018, with Dr. Ravindra Shitut.

Petitioner returned to Dr. Shitut's office on May 11, 2018, complaining of increased pain with radiation down his right leg. An MRI scan was performed on May 30, 2018, which, according to the radiologist, revealed "a right laminectomy at L3-L4. There is primarily granulation tissue within the epidural space. Perhaps very small amount of disc material measuring 6 x 4mm although significantly improved compared to the MRI from 11/27/2017. As a result of there is significant improvement in right lateral recess stenosis. There is enhancement of the right L4 nerve root within the thecal sac likely indicating mild inflammation/neuritis." (PX4) Petitioner returned to Dr. Shitut

on June 8, 2018, for follow-up reporting his back pain has continued even though it is not as bad as it was before the surgery. Dr. Shitut noted Petitioner has no detectable neurological deficits. He reviewed the May 30, 2018, MRI scan and noted some post-surgical scarring at L3-4 on the right side and a "very minute if any residual disc herniation that is not bad enough to necessitate additional surgery". (PX5) He recommended physical therapy followed by work conditioning and work hardening and to return in 6 weeks.

Petitioner contacted Dr. Shitut's office via telephone on July 6, 2018, and reported that on July 4 he had to pull his son out of a swimming pool and his back is hurting. Petitioner advised he has localized pain to his low back with no radiation of pain down his legs. (PX5) He was instructed to ice his low back, take muscle relaxers as prescribed and was prescribed a Medrol dose pack. He was to call next week if his symptoms did not improve. (PX5) Petitioner did not call the following week.

Petitioner returned to Dr. Shitut on July 20, 2018, for follow-up. Dr. Shitut noted Petitioner had repeat imaging studies done on May 30, 2018, and "has some postsurgical changes but no evidence of residual disc herniation. No repeat surgery is necessary." (PX5) Petitioner had residual symptoms of low back pain without sciatica and without any neurological deficit. (PX5) Petitioner advised Dr. Shitut that even after he completes his rehabilitation program, he will not be able to resume his regular job because it requires a heavy amount of lifting. Dr. Shitut noted Petitioner is probably right. Dr. Shitut stated Petitioner should complete his physical therapy and work hardening program before declaring him to be at MMI. (PX5)

Dr. Kevin Rutz, orthopedic surgeon, examined Petitioner on December 11, 2018, upon a referral from Petitioner's attorney. Petitioner reported low back pain and right lower extremity discomfort. (PX8) Dr. Rutz noted Petitioner has a 10 pack per year history of tobacco use. Examination revealed 5 over 5 strength in his hip adductors, abductors, quadriceps, hamstrings, ankle dorsiflexion, plantar flexion, and EHL. Sensation was diminished to the right lateral lower leg. The patient's hips and knees had full, painless range of motion and are stable to manipulation bilaterally. Straight leg raising was positive on the right with reproduction of right buttock and lower extremity discomfort. (PX8) Dr. Rutz diagnosed Petitioner's condition as a recurrent disc herniation at L3-L4 and recommended Petitioner undergo a revision discectomy and fusion. (PX8)

Dr. Rutz testified his surgical recommendation was based mostly on Petitioner's subjective reports of pain. (PX10, p.34) He further testified the lateral leg decreased symptomology only "sort of" fit the dermatome of L3-4 and called it a "soft finding". (TPX10, p.25) He stated, "[R]eally, what's most important is what his symptom timeline was, and how severe are your symptoms now, and how have they been trending over the last month, month after month after month." (PX10, p.25) Dr. Rutz testified he could not remember if he reviewed Dr. Shitut's records. (PX10, p.35)

At Respondent's request, Dr. Timothy Van Fleet, board certified orthopedic surgeon, examined Petitioner twice, for the first time, on February 20, 2018, pre-operatively, and again on

October 16, 2018, post-operatively. After the first examination and the review of the MRI scan, he agreed with Dr. Shitut's recommendation Petitioner undergo a right L3-L4 discectomy. (RX5, p.9)

Dr. Van Fleet examined Petitioner for a second time, post-operatively, on October 16, 2018. Petitioner was able to forward flex, touch his fingers to the level of his knees, he had good range of motion in his hips and knees, and he was neurologically intact. (RX5, p.11) Petitioner exhibited no neurotension signs, i.e. straight leg raise, or crossover straight leg raise, which would indicate there was no radiculopathy. (RX5, p.12) He contrasted the pre-operative MRI scan and report and postoperative MRI report and noted, in the post-operative report, the presence of granulation tissue but without significant compression of the nerve roots. He diagnosed Petitioner with post lumbar discectomy with chronic pain and found his symptoms related to what he termed "failed back syndrome". Petitioner was not in need of further medical treatment, and he recommended Petitioner undergo an FCE. Dr. Van Fleet subsequently reviewed the post-operative MRI images of May 30, 2018, and testified it showed evidence of granulation tissue and a small protrusion of disc which he described as a bulge more or less. (RX5, p.21) The large fragment that had been present during the pre-operative imaging study was gone. His recommendations for treatment did not change based on his review of the post-operative MRI scan. (RX5, p.21)

An FCE was completed on November 20, 2018, where Petitioner demonstrated statistically consistent effort during material handling and static strength testing, however, overall pain questionnaires were high indicating client has high pain perceptions. Petitioner demonstrated capabilities and functional tolerances to function within the heavy physical demand level with the heaviest weight able to lift within the demand level 75 pounds from waist to shoulder occasionally. (PX7) The physical demand level of Petitioner's job was noted as "heavy". (PX7)

The Workers' Compensation Act requires the employer to provide all "necessary first aid, medical and surgical services . . . reasonably required to cure or relieve from the effects of the accidental injury." 820 ILCS 305/8(a). It is within the Commission's province to judge the credibility of the medical experts and resolve conflicting medical opinions. *O'Dette v. Industrial Comm'n*, 79 Ill. 2d 249, 253, 403 N.E.2d 221, 223 (1980); *Fickas v. Industrial Comm'n*, 308 Ill. App. 3d 1037, 1041, 721 N.E.2d 1165, 1169 (1999); *Hosteny v. Ill. Workers' Comp. Comm'n*, 397 Ill. App. 3d 665, 675 (2009). In this case, the medical opinions concerning Petitioner's need for surgery to cure or relieve the effects of the accidental injury are in conflict.

I find the medical opinions of Dr. Shitut and Dr. Van Fleet more credible and persuasive than Dr. Rutz's opinion. Dr. Shitut was Petitioner's treating orthopedic surgeon. He examined Petitioner post-operatively and noted Petitioner had localized low back pain with no radiation of pain down his legs. On July 20, 2018, Dr. Shitut noted he had residual symptoms of low back pain without sciatica and without neurological deficits. Dr. Shitut reviewed the post-operative MRI scan and the radiologist's interpretation and opined "…is a very minute if any residual disc herniation they (sic) are not bad enough to necessitate additional surgery." (PX5)

Likewise, Dr. Van Fleet opined there was not a recurrent disc herniation. He testified there was no evidence of neuro-tension signs on examination which would be indicative of radiculopathy. (RX5, p. 11) He further testified:

A: Well, my—my—the reasoning for saying that is twofold. Number one, he has no evidence of tension signs on physical exam.

Q: Okay.

A: Every patient I've ever seen with a recurrent disc herniation has a positive tension sign, and in fact if they don't have a positive tension sign, I don't think they have radiculopathy. I don't operate on them because they don't have evidence of true radicular findings. If you have radiculopathy secondary to a disc herniation, you will have a tension sign more likely than not.

Q: Okay.

A: And certainly, in a setting of high risk patient who happens to have compensation involved, you should be sure that you have physical examination findings that are correlative to your assumption of your diagnosis. (RX5, p.23)

Dr. Van Fleet's opinion is based on his examination, his review of the medical records and MRI scans, and the lack of clinical findings to correlate with the findings on the MRI scan. His opinion is further supported by the findings in Dr. Shitut's records dated July 6, 2018, and July 20, 2018, where Petitioner reports he has no radiation of pain down his legs, no sciatica, and Petitioner demonstrates no neurological deficits.

In contrast, Dr. Rutz's surgical recommendation for a repeat microdiscectomy and fusion is not supported by the evidence. Dr. Rutz testified that the basis for his opinion for a surgical recommendation is "persistent symptoms" ever since his work injury. However, Dr. Rutz could not recall if he even reviewed Dr. Shitut's treating records. Notably, Dr. Shitut's treating records indicate Petitioner did not have persistent symptoms since the date of accident, i.e., he denied radiation of pain into his legs on July 6, 2018, and denied sciatica on July 20, 2018. Moreover, Dr. Van Fleet's exam likewise showed no evidence of any tension signs. (RX5, p.11) Thus, the basis for Dr. Rutz's recommendation for a repeat microdiscectomy and fusion is unsupported by the evidence and therefore not credible.

The substantiated, corroborated and consistent medical opinions of Dr. Shitut and Dr. Van Fleet are more credible and persuasive than that of Dr. Rutz's. Dr. Shitut's opinion that Petitioner's condition did not necessitate surgery is supported by the objective diagnostic tests and the paucity of clinical findings as noted in his medical records. Dr. Van Fleet reviewed the medical records, reviewed the diagnostic studies and examined Petitioner, and opined a repeat microdiscectomy is not warranted and, moreover, a fusion breaches the standard of care. These opinions are credible,

20IWCC0390

more persuasive and should be adopted. Therefore, I disagree with the award of prospective medical in this case and respectfully dissent.

Kathryn A. Doerries

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

HOLLINGER, MICHAEL ANTHONY Case# **17WC034710**

Employee/Petitioner

SPEE-DEE DELIVERY SERVICES

Employer/Respondent

20IWCC0390

On 8/1/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

4620 ADWB LLC
JOHN WINTERSCHEIDT
51 EXECUTIVE PLAZA COURT
MARYVILLE, IL 62062

2674 BRADY CONNOLLY & MASUDA PC
FARRAH L HAGAN
211 LANDMARK DR SUITE C-2
NORMAL, IL 61761

20IWCC0390

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)

Michael Anthony Hollinger
Employee/Petitioner

v.

Spee-Dee Delivery Service
Employer/Respondent

Case # 17 WC 34710

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 7, 2019. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's 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, October 11, 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 $17,295.25; the average weekly wage was $665.20.

On the date of accident, Petitioner was 38 years of age, married with 3 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 $27,367.80 for TTD, $9,236.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $36,603.80.

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 for medical treatment provided to Petitioner, as identified in Petitioner's Exhibit 9, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

Respondent shall authorize and pay for prospective medical treatment including, but not limited to, the revision discectomy and fusion as recommended by Dr. Kevin Rutz.

Respondent shall pay Petitioner temporary total disability benefits of $443.47 per week for 57 2/7 weeks commencing May 2, 2018, through June 7, 2019, as provided in Section 8(b) of the Act.

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

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

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

William R. Gallagher, Arbitrator
ICArbDec19(b)

July 30, 2019
Date

AUG 1 – 2019

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged he sustained an accidental injury arising out of and in the course of his employment by Respondent on October 11, 2017. According to the Application, "While delivering packages" Petitioner sustained an injury to the "Low back and body as a whole" (Arbitrator's Exhibit 2). This case was tried in a 19(b) proceeding and Petitioner sought an order for payment of medical bills and temporary total disability benefits as well as prospective medical treatment. Respondent disputed liability on the basis of causal relationship as well as the reasonableness and necessity of some of the prior medical treatment and the prospective medical treatment being sought (Arbitrator's Exhibit 1).

In regard to temporary total disability benefits, Petitioner claimed he was entitled to temporary total disability benefits of 57 2/7 weeks, commencing May 2, 2018, through June 7, 2019 (the date of trial). Respondent claimed Petitioner was entitled to temporary total disability benefits of 29 weeks, commencing May 2, 2018, through November 20, 2018. Petitioner and Respondent stipulated Petitioner was entitled to temporary partial disability benefits for 28 5/7 weeks, commencing October 12, 2017, through May 1, 2018, and that said benefits had been paid in full (Arbitrator's Exhibit 1).

The prospective medical treatment sought by Petitioner was surgery which consisted of a revision discectomy and fusion at L3-L4 as recommended by Dr. Kevin Rutz, an orthopedic surgeon. As noted herein, Respondent has taken the position that the surgery recommended by Dr. Rutz is medically unreasonable and unnecessary, based upon the opinion of their Section 12 examiner, Dr. Timothy VanFleet, an orthopedic surgeon (Arbitrator's Exhibit 1).

Petitioner worked for Respondent as a delivery driver. On October 11, 2017, Petitioner was pulling a dolly up a flight of stairs which had a package on it that weighed approximately 160 pounds. One of the wheels on the dolly broke and Petitioner experienced an immediate onset of pain in his low back.

Petitioner initially sought medical treatment at Gateway Occupational Health on October 12, 2017. At that time, Petitioner complained of low back pain which he rated as 6 to 7/10. Petitioner was diagnosed with a lumbar strain, was prescribed medication and various work restrictions were imposed (Petitioner's Exhibit 1).

Petitioner returned to Gateway Occupational Health on October 19 and October 26, 2017. On examination, Petitioner had muscular spasm, a decreased range of motion and straight leg raising on the right caused pain in the lumbar region. On October 26, 2017, physical therapy was ordered (Petitioner's Exhibit 1).

Petitioner received physical therapy from November 7, through November 17, 2017. On November 14, 2017, Petitioner was seen at Gateway Occupational Health by Dr. Christopher Knapp. Dr. Knapp opined Petitioner had sustained a lumbar strain but had not improved with medication and physical therapy. He ordered an MRI scan (Petitioner's Exhibit 1).

The MRI was performed on November 27, 2017. According to the radiologist, the MRI revealed an annular bulge and right central disc extrusion at L3-L4 with likely impingement of the right L4 nerve root (Petitioner's Exhibit 4).

Petitioner was subsequently seen and treated by Dr. Ravi Shitut, an orthopedic surgeon. On December 18, 2017, Dr. Shitut reviewed the MRI and opined it revealed a herniated disc at L3-L4. Dr. Shitut recommended Petitioner undergo a microdiscectomy at L3-L4 and imposed light duty work restrictions, specifically, no lifting over 15 pounds and no driving (Petitioner's Exhibit 5).

At the direction of Respondent, Petitioner was examined by Dr. Timothy VanFleet, an orthopedic surgeon, on February 20, 2018. In connection with his examination of Petitioner, Dr. VanFleet reviewed medical records provided to him by Respondent. Dr. VanFleet diagnosed Petitioner with lumbar disc disease and lumbar radiculopathy and opined Petitioner should undergo a right L3-L4 discectomy. Dr. VanFleet opined the diagnosis and recommended surgery were related to the accident of October 11, 2017. He also noted there was a 12 to 15% risk of recurrence following surgery (Respondent's Exhibit 1).

Dr. Shitut performed surgery on May 2, 2018. The procedure consisted of a microdiscectomy on the right at L3-L4 (Petitioner's Exhibit 6).

Petitioner was subsequently evaluated by Jill Speca, a Physician Assistant associated with Dr. Shitut, on May 11, 2018. At that time, Petitioner complained of increased pain with radiation down the right leg. Petitioner was prescribed oxycodone and Valium as needed for pain (Petitioner's Exhibit 5).

On May 23, 2018, Petitioner contacted Dr. Shitut's office and advised he was continuing to have right hip/leg pain. An MRI scan was ordered (Petitioner's Exhibit 5).

The MRI was performed on May 30, 2018. According to the radiologist, the MRI revealed a right laminectomy with enhancing granulation tissue within the laminectomy bed and adjacent epidural space. It also noted the presence of a very small amount of non-enhancing nidus possibly a residual or recurrent disc herniation. There was also enhancement of the right L4 nerve root likely indicating mild inflammation/neuritis (Petitioner's Exhibit 4).

Dr. Shitut saw Petitioner on June 8, 2018, and reviewed the MRI scan. He opined the surgical scarring at L3-L4 on the right was a "...very minute if any residual disc herniation" which was not bad enough to necessitate additional surgery. Dr. Shitut ordered work conditioning/hardening (Petitioner's Exhibit 5).

Petitioner participated in work conditioning/hardening in June/July, 2018. When Petitioner was seen by Dr. Shitut on July 20, 2018, he still had some work conditioning/hardening sessions to attend. Petitioner advised Dr. Shitut that he did not believe he would be able to return to work the job he had because of the heavy lifting even after he completed work conditioning/hardening. Dr. Shitut noted Petitioner was probably correct. Dr. Shitut opined Petitioner was post lumbar

microdiscectomy with residual symptoms. He ordered a functional capacity evaluation (FCE) (Petitioner's Exhibit 5).

At the direction of Respondent, Petitioner was examined by Dr. VanFleet for the second time on October 16, 2018. In connection with his examination of Petitioner, Dr. VanFleet reviewed medical records provided to him by Respondent, as well as the MRI obtained prior to surgery, but not the MRI obtained afterward. Dr. VanFleet's diagnosis was post lumbar discectomy with chronic pain which he opined was "bordering" on a failed back syndrome. Although Dr. VanFleet did not have the post operative MRI, he reviewed the report and noted the presence of granulation tissue, but without significant compression of the nerve roots. Dr. VanFleet opined Petitioner did not need any further medical treatment. In regard to Petitioner's work restrictions, he agreed with Dr. Shitut that Petitioner should undergo an FCE (Respondent's Exhibit 2).

The FCE was performed on November 20, 2018. According to the examiner, Petitioner demonstrated a consistent effort during testing. Petitioner was able to perform 22.22% (4/18) of the job demands of a delivery driver (Petitioner's Exhibit 7).

At the direction of his counsel, Petitioner was examined by Dr. Kevin Rutz, an orthopedic surgeon, on December 11, 2018. In connection with his examination of Petitioner, Dr. Rutz reviewed medical records and both MRI scans. On examination, Petitioner had a decreased range of motion, right greater than left low back pain, a positive straight leg raising on the right and diminished sensation in the right lower leg. Dr. Rutz opined Petitioner had a right L3-L4 recurrent disc herniation with right leg radiculopathy. Dr. Rutz recommended Petitioner undergo surgery consisting of a right L3-L4 revision discectomy and fusion (Petitioner's Exhibit 8).

At the direction of Respondent, Dr. VanFleet reviewed Dr. Rutz' report and prepared a report regarding same on February 26, 2019. Dr. VanFleet noted that when he examined Petitioner on October 16, 2018, there were no "tension signs" on examination. Dr. VanFleet opined Petitioner was not a candidate for surgery and noted Petitioner was a smoker which he anticipated would lead to a poor result because Dr. Rutz was recommending a fusion. Dr. VanFleet again noted he had not personally reviewed the post operative MRI and had only reviewed the radiologist's report. He requested that that MRI be provided to him for his review (Respondent's Exhibit 3).

At Respondent's direction, Dr. VanFleet reviewed the MRI of May 30, 2018, and the FCE of November 20, 2018, and prepared a report regarding same on April 30, 2019. He opined the MRI of May 30, 2018, revealed a small disk protrusion at L3-L4, but made no comment whether this changed his prior opinion about Dr. Rutz' surgical recommendation. In regard to the FCE, Dr. VanFleet opined it was valid, Petitioner did not exhibit signs of malingering or symptom magnification and, given the fact Petitioner could only perform four out of 18 of the demands of his job, he would not be able to return to work as a delivery driver (Petitioner's Exhibit 4).

Dr. Rutz was deposed on April 26, 2019, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Rutz' testimony was consistent with his medical report and he reaffirmed the opinions contained therein. In regard to his review of the MRI of May 30, 2018, Dr. Rutz testified it revealed a small recurrent disc herniation on the right at L3-L4 with right sided laminectomy post surgical changes. He testified Petitioner's decreased

sensation in the right lower leg loosely correlated with the MRI findings, but the positive straight leg raising on the right was consistent with a recurrent disc herniation. Dr. Rutz also stated there were no signs of symptom magnification or malingering by Petitioner (Petitioner's Exhibit 10; pp 12-15).

Dr. Rutz testified regarding his recommendation Petitioner undergo a repeat discectomy and fusion. Specifically, he noted Petitioner was not getting better and predicted that there was an 80 to 90% chance Petitioner would be able to return to work at full duty following surgery (Petitioner's Exhibit 10; pp 20-21).

On cross-examination, Dr. Rutz agreed Petitioner being a smoker did increase the risk of nonunion of a fusion. Dr. Rutz said that nonunion in fusions, even with smokers, is presently about 15%, at most. He reaffirmed the fact Petitioner did not exhibit any signs of malingering or symptom magnification (Petitioner's Exhibit 10; pp 36-38).

Dr. VanFleet was deposed on May 22, 2019, and his deposition testimony was received into evidence at trial. On direct examination, Dr. VanFleet's testimony was consistent with his medical reports and he reaffirmed the opinions contained therein. Specifically, Dr. VanFleet testified Petitioner did not need any further medical treatment because he had undergone surgery and was found to be at MMI. He described Petitioner's condition as being a "failed back syndrome" which he explained meant Petitioner had an operation, did not get better and there is nothing more that can be done for him (Respondent's Exhibit 5; pp 14-16).

When Dr. VanFleet was questioned about Dr. Rutz' recommendation Petitioner undergo a redo discectomy and fusion, Dr. VanFleet stated that even if someone had a recurrent disc herniation at L3-L4, a redo discectomy would be indicated, but not a fusion. He also stated that Petitioner being a smoker diminished the odds of there being a solid fusion (Respondent's Exhibit 5; pp 16-18).

Dr. VanFleet also testified the basis for performing a fusion was instability and he opined there was no medical documentation Petitioner was unstable at L3-L4. He also stated the lack of positive tension signs was indicative of there being no radiculopathy (Respondent's Exhibit 5; pp 20-22).

On cross-examination, Dr. VanFleet was questioned about the reasonableness and necessity of the surgery that was recommended by Dr. Rutz. Dr. VanFleet testified that if Dr. Rutz proceeded with the discectomy and fusion at L3-L4 that it would be an unreasonable and unnecessary medical procedure (Respondent's Exhibit 5; pp 57-58).

At trial, Petitioner testified he continues to have severe low back pain with radiation into his right hip, buttock and leg as well as numbness in the front of his right shin. Petitioner has not been able to work since shortly before the first surgery. He wants to proceed with the surgery as recommended by Dr. Rutz.

Conclusions of Law

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

The Arbitrator concludes Petitioner's current condition of ill-being is causally related to the accident of October 11, 2017.

In support of this conclusion the Arbitrator notes the following:

There was no dispute Petitioner sustained a work-related accident on October 11, 2017, which caused an injury to his low back.

Prior to Dr. Shitut performing surgery at L3-L4, Respondent's Section 12 examiner, Dr. VanFleet, evaluated Petitioner and opined Petitioner had lumbar disc disease and lumbar radiculopathy and should undergo a discectomy at L3-L4.

Petitioner's Section 12 examiner, Dr. Rutz, opined that subsequent to the discectomy performed at L3-L4, Petitioner had a recurrent disc herniation at L3-L4.

Respondent's Section 12 examiner, Dr. VanFleet, disagreed with Dr. Rutz' diagnosis of a recurrent disc herniation at L3-L4; however, he opined Petitioner had a "failed back syndrome."

Based upon the preceding, the Arbitrator finds Petitioner's current condition of ill-being is causally related to the accident of October 11, 2017.

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

Based upon the Arbitrator's conclusion of law in disputed issue (F) the Arbitrator concludes that all of the medical treatment provided to Petitioner was reasonable and necessary and Respondent is liable for payment of medical bills incurred therewith.

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibit 9, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

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

The Arbitrator concludes Petitioner is entitled to prospective medical treatment including, but not limited to, the repeat discectomy and fusion at L3-L4 as recommended by Dr. Rutz.

In support of this conclusion the Arbitrator notes the following:

Dr. Rutz examined Petitioner, reviewed the MRI scans and opined Petitioner had a recurrent disc herniation at L3-L4 and a repeat discectomy and fusion at L3-L4 was indicated.

When Dr. Rutz examined Petitioner, his findings on examination were consistent with an L3-L4 recurrent disc herniation and Petitioner exhibited no signs of symptom magnification or malingering.

When Dr. Rutz testified, he predicted an 80 to 90% chance of Petitioner being able to return to work full duty following surgery.

Respondent's Section 12 examiner, Dr. VanFleet, opined Petitioner was at MMI and the surgery recommended by Dr. Rutz was unreasonable and unnecessary. Dr. VanFleet was, in fact, stating that if Dr. Rutz proceeded with the surgery he recommended, Dr. Rutz would be guilty of professional negligence.

Dr. VanFleet also opined Petitioner has a "failed back syndrome" and his current permanent restrictions will not allow Petitioner to return to work as a delivery driver. Obviously, adopting Dr. VanFleet's opinion would give Petitioner a zero percent chance of his ever being able to return to work as a delivery driver. However, Dr. VanFleet did agree with Dr. Rutz that Petitioner did not exhibit any signs of symptom magnification or malingering.

Based upon the preceding, the Arbitrator finds the opinion of Dr. Rutz to be more persuasive than that of Dr. VanFleet in regard to Petitioner's need for prospective medical treatment.

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 57 2/7 weeks commencing May 2, 2018, through June 7, 2019.

In support of this conclusion the Arbitrator notes the following:

Since May 2, 2018, Petitioner has been subject to work restrictions which Respondent could not accommodate. Petitioner has been unable to work since that time.

William R. Gallagher, Arbitrator

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Raul Madrigal,

Petitioner,

vs.

NO: 17 WC 25147

Chicago Meat Authority,

20IWCC0391

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petitions for Review under §19(b) 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's current condition of ill-being regarding his right shoulder is causally related to the work injury. The Commission modifies the Arbitrator's Decision and finds Petitioner is entitled to prospective medical treatment in the form of the recommended right shoulder surgery. The Commission further modifies the Arbitrator's Decision and finds Petitioner is entitled to additional temporary total disability ("TTD") benefits. Finally, 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

At the arbitration hearing, Petitioner testified through a Spanish language interpreter. Petitioner testified that he communicated with his medical providers as well as Respondent's Section 12 examiner through a Spanish language interpreter as well.

Petitioner has worked as a butcher in Respondent's plant since approximately 2010. Petitioner works on a long assembly line with other butchers. His job duties involve grabbing and deboning slabs of meat. He testified that sometimes meat parts fall on the floor while they work. He testified that on the date of accident, at 6 p.m. he was walking to the cafeteria for a break when he slipped on water and meat debris on the floor. Petitioner testified that he fell directly onto his right shoulder. He fell onto a cement floor.

Petitioner testified he never had any complaints regarding his right arm or shoulder before this work accident. Under cross-examination, Petitioner testified that before he began working for Respondent, he was a butcher at a Sara Lee plant on the south side of Chicago. He has worked as a butcher for 28 years and has never had any problems with his job duties before the work injury.

Petitioner visited an urgent care clinic approximately one hour after his fall. (PX 1). He reported slipping and falling at work and landing on his right shoulder. X-rays of the right arm taken that day were negative for any gross fractures. Petitioner was prescribed medication and a sling and was taken off work. On August 18, 2017, Dr. Sompalli, an orthopedic doctor, first examined Petitioner. Petitioner complained of pain rating 9/10 radiating to his neck and right shoulder blade. He denied any right shoulder pain before his fall. Dr. Sompalli suspected a full thickness traumatic rotator cuff tear and ordered an MRI and physical therapy. Petitioner last visited the clinic on August 25, 2017.

On August 30, 2017, Petitioner began chiropractic treatment with Dr. Aleman. (PX 4). Petitioner reported falling on his right side and hitting his shoulder, right side, and head on the floor. He complained of cervical, right shoulder, and thoracic pain. The chiropractor diagnosed cervical radiculitis, cervical disc degeneration, thoracic sprain, right shoulder tendinitis, and a right shoulder sprain. He performed electrical stimulation and manipulation and recommended a five-week course of treatment. Petitioner received chiropractic treatment with limited improvement. The October 5, 2017, right shoulder MRI had the impression of a supraspinatus and infraspinatus full tear with subluxation of the humeral head in relationship to the glenoid, and AC arthrosis. (PX 5). After reviewing the MRI results, Dr. Aleman referred Petitioner to Dr. Wolin, an orthopedic surgeon.

Dr. Wolin examined Petitioner on November 7, 2017. (PX 6). Petitioner reported slipping and falling at work and hitting his right shoulder. Petitioner complained of weakness and problems with ADLs as well as pain on the side of his shoulder that wakes him up at night. He denied any prior problems with his right shoulder. Dr. Wolin interpreted the MRI as showing a large full-thickness rotator cuff tear. He recommended right shoulder arthroscopy with rotator cuff repair, possible patch augmentation, and possible open biceps tenodesis. There are no further office visit notes.

Expert Opinions and Testimony

Dr. Steven Mash – Respondent Section 12 Examiner

Dr. Mash, an orthopedic surgeon, examined Petitioner on behalf of Respondent on December 15, 2017. (RX 1). He diagnosed a right shoulder contusion superimposed on a rotator cuff tear. Dr. Mash opined the MRI showed a complete chronic rotator cuff tear as seen by the combination of a high-riding humerus and complete retraction. He further opined that Petitioner's described mechanism of injury of a direct blow to the shoulder, would not cause a rotator cuff tear. He opined that as a result of the work injury, Petitioner sustained a significant contusion to the right shoulder which had resolved. According to Dr. Mash, Petitioner's work injury only temporarily aggravated his preexisting right shoulder condition.

Dr. Mash opined that Petitioner's need for surgery was completely unrelated to the work accident; instead, it was solely related to his preexisting full-thickness rotator cuff tear. He opined that Petitioner reached MMI for the work injury. He wrote,

> "...this claimant does have objective findings to support his subjective complaints. He has positive findings on physical examination and MRI. Even though the patient denies prior history of difficulty to his right shoulder, the mechanism of injury described by claimant, that being a direct blow to the shoulder, is not consistent with causation for a complete retracted rotator cuff tear. The complete retraction and proximal migration of the humeral head are imaging findings that are consistent with chronic rotator cuff arthropathy which would not have been caused by the single episode described by this claimant."

Id.

Dr. Mash testified via evidence deposition on June 21, 2018. (RX 2). His testimony was consistent with his IME report. He testified that the edema seen on Petitioner's right shoulder MRI was due to the bone rubbing against the above bone. He also testified that acute tears show little retraction, whereas significant retraction of the rotator cuff happens because both the muscle and tendon atrophy. According to Dr. Mash, there would be no significant retraction of Petitioner's rotator cuff if the MRI findings were the result of a direct blow as described by Petitioner. Dr. Mash disagreed with Dr. Wolin's rebuttal opinion. He testified that Dr. Wolin was not referring to any existing literature when he opined that a direct impact can cause rotator cuff tearing. Dr. Mash testified that the MRI revealed significant retraction of the infraspinatus. He opined most of Petitioner's complaints relate to the supraspinatus findings.

Under cross-examination, Dr. Mash testified that to a reasonable degree of medical and surgical certainty, direct blows to the shoulder do not cause rotator cuff tears. He agreed that Petitioner reported no prior injuries or complaints regarding the right shoulder; however, the doctor was very skeptical that Petitioner had no prior right shoulder complaints in light of the significant chronic MRI findings.

Dr. Preston Wolin – Treater

On January 14, 2018, Dr. Wolin reviewed Dr. Mash's Section 12 report and wrote a narrative report to Petitioner's attorney in response. (PX 6). He wrote that in his experience, a direct impact can case rotator cuff tearing because the impact produces a downward force on the shoulder. While he agreed that there was evidence of a chronic tear of the supraspinatus, Dr. Wolin did not believe there was evidence of atrophy of the infraspinatus muscle. He wrote:

> "The infraspinatus tendon is retracted only to the level of the midpoint of the humeral head. These findings indicate that the infraspinatus tear is not chronic and is in fact consistent with an injury occurring at the time of the reported work accident. It is well

> known that [an] isolated supraspinatus tear can be well compensated for as long as there is an intact infraspinatus. In this case, I believe that the supraspinatus tear was in fact pre-existing, however, the infraspinatus tear resulted in decompensation of the rotator cuff complex leading to the pain and weakness seen on the physical examination."

Id. The doctor opined that the recommended surgery is causally related to the work injury. Dr. Wolin continued to prescribe work restrictions.

Petitioner testified that he would like to proceed with the shoulder surgery recommended by Dr. Wolin. He is right-handed and is able to drive. He does not help a lot around the house. He testified that he spends most of his time at home in his yard. He testified that he tried to work someplace since the injury but did not receive any work because he can't lift his right arm. He testified that he is unable to lift his right arm like he used to before his fall. The highest point where he can lift the arm still has the elbow lower than shoulder level. He testified that he lacks strength in the arm. Petitioner testified that he has not worked in any capacity since the date of accident. He currently only takes over the counter Tylenol to treat his ongoing complaints.

Conclusions of Law

Petitioner bears the burden of proving every element of his 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 the denial of prospective medical treatment. The Commission also 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.

As an initial matter, the Commission reverses the Arbitrator's finding that the January 14, 2018, narrative report authored by Dr. Wolin is inadmissible. The Commission finds there were no grounds upon which the Arbitrator could legitimately reject the admission of the narrative report. After all, Respondent raised no objection to the admission of the narrative report. Furthermore, Dr. Mash reviewed Dr. Wolin's narrative report and gave testimony rebutting the opinions Dr. Wolin expressed in his report. Therefore, the Commission admits Petitioner's Exhibit 6 in its entirety, including the January 14, 2018, narrative report.

After carefully weighing the evidence, the Commission concludes that Petitioner met his burden of proving his current condition of ill-being regarding his right shoulder is related to the work accident. The Commission finds the most credible evidence proves Petitioner sustained a significant right shoulder injury after he slipped and fell at work and landed directly onto his right shoulder. Dr. Wolin, Petitioner's treating physician, interpreted the October 2017 right shoulder MRI as revealing a full-thickness rotator cuff tear. After examining Petitioner, he recommended Petitioner undergo right shoulder arthroscopy with a rotator cuff repair, possible patch augmentation, and possible open biceps tenodesis. In his January 2018 narrative report, Dr. Wolin credibly opined that while the MRI certainly showed evidence of a chronic tear of the

20 IWCC0391

supraspinatus, there was no evidence of atrophy of the infraspinatus tendon. He further opined that the lack of atrophy of the infraspinatus tendon indicates the infraspinatus tear is not chronic and instead is consistent with a traumatic injury occurring during Petitioner's fall at work. Dr. Wolin also credibly opined that Petitioner's described mechanism of injury—falling directly onto his right shoulder—can cause the rotator cuff tearing seen on the MRI. The doctor provided a credible explanation that the direct impact on the shoulder produces a downward force on the shoulder that can cause a rotator cuff tear.

Respondent's Section 12 examiner, Dr. Mash, disagreed with several of Dr. Wolin's conclusions. In contrast to Dr. Wolin, Dr. Mash interpreted the right shoulder MRI as showing a chronic complete right rotator cuff tear with retraction. Dr. Mash disagreed with Dr. Wolin's opinion that the mechanism of injury described by Petitioner could cause a complete retracted rotator cuff tear. The doctor also opined that the majority of Petitioner's complaints were due to the chronic supraspinatus tendon findings, not the condition of the infraspinatus tendon. While Dr. Mash believed Petitioner credibly reported his current symptoms, he did not believe Petitioner's report that he never had any prior complaints regarding the right shoulder. The doctor's disbelief in Petitioner's statements regarding a lack of any prior complaints is based solely on his interpretation of the right shoulder MRI. Dr. Mash opined that this history of a lack of prior complaints is inconsistent with his interpretation of the MRI. Dr. Mash opined that Petitioner only sustained a right shoulder contusion, which resulted in a temporary aggravation of his preexisting chronic rotator cuff tear. Thus, he concluded the need for surgery to repair the right shoulder is unrelated to the work accident.

After carefully considering the totality of the evidence, the Commission finds Dr. Wolin's opinions regarding the causal connection of Petitioner's work accident to his right shoulder condition and need for surgery are the most credible. The opinions of Dr. Wolin are supported by Petitioner's testimony and the medical records. Although Dr. Mash was skeptical of Petitioner's reports that he never experienced any problems with his right shoulder before his fall, the evidence simply does not support his skepticism. Petitioner has worked as a butcher for 28 years and testified that he never had any problems with his right shoulder before his work injury. There is no evidence of any pre-accident complaints about or treatment for the right shoulder. Furthermore, Petitioner testified that before his fall he never had any trouble completing his intensive and repetitive work duties. Dr. Mash's opinion that Petitioner's ongoing complaints actually support his conclusion that the work accident only temporarily aggravated Petitioner's preexisting right shoulder condition lacks credibility in light of the evidence. The most credible evidence leads the Commission to conclude that Petitioner's current condition of ill-being regarding his right shoulder is causally related to the August 12, 2017, work accident.

As Petitioner's current condition is causally related to the work accident, the Commission must also reverse the Arbitrator's denial of prospective medical treatment. As already discussed, Petitioner's current condition regarding the right shoulder is causally related to the work accident. The Commission finds the right shoulder surgery recommended by Petitioner's treating physician, Dr. Wolin, is reasonable, necessary, and causally related to the work injury. Petitioner testified that he continues to experience symptoms when trying to use his right arm and would like to proceed with the recommended surgery. Therefore, the Commission finds Petitioner is entitled to the requested right arthroscopy with rotator cuff repair, possible patch augmentation, and possible

20IWCC0391

open biceps tenodesis, and Respondent shall pay the associated medical expenses.

Finally, the Commission modifies the Arbitrator's award of TTD benefits. No treating physician has cleared Petitioner to return to work full duty since the date of accident. While Dr. Mash, Respondent's Section 12 examiner opined that Petitioner reached MMI and could return to work in relation to the work injury by December 15, 2017, the date he examined Petitioner, the Commission has already determined that Dr. Mash's opinions in this matter are not the most credible. Instead, for reasons already explained, the opinions of Dr. Wolin, Petitioner's current treating physician, are the most credible. As of the date of hearing, Dr. Wolin had not released Petitioner to return to work without restrictions. Thus, the Commission finds Petitioner is entitled to TTD benefits from August 13, 2017, through December 21, 2018, or 70-5/7 weeks. Petitioner has a TTD rate of $420.53. The Commission finds Petitioner is entitled to $29,737.36 in TTD benefits. Respondent is entitled to a credit of $6,812.64 for benefits it previously paid; therefore, Respondent shall pay $22,924.72 in TTD benefits to Petitioner.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 11, 2019, is hereby reversed.

IT IS FURTHER ORDERED that Petitioner's current condition of ill-being relating to his right shoulder is causally related to the August 12, 2017, work accident.

IT IS FURTHER ORDERED that Respondent shall approve and pay for reasonable and necessary prospective medical treatment in the form of the right shoulder arthroscopy with rotator cuff repair, possible patch augmentation, and possible open biceps tenodesis recommended by Dr. Wolin.

IT IS FURTHER ORDERED that Respondent shall pay Petitioner temporary total disability benefits of $**420.53**/week for **70-5/7** weeks, commencing **August 13, 2017** through **December 21, 2018**, as provided in Section 8(b) of the Act. Respondent shall receive a credit in the amount of $6,812.64 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.

20 IWCC0391

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $23,100.00. 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: JUL 13 2020

o: 5/19/2020
TJT/jds
51

Thomas J. Tyrrell

Maria E. Portela

Kathryn A. Doerries

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

KEVIN J. HAIN,

Petitioner,

vs. NO: 07 WC 54701

RAYMOND CHEVROLET,

20IWCC0392

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issue of permanent partial disability (PPD) and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 29, 2019 is hereby affirmed and adopted.

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

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

Bond for the removal of this cause to the Circuit Court by the Respondent is hereby fixed at the sum of $54,300.00. 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: JUL 13 2020

D. Douglas McCarthy

Stephen J. Mathis

L. Elizabeth Coppoletti

DDM/pm
O: 7/8/2020
052

Sections

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HAIN, KEVIN J
Employee/Petitioner

Case# **07WC054701**

RAYMOND CHEVROLET
Employer/Respondent

20IWCC0392

On 8/29/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.84% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2234 CHEPOV & SCOTT LLC
NICHOLAS W CLIFFORD
5440 N CUMBERLAND AVE #150
CHICAGO, IL 60656

0081 LORENZ & BERGIN PC
PETER J LORENZ
120 N LASALLE ST SUITE 1420
CHICAGO, IL 60602

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION

NATURE AND EXTENT ONLY

Kevin J. Hain
Employee/Petitioner

v.

Raymond Chevrolet
Employer/Respondent

Case # **07** WC **054701**

Consolidated cases: _____

20 IWCC0392

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jessica Hegarty**, Arbitrator of the Commission, in the city of **Waukegan**, on **March 20, 2019**. By stipulation, the parties agree:

On the date of accident, **November 17, 2006**, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned **$61,256.00**, and the average weekly wage was **$1,178.00**.

At the time of injury, Petitioner was **42** years of age, ***single*** with **0** dependent children.

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

Respondent shall be given a credit of $ for TTD, $ for TPD, $ for maintenance, and **$29,273.60 (for TTD, TPD or PPD as per IWCC Decision and stipulation)** for other benefits, for a total credit of $.

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

ORDER

Respondent shall pay Petitioner the sum of $**619.97**/week for a further period of **87.5** weeks, as provided in Section **8(d)2** of the Act, because the injuries sustained caused **17.5% loss of use of person as a whole.**

Respondent shall pay Petitioner compensation that has accrued from **June 30, 2007** through **February 25, 2009**, and shall pay the remainder of the award, if any, in weekly payments.

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

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

Jason C. Hyatt

Signature of Arbitrator

8-22-19

Date

ICArbDecN&E p.2

AUG 29 2019

BEFORE THE WORKERS' COMPENSATION COMMISSION
OF THE STATE OF ILLINOIS

KEVIN HAIN,	)	
	)	
Petitioner,	)	
	)	
VS.	)	NO. 07 WC 54701
	)	
RAYMOND CHEVROLET,	)	
	)	
Respondent.	)	20IWCC0392

ADDENDUM TO THE DECISION OF THE ARBITRATOR

FINDINGS OF FACT

This matter was tried on March 20, 2019, solely on the issue of nature and extent of the injury.

The matter was previously tried and affirmed on review, IWCC Decision 11 IWCC 0385, April 15, 2011, RX#16.

In this proceeding, the Petitioner waived entitlement to permanency under §8(d)1, both on the record and on the stipulation sheet. Arbitrator's Exhibit 1.

Additionally, the Arbitrator notes the referenced IWCC Decision was appealed by the Petitioner to the Illinois Appellate Court and affirmed. *Hain v. Illinois Workers' Compensation Commission*, 2013 Ill. App. (2d) 120074 WC-U, RX#17.

Given the final Commission Decision, referenced above, affirmed by the Appellate Court, that Petitioner's alleged cervical condition was not causally related to the accident of November 17, 2006, and given Petitioner's waiver of entitlement to benefits under §8(d)1, the nature and extent of the injury is limited to evaluating residual disability related to the right shoulder injury and is to be awarded under §8(d)2 of the Act. *Will County Forest Preserve District v. Illinois Workers' Compensation Commission*, 2012 Ill. App. (3d) 110077 WC.

The Arbitrator notes the Petitioner did not return to work for Respondent when offered full-duty work in November 2007 after he was released to return to work with no restrictions. Notwithstanding, Petitioner has alleged a "loss of trade" and there was testimony of a self-directed job search (PX#1 see further, below). Dr. Michael Orth examined Petitioner on behalf of Respondent, whose opinion (along with those of Drs. Goldberg and Lami) was adopted by the Arbitrator/IWCC in the prior proceeding, finding Petitioner could return to work with no restrictions as of October 30, 2007. The evidence shows the Petitioner was able to "earn more than he actually earned," an amount itself that was not established at this hearing. See *Pietrzak v. Industrial Commission of Illinois*, 329 Ill. App. 3d 828, 769 N.E. 2d 66, 263 Ill. Dec. 864 (2002).

Petitioner testified as to a job search. When examining Petitioner's job search logs, the Arbitrator had difficulty deciphering the document as to the regularity of the job search and the dates they purportedly occurred (page 1 of PX 1 begins in March 2015; page 2 in May 2014; page 3 in February 2015, the remaining four pages contain month and days but not years). Granting the Petitioner the benefit of the doubt (that the search occurred as documented), the earliest evidence of a job application was on May 26, 2014, almost six-and-a-half years after he was released to return to work full-duty by Dr. Orth (October 30, 2007) and offered a job by Respondent (November 2007) (See Arbitrator's Decision, page 4, last sentence, first full paragraph) over three years after the IWCC Decision affirmed the findings of the Arbitrator (April 15, 2011), and over one year after the Illinois Appellate Court's Order affirming the IWCC Decision. (N.B. Illinois Appellate Court Decision filed February 20, 2013.) See *Euclid v. IWCC, in fra.*

Petitioner testified he was able to secure only one job. His testimony about that job was exceptionally vague. He was unsure of the year he worked and unsure of the name and location of the establishment. He testified he worked this job for one day, on a single vehicle, attempting to replace a fuel system on a minivan, stating that he "could not do [the] overhead work."

The Petitioner has not sought maintenance or vocational rehabilitation and was not in a prescribed rehabilitation program.

Based on the totality of evidence contained in the record, the Arbitrator finds Petitioner has failed to establish a loss of trade.

Nonetheless, it is undisputed that Petitioner realized a work injury to his right shoulder. The resulting pathology, based on an MRI film, revealed a full thickness tear of the supraspinatus tendon requiring surgery by Dr. Suchy on February 2, 2017, in the form of arthroscopy with trans-arthroscopic debridement of the right biceps tendon, open repair of the complete rotator cuff tear, and arthroplasty of the right acromial clavicular joint and modified open NEER acromioplasty to the right shoulder.

At the hearing, Petitioner testified he continued to have pain in his right shoulder, and there was limitation on overhead work. However, the Petitioner testified that he had a surgery "in 2018" to his right shoulder and a recent surgery "nine or ten days ago" but his Counsel stated on the record and Petitioner testified that that medical care was unrelated to the accident of November 17, 2016.

Based on review of the evidence, both documentary and testimonial, the Arbitrator awards Petitioner 17.5% loss of use of person as a whole pursuant to §8(d)2 of the IWCA.

Finally, the Arbitrator notes that the Respondent shall be given a credit of $29,273.60 to be credited towards this award, as per stipulation and as required by the IWCC Decision of April 15, 2011.

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

FALYNNE MUZZY,

Petitioner,

vs.

NO: 18 WC 30619

STATE OF ILLINOIS,
MENARD CORRECTIONAL CENTER,

20IWCC0393

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 13, 2019 is hereby affirmed and adopted.

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

20 IWCC0393

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 JUL 13 2020
DDM/tdm
O: 5/19/20
052

D. Douglas McCarthy

Stephen Mathis

DISSENT

A claimant who claims injury based upon a theory of repetitive trauma must show a causal connection between her work duties and her resulting condition of ill-being. *Peoria County Belwood Nursing Home v. Industrial Commission*, 115 Ill. 2d 524, 505 N.E.2d 1026 (1987). In order to prove such a causal link, a claimant must establish the manner and method of her work duties is sufficiently repetitive in nature. *Williams v. Industrial Commission*, 244 Ill. App. 3d 204, 211, 614 N.E.2d 177 (1993). The same standard applies to proof of an aggravation of a pre-existing condition. *Nunn v. Industrial Commission*, 157 Ill. App. 3d 470, 476, 510 N.E.2d 502 (1987). "Furthermore, in cases relying on the repetitive trauma concept, the claimant generally relies on medical testimony establishing a causal connection between the work performed and claimant's disability. [citations omitted]." *Id.* at 477. See *Berry v. Industrial Commission*, 99 Ill. 2d 401, 459 N.E.2d 963 (1984). Petitioner failed to prove the necessary causal relationship. Therefore, I respectfully dissent.

Petitioner testified she was hired as a correctional officer on January 7, 2013 and was subsequently promoted to a correctional sergeant. T. 17-18. As a correctional officer/sergeant she

was required to bar-rap, utilize a Folger-Adams key to lock/unlock cell doors as well as chuckholes, apply hand cuffs to inmates, and conduct property box searches and shakedowns. T. 19-23. Petitioner testified these duties required significant bending, stooping, and reaching above head with her arms. T. 24. Moreover, the locks, doors, and chuckholes were old and required both hands to turn and or/move. T. 21. Petitioner testified she owned and rode a motorcycle. T. 37.

On cross-examination, Petitioner reiterated she owned and rode a motorcycle. T. 37. Petitioner testified she was placed on light duty in the mailroom beginning in March of 2016 due to an unrelated foot condition. T. 40. Prior to her light duty assignment, Petitioner worked the midnight shift beginning in January of 2015 through March 2016. T. 41. While on the midnight shifts, correctional officers do not perform bar-rapping, and there is "less movement except for food service workers." T. 41-2. Petitioner continued performing light duty activities through March of 2017 in the mailroom at which time she promoted to sergeant. T. 43. As sergeant, Petitioner was temporarily assigned to an office setting for three to four months and then to the dinning hall. T. 44. Following the dining hall assignment, Petitioner was assigned to the midnight shift and then an account sergeant followed by a visiting room sergeant. T. 47-48. These assignments were clerical/supervisory which did not require sustained use of the Folger-Adams key and bar wrapping. T. 48-49.

On April 12, 2019, Dr. Mirly provided testimony via evidence deposition. Dr. Mirley testified based upon his understanding of the duties of a correction officer as well as Petitioner's description of her job duties, it was his opinion such duties were a contributing factor in rendering her condition of ill-being, bilateral carpal tunnel syndrome, symptomatic. PX10, p. 11. In rendering his opinion, Dr. Mirly specifically indicated riding motorcycles is common cause of carpal tunnel syndrome, but he possessed no information that Petitioner participated in such activity. PX10, p. 12; 23. Moreover, Dr. Mirly indicated the duties of a correctional officer which contributed to the development of carpal tunnel syndrome were the use of Folger-Adams keys, bar-rapping, and moving of the cell doors. PX10, p.19.

20 IWCC0393

I would afford little weight to Dr. Mirly's opinion. 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. Dr. Mirly possess an inaccurate understanding of Petitioner's job duties. The evidence establishes the majority of Petitioner's job duties did not require the repeated use of the Folger-Adams key or bar-rapping. Instead, Petitioner was assigned to light duties or supervisory duties as well as midnight shifts. Moreover, Dr. Mirly testified riding motorcycles was a competent cause of carpal tunnel syndrome but was seemingly aware of Petitioner participation in this activity. As such, I would afford greater weight to the opinion of Dr. Sudekum who opinions Petitioner's "bilateral upper extremity symptoms were not caused or aggravated by her employment activities as a correctional officer." RX6, p. 15. Therefore, I respectfully dissent.

L. Elizabeth Coppoletti

L. Elizabeth Coppoletti

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

MUZZY, FALYNNE
Employee/Petitioner

Case# **18WC030619**

18WC030620

STATE OF IL/MENARD C C
Employer/Respondent

20IWCC0393

On 8/13/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0969 RICH RICH & COOKSEY PC
THOMAS C RICH
6 EXECUTIVE DR SUITE 3
FAIRVIEW HTS, IL 62208

0558 ASSISTANT ATTORNEY GENERAL
KENTON OWENS
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

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

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

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

AUG 13 2019

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

20 IWCC0393

STATE OF ILLINOIS)
)SS.
COUNTY OF WILLIAMSON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Falynne Muzzy
Employee/Petitioner

v.

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

Case # 18 WC 30619

Consolidated cases: 18 WC 30620

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Herrin, on July 17, 2019. 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 19, 2016, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $56,571.10; the average weekly wage was $1,087.91.

On the date of accident, Petitioner was 33 years of age, married with 3 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

Respondent shall pay reasonable and necessary medical services for medical services provided to Petitioner from January 7, 2016, through January 19, 2016, as identified in Petitioner's Exhibit 1, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

Prospective medical treatment is awarded in case number 18 WC 30620.

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 8, 2019
Date

AUG 13 2019

Findings of Fact

Petitioner filed two Applications for Adjustment of Claim both of which alleged Petitioner sustained a repetitive trauma injury arising out of and in the course of her employment by Respondent. In case 18 WC 30619, the Application alleged a date of accident (manifestation) of January 19, 2016, and that Petitioner sustained an injury to her right hand, wrist, arm and shoulder as a result of "Repetitive Duties" (Arbitrator's Exhibit 3). In case 18 WC 30620, the Application alleged date of accident (manifestation) of September 19, 2018, and that Petitioner sustained an injury to her bilateral wrists, elbows and arms as a result of "Repetitive Duties" (Arbitrator's Exhibit 4). The cases were consolidated and tried in a 19(b) proceeding in which Petitioner sought orders for payment of medical bills as well as prospective medical treatment. In both cases Respondent disputed liability on the basis of accident, notice and causal relationship (Arbitrator's Exhibits 1 and 2).

Petitioner started working for Respondent in January, 2013, as a Correctional Officer. In March, 2017, Petitioner was promoted to Correctional Sergeant. At trial, Petitioner tendered into evidence a document entitled "Work History Timeline." According to it, Petitioner worked as a Correctional Officer from January 7, 2013, to March 15, 2017, and worked as a Correctional Sergeant from March 16, 2017, to "current." The document included a written description of the job duties of both positions. As a Correctional Officer, Petitioner would supervise inmate movement, conduct, work, discipline, recreation and training. Petitioner would act as a turnkey at gates and would search inmates, cells and cell houses. She would also prepare reports. As a Correctional Sergeant, Petitioner would supervise a number of assigned officers, was in charge of a gate and enforced/maintained discipline. Petitioner also maintained constant visual of the area she was assigned to while working as a turnkey or gatekeeper. Petitioner, when necessary, assumed the duties of a Correctional Officer or Correctional Lieutenant (Petitioner's Exhibit 7).

Petitioner also tendered into evidence a document entitled "Detailed Job Description" which Petitioner prepared and signed on October 15, 2018. This document contained a detailed statement of the various physical requirements of Petitioner's job, including lifting, pushing/pulling, bending/stooping, reaching above shoulder level, use of hands for gross manipulation and use of hands for fine manipulation. In regard to Petitioner's use of hands for gross and fine manipulation, Petitioner noted on the documents she had to turn keys to open doors and chuckholes, roll the cranks on a gallery, turn keys to open doors multiple times per shift, type reports, filing, etc. (Petitioner's Exhibit 8).

At trial, Petitioner testified she used both hands extensively while at work. Petitioner would have to lock/unlock both the cell doors and chuckholes with a Folger Adams key. This required forceful use and gripping by both hands because the locks were hard to operate because of their age, heat, humidity, rust, etc. There were occasions in which Petitioner would need the assistance of another Correctional Officer.

Once the cell door was unlocked, it was necessary to slide them to one side to open them. This also required forceful use and gripping by both hands because the doors were made of steel, were old, rusted, etc.

Petitioner would also use a Folger Adams key to unlock the crank box outside a cell gallery. Upon being opened, it was necessary to pull out a crank lever and spin it. This likewise would require the forceful use of both hands because of the age of the crank boxes and their propensity to stick.

Petitioner would also use a metal baton to rap the metal bars to determine if the integrity of any of the metal bars had been compromised. Petitioner testified she did more bar rapping when she was working the day shift than when she worked the midnight shift. Petitioner would also have to cuff/uncuff inmates, move/inspect inmate property boxes, lift racks and trays, etc.

Petitioner testified there was not a significant difference between the job duties of a Correctional Officer and a Correctional Sergeant. Petitioner stated Correctional Sergeants would perform the same job duties of a Correctional Officer. The main difference between the two was that a Correctional Sergeant had more paperwork/reports to do.

On cross-examination, Petitioner was interrogated about her job duties. From January, 2015, through March, 2016, Petitioner worked the midnight shift and did a lesser amount of bar rapping. From March, 2016, through the Fall of 2016, Petitioner was on a light duty assignment because of a foot condition. After Petitioner was promoted to Correctional Sergeant, she worked in dietary and performed office duty for approximately three to four months. From March, 2017, through July, 2018, Petitioner worked in cell houses on the midnight shift and did a lesser amount of bar rapping and had less direct contact with the inmates.

Petitioner testified she began to experience numbness/tingling primarily in her right hand in 2016. Petitioner initially sought medical treatment from Dr. Joseph Molnar, her family physician, on January 7, 2016. At that time, Petitioner complained of numbness in her right arm, worse in her right hand. On examination, Dr. Molnar noted Petitioner had a positive Phalen's signs on the right and unequal grip strength. He suspected carpal tunnel syndrome and ordered EMG/nerve conduction studies (Petitioner's Exhibit 3).

EMG/nerve conduction studies were performed on January 19, 2016 (the date of manifestation), by Dr. James Goldring, a neurologist. According to Dr. Goldring, the studies showed evidence of carpal tunnel syndrome on the right side (Petitioner's Exhibit 4).

On January 27, 2016, Petitioner completed and signed an "Employee's Notice of Injury" in which Petitioner indicated she sustained a work-related injury to her right arm as a result of opening cell doors and cranking the deadlock. She indicated the date of accident was January 5, 2016. A "Supervisor's Report of Injury or Illness" was prepared the following day, January 28, 2016, and signed by Major Monje (Respondent's Exhibit 1).

Subsequent to Petitioner undergoing the EMG/nerve conduction studies, she continued to work, but on light duty restrictions due to her left foot condition. Petitioner's right hand symptoms were not as severe during this period of time; however, when Petitioner was promoted to Correctional Sergeant in March, 2017, her right hand symptoms worsened and she began to experience left hand symptoms as well.

Petitioner was again seen by that Dr. Molnar on September 12, 2018. At that time, Petitioner complained of progressive bilateral hand numbness which also included the right elbow that had been ongoing for the preceding 33 months. Dr. Molnar noted Petitioner had previously undergone EMG/nerve conduction studies in January, 2016, which revealed carpal tunnel syndrome in the right hand. He ordered an up-to-date EMG nerve conduction study and referred Petitioner to Dr. Harvey Mirly, an orthopedic surgeon (Petitioner's Exhibit 3).

EMG/nerve conduction studies were performed on September 19, 2018 (the date of manifestation) by Dr. Andrew Godby. The studies were positive for very mild bilateral carpal tunnel syndrome, but there was no evidence of bilateral ulnar neuropathy (Petitioner's Exhibit 5).

On September 22, 2018, Petitioner completed and signed an "Employee's Notice of Injury" in which she reported a work-related injury to both hands. In this document, Petitioner noted she had undergone a second nerve conduction study and was told she had an injury to both hands (Petitioner's Exhibit 9).

Dr. Mirly evaluated Petitioner on October 30, 2018. At that time, Petitioner complained of bilateral hand pain/numbness, left worse than right. Petitioner informed Dr. Mirly she used a crank box at work for unlocking cell doors. Dr. Mirly reviewed both EMG/nerve conduction studies and opined Petitioner had bilateral hand pain/numbness with mild carpal tunnel syndrome as shown on the nerve conduction studies. Dr. Mirly provided Petitioner was bilateral splints for use at night and driving. He authorized Petitioner to continue to work without restrictions (Petitioner's Exhibit 6).

Dr. Mirly again saw Petitioner on December 27, 2018. At that time, Petitioner advised the splints were helpful at night, but she had symptoms during the day when she was not wearing them. Dr. Mirly reaffirmed his diagnosis of bilateral carpal tunnel syndrome. He recommended Petitioner undergo bilateral carpal tunnel release surgeries (Petitioner's Exhibit 6).

At the direction of Respondent, Petitioner was examined by Dr. Anthony Sudekum, a hand surgeon, on March 19, 2019. In connection with his examination of Petitioner, Dr. Sudekum reviewed medical records provided to him by Respondent. When examined by Dr. Sudekum, Petitioner complained of numbness/tingling in both hands, right more than left, primarily the index and middle fingers. Dr. Sudekum obtained his own nerve conduction studies and, based upon them and his findings on examination, he opined Petitioner did not have bilateral carpal tunnel syndrome. He diagnosed Petitioner with a nonspecific bilateral upper extremity pain and parasthesias, but opined Petitioner had possible thoracic outlet syndrome or cervical pathology. He also noted Petitioner was obese because she was 4 foot 11 and weighed 203.6 pounds and smoked five to seven cigarettes per day (Respondent's Exhibit 6).

Dr. Mirly was deposed on April 12, 2019, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Mirly's testimony was consistent with his medical records and he reaffirmed the opinions contained therein. In regard to causality, Dr. Mirly testified he had Petitioner's work history timeline (Petitioner's Exhibit 7) and was generally familiar with the job duties of Correctional Officers and Correctional Sergeants because he had treated a number of them in the past. Dr. Mirly testified Petitioner's job duties were a

contributing cause, but not solely causative. He recommended Petitioner undergo bilateral carpal tunnel release surgeries, doing the left first because it was more symptomatic (Petitioner's Exhibit 10; pp 10-12).

On cross-examination, Dr. Mirly agreed Petitioner's job duties as a Correctional Sergeant might be less hand intensive than a Correctional Officer, in particular, less bar rapping. Dr. Mirly also agreed Petitioner had other risk factors for the development of carpal tunnel syndrome, specifically, being female and obese. He noted Petitioner smoked, but not a great deal, and she did not have diabetes or hypothyroidism (Petitioner's Exhibit 10; pp 19-21).

Petitioner testified she has not lost time from work because of her hand condition. She continues to work as a Correctional Sergeant. Petitioner continues to have bilateral hand symptoms and wants to proceed with the surgery as recommended by Dr. Mirly.

Major Trevor Rowland, Petitioner's shift supervisor, testified for Respondent. Rowland's testimony focused on the duties of a Correctional Sergeant and the fact that it was more of a supervisory position. Specifically, he noted that a Correctional Sergeant would not do any bar rapping.

Rowland was present during Petitioner's testimony. On cross-examination, he agreed Petitioner's testimony regarding her daily job duties was accurate. He also agreed Petitioner could be assigned anywhere during any given shift.

Conclusions of Law

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

The Arbitrator concludes Petitioner sustained a repetitive trauma injury arising out of and in the course of her employment by Respondent to her right hand which manifested itself on January 19, 2016, and her current condition of ill-being is, in part, related to same.

In support of this conclusion the Arbitrator notes the following:

Petitioner worked as a Correctional Officer and testified she used both hands extensively at work. From January, 2015, through March, 2016, Petitioner worked the midnight shift and did a lesser amount of bar rapping; however, she continued to use both of her hands performing other repetitive tasks.

When Petitioner initially sought medical treatment on January 7, 2016, from Dr. Molnar, her family physician, he noted she had a positive Phalen's signs on the right and ordered EMG/nerve conduction studies.

The EMG/nerve conduction studies were performed on January 19, 2016 (date of manifestation) and revealed evidence of carpal tunnel syndrome on the right.

Petitioner's primary treating physician, Dr. Mirly, opined Petitioner had bilateral carpal tunnel syndrome when he saw her in October, 2018, and testified Petitioner's job duties were a contributing cause, but not the sole cause. Dr. Mirly acknowledged Petitioner had other risk factors, specifically being female and obese, but noted her smoking was minimal and she did not have either diabetes or hypothyroidism.

Respondent's Section 12 examiner, Dr. Sudekum, opined Petitioner did not have carpal tunnel syndrome, which was contrary to the opinions of Dr. Molnar and Dr. Mirly, as well as the prior EMG/nerve conduction studies. Dr. Sudekum indicated Petitioner's symptoms might be attributable to thoracic outlet syndrome or cervical pathology, diagnoses that were not made by either Dr. Molnar or Dr. Mirly.

Based upon the preceding, the Arbitrator finds the opinion of Dr. Mirly in regard to causality to be more persuasive than that of Dr. Sudekum.

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

The Arbitrator concludes Petitioner gave notice to Respondent within the time required by the Act.

In support of this conclusion the Arbitrator notes follow:

On January 27, 2016, Petitioner completed and signed an "Employee's Notice of Injury" which indicated she had sustained a work-related injury to her right arm. While it indicated the date of accident was January 5, 2016, it was clear that Petitioner gave notice to Respondent that she was claiming to have sustained a work-related injury. Obviously, Petitioner gave notice to Respondent within the time required by the Act.

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

The Arbitrator concludes that all of the medical treatment provided to Petitioner was reasonable and necessary and Respondent is liable for payment of the medical bills incurred therewith.

Respondent shall pay reasonable and necessary medical services provided to Petitioner from January 7, 2016, through January 19, 2016, as identified in Petitioner's Exhibit 1, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

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

The Arbitrator concludes Petitioner is entitled to prospective medical treatment, but it is awarded in case number 18 WC 30620.

William R. Gallagher, Arbitrator

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

FALYNNE MUZZY,

Petitioner,

vs. NO: 18 WC 30620

20IWCC0394

STATE OF ILLINOIS,
MENARD CORRECTIONAL CENTER,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 13, 2019 is hereby affirmed and adopted.

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

20 IWCC0394

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 JUL 13 2020
DDM/tdm
O: 5/19/20
052

D. Douglas McCarthy

Stephen Mathis

DISSENT

A claimant who claims injury based upon a theory of repetitive trauma must show a causal connection between her work duties and her resulting condition of ill-being. *Peoria County Belwood Nursing Home v. Industrial Commission*, 115 Ill. 2d 524, 505 N.E.2d 1026 (1987). In order to prove such a causal link, a claimant must establish the manner and method of her work duties is sufficiently repetitive in nature. *Williams v. Industrial Commission*, 244 Ill. App. 3d 204, 211, 614 N.E.2d 177 (1993). The same standard applies to proof of an aggravation of a pre-existing condition. *Nunn v. Industrial Commission*, 157 Ill. App. 3d 470, 476, 510 N.E.2d 502 (1987). "Furthermore, in cases relying on the repetitive trauma concept, the claimant generally relies on medical testimony establishing a causal connection between the work performed and claimant's disability. [citations omitted]." *Id.* at 477. See *Berry v. Industrial Commission*, 99 Ill. 2d 401, 459 N.E.2d 963 (1984). Petitioner failed to prove the necessary causal relationship. Therefore, I respectfully dissent.

Petitioner testified she was hired as a correctional officer on January 7, 2013 and was subsequently promoted to a correctional sergeant. T. 17-18. As a correctional officer/sergeant she

was required to bar-rap, utilize a Folger-Adams key to lock/unlock cell doors as well as chuckholes, apply hand cuffs to inmates, and conduct property box searches and shakedowns. T. 19-23. Petitioner testified these duties required significant bending, stooping, and reaching above head with her arms. T. 24. Moreover, the locks, doors, and chuckholes were old and required both hands to turn and or/move. T. 21. Petitioner testified she owned and rode a motorcycle. T. 37.

On cross-examination, Petitioner reiterated she owned and rode a motorcycle. T. 37. Petitioner testified she was placed on light duty in the mailroom beginning in March of 2016 due to an unrelated foot condition. T. 40. Prior to her light duty assignment, Petitioner worked the midnight shift beginning in January of 2015 through March 2016. T. 41. While on the midnight shifts, correctional officers do not perform bar-rapping, and there is "less movement except for food service workers." T. 41-2. Petitioner continued performing light duty activities through March of 2017 in the mailroom at which time she promoted to sergeant. T. 43. As sergeant, Petitioner was temporarily assigned to an office setting for three to four months and then to the dinning hall. T. 44. Following the dining hall assignment, Petitioner was assigned to the midnight shift and then an account sergeant followed by a visiting room sergeant. T. 47-48. These assignments were clerical/supervisory which did not require sustained use of the Folger-Adams key and bar wrapping. T. 48-49.

On April 12, 2019, Dr. Mirly provided testimony via evidence deposition. Dr. Mirley testified based upon his understanding of the duties of a correction officer as well as Petitioner's description of her job duties, it was his opinion such duties were a contributing factor in rendering her condition of ill-being, bilateral carpal tunnel syndrome, symptomatic. PX10, p. 11. In rendering his opinion, Dr. Mirly specifically indicated riding motorcycles is common cause of carpal tunnel syndrome, but he possessed no information that Petitioner participated in such activity. PX10, p. 12; 23. Moreover, Dr. Mirly indicated the duties of a correctional officer which contributed to the development of carpal tunnel syndrome were the use of Folger-Adams keys, bar-rapping, and moving of the cell doors. PX10, p.19.

20 IWCC0394

I would afford little weight to Dr. Mirly's opinion. 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. Dr. Mirly possess an inaccurate understanding of Petitioner's job duties. The evidence establishes the majority of Petitioner's job duties did not require the repeated use of the Folger-Adams key or bar-rapping. Instead, Petitioner was assigned to light duties or supervisory duties as well as midnight shifts. Moreover, Dr. Mirly testified riding motorcycles was a competent cause of carpal tunnel syndrome but was seemingly aware of Petitioner participation in this activity. As such, I would afford greater weight to the opinion of Dr. Sudekum who opinions Petitioner's "bilateral upper extremity symptoms were not caused or aggravated by her employment activities as a correctional officer." RX6, p. 15. Therefore, I respectfully dissent.

L. Elizabeth Coppoletti

L. Elizabeth Coppoletti

Appendix A

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

MUZZY, FALYNNE
Employee/Petitioner

Case# **18WC030620**

18WC030619

STATE OF IL/MENARD CC
Employer/Respondent

20IWCC0394

On 8/13/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0969 RICH RICH & COOKSEY PC
THOMAS C RICH
6 EXECUTIVE DR SUITE 3
FAIRVIEW HTS, IL 62208

0558 ASSISTANT ATTORNEY GENERAL
KENTON OWENS
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

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

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

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

AUG 13 2019

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

20 IWCC0394

STATE OF ILLINOIS)
)SS.
COUNTY OF WILLIAMSON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Falynne Muzzy
Employee/Petitioner

Case # 18 WC 30620

v.

Consolidated cases: 18 WC 30619

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

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Herrin, on July 17, 2019. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, September 19, 2018, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $58,081.20; the average weekly wage was $1,116.95.

On the date of accident, Petitioner was 35 years of age, married with 3 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

Respondent shall pay reasonable and necessary medical services for medical services provided to Petitioner from September 12, 2018, through December 27, 2018, 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 authorize and pay for prospective medical treatment including, but not limited to, bilateral carpal tunnel release surgeries as recommended by Dr. Harvey Mirly.

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 8, 2019
Date

AUG 13 2019

Findings of Fact

Petitioner filed two Applications for Adjustment of Claim both of which alleged Petitioner sustained a repetitive trauma injury arising out of and in the course of her employment by Respondent. In case 18 WC 30619, the Application alleged a date of accident (manifestation) of January 19, 2016, and that Petitioner sustained an injury to her right hand, wrist, arm and shoulder as a result of "Repetitive Duties" (Arbitrator's Exhibit 3). In case 18 WC 30620, the Application alleged date of accident (manifestation) of September 19, 2018, and that Petitioner sustained an injury to her bilateral wrists, elbows and arms as a result of "Repetitive Duties" (Arbitrator's Exhibit 4). The cases were consolidated and tried in a 19(b) proceeding in which Petitioner sought orders for payment of medical bills as well as prospective medical treatment. In both cases Respondent disputed liability on the basis of accident, notice and causal relationship (Arbitrator's Exhibits 1 and 2).

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At trial, Petitioner testified she used both hands extensively while at work. Petitioner would have to lock/unlock both the cell doors and chuckholes with a Folger Adams key. This required forceful use and gripping by both hands because the locks were hard to operate because of their age, heat, humidity, rust, etc. There were occasions in which Petitioner would need the assistance of another Correctional Officer.

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Petitioner would also use a Folger Adams key to unlock the crank box outside a cell gallery. Upon being opened, it was necessary to pull out a crank lever and spin it. This likewise would require the forceful use of both hands because of the age of the crank boxes and their propensity to stick.

Petitioner would also use a metal baton to rap the metal bars to determine if the integrity of any of the metal bars had been compromised. Petitioner testified she did more bar rapping when she was working the day shift than when she worked the midnight shift. Petitioner would also have to cuff/uncuff inmates, move/inspect inmate property boxes, lift racks and trays, etc.

Petitioner testified there was not a significant difference between the job duties of a Correctional Officer and a Correctional Sergeant. Petitioner stated Correctional Sergeants would perform the same job duties of a Correctional Officer. The main difference between the two was that a Correctional Sergeant had more paperwork/reports to do.

On cross-examination, Petitioner was interrogated about her job duties. From January, 2015, through March, 2016, Petitioner worked the midnight shift and did a lesser amount of bar rapping. From March, 2016, through the Fall of 2016, Petitioner was on a light duty assignment because of a foot condition. After Petitioner was promoted to Correctional Sergeant, she worked in dietary and performed office duty for approximately three to four months. From March, 2017, through July, 2018, Petitioner worked in cell houses on the midnight shift and did a lesser amount of bar rapping and had less direct contact with the inmates.

Petitioner testified she began to experience numbness/tingling primarily in her right hand in 2016. Petitioner initially sought medical treatment from Dr. Joseph Molnar, her family physician, on January 7, 2016. At that time, Petitioner complained of numbness in her right arm, worse in her right hand. On examination, Dr. Molnar noted Petitioner had a positive Phalen's signs on the right and unequal grip strength. He suspected carpal tunnel syndrome and ordered EMG/nerve conduction studies (Petitioner's Exhibit 3).

EMG/nerve conduction studies were performed on January 19, 2016 (the date of manifestation), by Dr. James Goldring, a neurologist. According to Dr. Goldring, the studies showed evidence of carpal tunnel syndrome on the right side (Petitioner's Exhibit 4).

On January 27, 2016, Petitioner completed and signed an "Employee's Notice of Injury" in which Petitioner indicated she sustained a work-related injury to her right arm as a result of opening cell doors and cranking the deadlock. She indicated the date of accident was January 5, 2016. A "Supervisor's Report of Injury or Illness" was prepared the following day, January 28, 2016, and signed by Major Monje (Respondent's Exhibit 1).

Subsequent to Petitioner undergoing the EMG/nerve conduction studies, she continued to work, but on light duty restrictions due to her left foot condition. Petitioner's right hand symptoms were not as severe during this period of time; however, when Petitioner was promoted to Correctional Sergeant in March, 2017, her right hand symptoms worsened and she began to experience left hand symptoms as well.

Petitioner was again seen by that Dr. Molnar on September 12, 2018. At that time, Petitioner complained of progressive bilateral hand numbness which also included the right elbow that had been ongoing for the preceding 33 months. Dr. Molnar noted Petitioner had previously undergone EMG/nerve conduction studies in January, 2016, which revealed carpal tunnel syndrome in the right hand. He ordered an up-to-date EMG nerve conduction study and referred Petitioner to Dr. Harvey Mirly, an orthopedic surgeon (Petitioner's Exhibit 3).

EMG/nerve conduction studies were performed on September 19, 2018 (the date of manifestation) by Dr. Andrew Godby. The studies were positive for very mild bilateral carpal tunnel syndrome, but there was no evidence of bilateral ulnar neuropathy (Petitioner's Exhibit 5).

On September 22, 2018, Petitioner completed and signed an "Employee's Notice of Injury" in which she reported a work-related injury to both hands. In this document, Petitioner noted she had undergone a second nerve conduction study and was told she had an injury to both hands (Petitioner's Exhibit 9).

Dr. Mirly evaluated Petitioner on October 30, 2018. At that time, Petitioner complained of bilateral hand pain/numbness, left worse than right. Petitioner informed Dr. Mirly she used a crank box at work for unlocking cell doors. Dr. Mirly reviewed both EMG/nerve conduction studies and opined Petitioner had bilateral hand pain/numbness with mild carpal tunnel syndrome as shown on the nerve conduction studies. Dr. Mirly provided Petitioner was bilateral splints for use at night and driving. He authorized Petitioner to continue to work without restrictions (Petitioner's Exhibit 6).

Dr. Mirly again saw Petitioner on December 27, 2018. At that time, Petitioner advised the splints were helpful at night, but she had symptoms during the day when she was not wearing them. Dr. Mirly reaffirmed his diagnosis of bilateral carpal tunnel syndrome. He recommended Petitioner undergo bilateral carpal tunnel release surgeries (Petitioner's Exhibit 6).

At the direction of Respondent, Petitioner was examined by Dr. Anthony Sudekum, a hand surgeon, on March 19, 2019. In connection with his examination of Petitioner, Dr. Sudekum reviewed medical records provided to him by Respondent. When examined by Dr. Sudekum, Petitioner complained of numbness/tingling in both hands, right more than left, primarily the index and middle fingers. Dr. Sudekum obtained his own nerve conduction studies and, based upon them and his findings on examination, he opined Petitioner did not have bilateral carpal tunnel syndrome. He diagnosed Petitioner with a nonspecific bilateral upper extremity pain and parasthesias, but opined Petitioner had possible thoracic outlet syndrome or cervical pathology. He also noted Petitioner was obese because she was 4 foot 11 and weighed 203.6 pounds and smoked five to seven cigarettes per day (Respondent's Exhibit 6).

Dr. Mirly was deposed on April 12, 2019, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Mirly's testimony was consistent with his medical records and he reaffirmed the opinions contained therein. In regard to causality, Dr. Mirly testified he had Petitioner's work history timeline (Petitioner's Exhibit 7) and was generally familiar with the job duties of Correctional Officers and Correctional Sergeants because he had

treated a number of them in the past. Dr. Mirly testified Petitioner's job duties were a contributing cause, but not solely causative. He recommended Petitioner undergo bilateral carpal tunnel release surgeries, doing the left first because it was more symptomatic (Petitioner's Exhibit 10; pp 10-12).

On cross-examination, Dr. Mirly agreed Petitioner's job duties as a Correctional Sergeant might be less hand intensive than a Correctional Officer, in particular, less bar rapping. Dr. Mirly also agreed Petitioner had other risk factors for the development of carpal tunnel syndrome, specifically, being female and obese. He noted Petitioner smoked, but not a great deal, and she did not have diabetes or hypothyroidism (Petitioner's Exhibit 10; pp 19-21).

Petitioner testified she has not lost time from work because of her hand condition. She continues to work as a Correctional Sergeant. Petitioner continues to have bilateral hand symptoms and wants to proceed with the surgery as recommended by Dr. Mirly.

Major Trevor Rowland, Petitioner's shift supervisor, testified for Respondent. Rowland's testimony focused on the duties of a Correctional Sergeant and the fact that it was more of a supervisory position. Specifically, he noted that a Correctional Sergeant would not do any bar rapping.

Rowland was present during Petitioner's testimony. On cross-examination, he agreed Petitioner's testimony regarding her daily job duties was accurate. He also agreed Petitioner could be assigned anywhere during any given shift.

Conclusions of Law

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

The Arbitrator concludes Petitioner sustained a repetitive trauma injury arising out of and in the course of her employment by Respondent to her right and left hands which manifested itself on September 19, 2018, and her current condition of ill-being is causally related to same.

In support of this conclusion the Arbitrator notes the following:

Petitioner worked as a Correctional Officer from January 7, 2013, to March 15, 2017, and as a Correctional Sergeant from March 16, 2017, to the present. Petitioner testified both jobs required extensive use of her right and left hands. As a Correctional Sergeant, Petitioner did less bar rapping and even though she was in a supervisory position, Petitioner still had to perform many of the same job duties performed by Correctional Officers.

Respondent's witness and Petitioner's supervisor, Major Rowland, was present during Petitioner's testimony and agreed with Petitioner's description of her job duties and that Petitioner could be assigned anywhere.

When Petitioner was on light duty because of her foot condition, her hand symptoms were not as severe; however, when she was promoted to Correctional Sergeant in March, 2017, her right hand symptoms worsened and she began to experience left hand symptoms as well.

Petitioner's primary treating physician, Dr. Mirly, opined Petitioner had bilateral carpal tunnel syndrome and testified Petitioner's job duties were a contributing cause, but not the sole cause. Dr. Mirly acknowledged Petitioner had other risk factors, specifically, being female and obese, but noted her smoking was minimal and she did not have either diabetes or hypothyroidism.

Respondent's Section 12 examiner, Dr. Sudekum, opined Petitioner did not have carpal tunnel syndrome which was contrary to the opinions of both Dr. Molnar and Dr. Mirly, as well as the prior EMG/nerve conduction studies. Dr. Sudekum indicated Petitioner's symptoms might be attributable to thoracic outlet syndrome or cervical pathology, diagnoses there were not made by either Dr. Molnar or Dr. Mirly.

Based upon the preceding, the Arbitrator finds the opinion of Dr. Mirly in regard to causality to be more persuasive than that of Dr. Sudekum.

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

The Arbitrator concludes Petitioner gave notice to Respondent within the time required by the Act.

In support of this conclusion the Arbitrator notes the following:

On September 22, 2018, Petitioner prepared and signed an "Employee's Notice of Injury" in which she reported having sustained a work-related injury to both hands. This notice was made by Petitioner to Respondent within the time required by the Act.

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

The Arbitrator concludes all of the medical treatment provided to Petitioner was reasonable and necessary and Respondent is liable for payment of the medical bills incurred therewith.

Respondent shall pay reasonable and necessary medical services provided to Petitioner from September 12, 2018, through December 27, 2018, as identified in Petitioner's Exhibit 1, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

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 bilateral carpal tunnel surgeries recommended by Dr. Mirly.

In support of this conclusion the Arbitrator notes the following:

Dr. Mirly has examined Petitioner, reviewed the EMG/nerve conduction studies, diagnosed Petitioner with bilateral carpal tunnel syndrome, attempted conservative treatment and has now recommended surgery.

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF MC LEAN)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MARK MC CAIN,

Petitioner,

vs. NO: 18 WC 000717

MENARDS,

Respondent.

20IWCC0395

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent and Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, temporary benefits, and permanent partial disability (PPD) benefits, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

So that the record is clear, and there is no mistake as to the intentions or actions of the Commission, we have considered the record in its entirety. We have reviewed the facts of the matter, both from a legal and a medical/legal perspective. The Commission has considered all the testimony, exhibits, pleadings, and arguments submitted by the parties. The Commission is not bound by the Arbitrator's findings. Our Supreme Court has long held that it is the Commission's province "to assess the credibility of witnesses, resolve conflicts in the evidence, assign weight to be accorded the evidence, and draw reasonable inferences from the evidence." *City of Springfield v. Indus. Comm'n*, 291 Ill. App. 3d 734, 740 (1997) (citing *Kirkwood v. Indus. Comm'n*, 84 Ill. 2d 14, 20 (1981)). Interpretation of medical testimony is particularly within the province of the Commission. *A. O. Smith Corp. v. Indus. Comm'n,* 51 Ill. 2d 533, 536-37 (1972).

The Arbitrator considered and assigned weight to the five factors under Section 8.1b of the Act and determined that Petitioner sustained thirty-five percent (35%) loss of use of each leg, with a credit of twenty-seven-and-a-half percent (27.5%) loss of use of the left leg from a prior

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settlement. The Commission agrees that the fifth factor [evidence of disability], under Section 8.1b of the Act, merits significant weight, but finds the Arbitrator's PPD award for the left leg to be excessive. The Commission instead reduces the PPD award for the left leg to twenty-seven-and-a-half percent (27.5%) loss of use of the left leg under Section 8(e) of the Act, less a credit of twenty-seven-and-a-half percent (27.5%) loss of use of the left leg from Petitioner's prior settlement.

The evidence demonstrates that Petitioner's right knee suffered the brunt of the blow by an 80 to 100-pound metal pole. The Commission further agrees with the Arbitrator's findings and conclusion that Petitioner's right knee injury from May 8, 2017 led to Petitioner overcompensating with the left leg, causing the left knee condition and the need for surgery on that leg.

Petitioner underwent surgery to both knees. On August 25, 2017, Petitioner underwent right knee arthroscopy, partial medial and lateral meniscectomy, and an abrasion chondroplasty of the medial femoral condyle and patella. Petitioner's post-operative diagnoses were medial and lateral meniscus tears, Grade 2 chondral injuries to the medial femoral condyle, and Grade 2 and 3 chondral injuries to the patella. Petitioner's treating orthopedic surgeon, Dr. Lawrence Li, testified that Petitioner had a significant injury to his right meniscus. "So the posterior horn and medial meniscus was torn. And in order to trim it back to a stable edge, we could leave only about 10 percent. I had to remove about 90 percent of it." (PX1, pg. 12). Petitioner proceeded with a left knee arthroscopy on December 1, 2017; the surgery included a partial medial meniscectomy and abrasion chondroplasty of the patella. Petitioner's post-operative diagnoses were left knee medial meniscus tear and grade 3 chondral injury of the patella.

Dr. Li further testified that Petitioner had lost a lot of meniscus in the right knee and for now he would be able to function. However, in the long-term, Petitioner had a higher risk of developing arthritis at an earlier age and would need anti-inflammatory medications, therapy, injections, arthroscopic surgery and/or a knee replacement. With respect to the left knee, Dr. Li testified that Petitioner had an increased risk of arthritis in the left knee but not as severe as the right knee.

Based on the totality of the evidence, the Commission modifies and reduces the Arbitrator's PPD award for the left leg to twenty-seven-and-a-half percent (27.5%) loss of use of the left leg as provided in Section 8(e) of the Act. The Commission finds that this award corresponds with the evidence in the record and the injuries sustained by Petitioner as a result of the May 8, 2017 work accident. The Commission affirms the Arbitrator's award of thirty-five percent (35%) loss of use of the right leg pursuant to Section 8(e) of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, filed June 11, 2019, is hereby modified as stated above, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay all reasonable and necessary medical services of $25,010.17 – Orthopedic and Shoulder Center; $4,509.67 – Prescription Partners; $97.00 – Bloomington Radiology; $28.00 – Advocate Medical

Group; $16,153.83 – Ireland Grove Center for Surgery; and $543.20 – Ambulatory Anesthesia, as provided in Sections 8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner temporary total disability benefits of $1,063.33 per week for 7 1/7 weeks, commencing December 13, 2017 through January 24, 2018, that being the period of temporary total incapacity for work under Section 8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner temporary partial disability (TPD) benefits of $155.59 per week for 25 2/7 weeks, commencing June 1, 2017 through November 11, 2017, and from December 1, 2017 through December 12, 2017, as provided in Section 8(a) of the Act. Respondent shall receive a credit of $2,209.40 for an overpayment of TPD which shall be applied against the TTD benefits awarded.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner permanent partial disability benefits of $775.18 per week for 75.25 weeks because the injuries sustained caused twenty-seven-and-a-half percent (27.5%) loss of use of the left leg and thirty-five percent (35%) loss of use of the right leg, as provided in Section 8(e) of the Act. Respondent is entitled to a credit of twenty-seven-and-a-half percent (27.5%) loss of use of the left leg from Petitioner's prior settlement.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in the Circuit Court.

DATED: JUL 13 2020

D. Douglas McCarthy

DDM/pm
O: 5/19/2020
052

Stephen J. Mathis

SPECIAL CONCURRENCE/DISSENT

I concur with all aspects of the Majority's decision save its award of permanent partial disability benefits for the right leg. I would award 20% loss use of the right leg pursuant to Section 8(e)12 of the Act. Therefore, I respectfully dissent.

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Petitioner's work accident occurred after September 1, 2011; therefore, Section 8.1b applies. Section 8.1b(b) requires permanent partial disability be determined following consideration of five 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. *820 ILCS 305/8.1b(b).* I review factors (i) and (iv) differently than the Majority.

Section 8.1b(b)(i) – impairment report

Respondent submitted an impairment report pursuant to Section 8.1b(a). Dr. Anderson provided an impairment evaluation of 13% of the right lower extremity. RX1. I place significant weight on this factor as being indicative of reduced permanent disability.

Section 8.1(b)(v) – evidence of disability corroborated by treating medical records

Petitioner underwent right knee arthroscopic surgery on August 25, 2017, followed by post-operative therapy. Petitioner testified he still experiences pain, and he remains limited with sustained standing or walking especially on uneven ground; he also reports difficulty descending stairs. At his final medical visit, on February 15, 2018, Dr. Li documented physical examination findings of normal range of motion, no effusion, no bruising, and no redness; some pain with palpitation and mild qual atrophy. Dr. Li placed Petitioner at maximum medical improvement and advance activities as tolerated. PX17. I find these facts evidence a positive surgical outcome and weigh heavily in favor of reduced permanent disability. The Majority highlights Dr. Li's speculative testimony as to what treatment Petitioner may have in the future which ignores Dr. Li's testimony that Petitioner was capable of working without restrictions and no further medical treatment was recommended.

Based on the above, I find Petitioner sustained permanent partial disability to the extent of 20% loss of the right leg pursuant to Section 8(e)12 of the Act.

L Elizabeth Coppoletti

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

McCAIN, MARK
Employee/Petitioner

Case# **18WC000717**

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MENARDS
Employer/Respondent

On 6/11/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 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:

0564 WILLIAMS & SWEE LTD
JEAN A SWEE
2011 FOX CREEK RD
BLOOMINGTON, IL 61701

0358 QUINN JOHNSTON HENDERSON ET AL
CHRISTOPHER CRAWFORD
227 N E JEFFERSON ST
PEORIA, IL 61602

STATE OF ILLINOIS)
)SS.
COUNTY OF MC CLEAN)

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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

Mark McCain
Employee/Petitioner

v.

Menards
Employer/Respondent

Case # **18** WC **717**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gerald Granada**, Arbitrator of the Commission, in the city of **Bloomington**, on **5/17/19**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **5/8/17**, 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 in both legs ***is*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**82,940.00**; the average weekly wage was $**1595.00**.

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

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

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

Respondent shall be given a credit of $**0** for TTD, $**6144.27** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**6144.27**.

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 $25,010.17 – Orthopedic and Shoulder Center; $4,509.67 – Prescription Partners; $97.00 – Bloomington Radiology; $28.00 – Advocate Medical Group; $16,153.83 – Ireland Grove Center for Surgery; and $543.20 – Ambulatory Anesthesia, as provided in Sections 8(a) and 8.2 of the Act and subject to the medical fee schedule.

Respondent shall pay Petitioner temporary total disability benefits of $1,063.33/week for 7-17 weeks, commencing 12/13/17 through 1/24/18, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner temporary partial disability benefits of $155.59/week for 25-2/7 weeks, commencing 6/1/17 through 11/11/17 and from 12/1/17 through 12/12/17, as provided in Section 8(a) of the Act. Respondent shall receive a credit of $2,549.98 for an overpayment of TPD which shall be applied against the TTD benefits awarded.

After factoring in a credit from Petitioner's prior settlement of 27.5% loss of the left leg, Respondent shall pay Petitioner permanent partial disability benefits of $775.18/week for 91.375 weeks, because the injuries sustained caused the 35% loss of each 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 Gerald Granada

6/10/19
Date

JUN 11 2019

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FINDINGS OF FACT

This case involves a Petitioner alleging injuries sustained while working for the Respondent on May 8, 2017. Respondent disputes Petitioner's claim, with the issues in dispute being: 1) causation with regard to the left leg condition; 2) medical expenses; 3) TTD; and 4) nature and extent.

Petitioner was employed by Respondent, Menard's, in the plumbing department in the early morning hours on May 8, 2017. Petitioner was also concurrently employed as the director of purchasing for Destihl, a brewery and restaurant. While working for Respondent on May 8, 2017, he was lifting large metal poles/pipes with a co-worker and stacking them in cavities. While he was lifting and positioning a 80 to 100 pound pipe with a co-worker, the pipe suddenly fell down and struck Petitioner just above the right kneecap causing him to twist his right leg and body. Petitioner noticed immediate pain in his right knee and, shortly afterwards, he noticed a big lump just above his kneecap with swelling and soreness in his knee. He continued working after his accident, but noticed that his right knee was sore and that he could not extend it. He began to notice numbness into his right foot and he testified that he began to limp, favoring the right knee. Petitioner reported this incident on May 24, 2017 and filled out a Form 45 report that day. (PX 27)

On May 30, 2017 Petitioner treated with Kelsey Wickenhauser, a P.A. Ms. Wickenhauser took a history of accident and noted that Petitioner had pain in his distal anterior right thigh that was getting worse with pain radiating into his lower leg at times. Ms. Wickenhauser ordered an MRI of Petitioner's upper leg (PX 3).

On June 2, 2017, Petitioner saw orthopedic surgeon Dr. Li, who testified via evidence deposition on February, 18, 2019. Dr. Li testified that on June 2, 2017, Petitioner had some swelling in the right knee, the calf and the foot. Dr. Li performed an exam and diagnosed possible medial meniscus tear due to the right knee twist injury (PX 1, p.p. 6, 7). Dr. Li ordered an MRI on June 2, 2017 in which the radiologist stated that: Petitioner had a complex tear of the body and posterior horn of the medial meniscus; findings compatible with a Grade I MCL sprain; a high grade chondral loss along the medial aspect of the medial tibial plateau with underlying subchondral bone marrow edema; and a suspected small oblique tear of the posterior horn of the lateral meniscus (PX 4).

On June 12, 2017, Petitioner was working for Destihl when he injured his low back while lifting a prep table. Petitioner testified that he did not injure his right or his left knee in that accident.

On June 13, 2017, Petitioner saw Dr. Li, who noted that Petitioner gave him a history of his June 12, 2017 work accident at Destihl. Dr. Li testified that while Petitioner was lifting a table at Destihl, he felt a sharp pain in his lower back. Dr. Li testified that Petitioner did not injure either one of his knees in the June 12, 2017 accident, but had some radicular pain from his back after the accident (PX 1, p.p. 8, 9).

On July 14, 2017, Dr. Li took a history that Petitioner had continued right knee pain with walking and that it was worse with twisting and pivoting. On exam, Petitioner had positive medial McMurray's, pain with palpation in the medial joint line, positive patella compression test, and slight decreased range of motion with mild swelling (PX 1, p. 10; PX 17, p.p. 29-30).

On July 31, 2017, Respondent's Section 12 doctor, Dr. David Anderson, examined Petitioner. Dr. Anderson testified by deposition taken April 1, 2019. Dr. Anderson gave a history of accident consistent with Petitioner's testimony. Dr. Anderson stated that Petitioner had symptoms including stiffness, soreness, and a throbbing at

bedtime (RX 1, p.p. 8, 9). Dr. Anderson took a history that Petitioner was in constant pain, which increased with activities, and was worse with sitting. Dr. Anderson stated that Petitioner had a lot of soreness and stiffness in the right knee, especially worse with stairs. He stated that Petitioner had two occasions where the knee had given out since the injury. (RX 1, p. 10) Dr. Anderson stated that Petitioner had undergone bilateral left and right knee surgery at least 6 years prior to his evaluation on July 31, 2017. Dr. Anderson stated that Petitioner gave a separate history of a work accident to his low back. (RX 1, p.p. 11, 12) Dr. Anderson stated that during the physical exam, he observed Petitioner walk with an antalgic gait, noted that Petitioner's right knee was stiff, and that he walked favoring his right side. (RX 1, p. 14) Dr. Anderson diagnosed Petitioner with a contusion of his right quadriceps and with an aggravation of a pre-existing medial meniscus tear, or possible medial meniscus tear. (RX 1, p. 18) Dr. Anderson opined that it was reasonable to proceed with a knee arthroscopy after injection. (RX 1, p. 20)

On May 30, 2017, Petitioner saw Ms. Wickenhauser. At the time, he was off work at Menard's, but he continued to work as a director of purchasing at Destihl.

On August 25, 2017, Dr. Li performed surgery on Petitioner consisting of a right knee arthroscopy, partial medial and lateral meniscectomy, and abrasion chondroplasty of the medial femoral condyle and patella. Dr. Li's post-operative diagnosis was medial and lateral meniscus tears, Grade II chondral injuries to the medial femoral condyle, and Grade II and III chondral injuries to the patella (PX 5). Following the surgery, Dr. Li prescribed crutches, which the Petitioner used for approximately one week post-surgery.

Petitioner testified that shortly after the surgery, he developed right calf pain and swelling. Dr. Li ordered a venous Doppler test at BroMenn on August 28, 2017. On September 1, 2017, Dr. Li stated that post-operatively, Petitioner developed a significant amount of calf pain and that the Doppler revealed that Petitioner developed a DVT. Dr. Li recommended continued use of the compression pump for the DVT, compression therapy, and compression stockings (PX 17, p.p. 70-72). On August 31, 2017, Petitioner underwent an angiogram of the lower extremity, which was read as being in the normal limits (PX 6, p. 6).

Dr. Li testified that Petitioner had a significant amount of calf pain from the DVT with swelling in the right lower extremity and moderate bruising. Dr. Li testified that on September 1, 2017, Petitioner had a very limited range of motion in his right knee on exam. He explained that Petitioner had an impaired gait because he could not straighten out his knee and walk normally (PX 1, p.p. 14, 15).

Petitioner testified that after his surgery, his right knee and leg was painful from the surgery and DVT. He had swelling in his right knee, loss of range of motion, and that he favored his right leg walking. Petitioner said that Dr. Li recommended that he remain active. Petitioner continued to work at Destihl and he would regularly climb 25 to 50 stairs at work to get to his office, which aggravated both of his knees at times. Petitioner said that he had stairs at home and that those activities aggravated both of his knees as well. He continued with physical therapy through Dr. Li's office for both his low back and his right knee. He said that both knees were irritated by some of the physical therapy activities such as leg extensions, leg presses, biking, and duck walking. The physical therapy records document Petitioner's complaints of pain and soreness with each visit.

When Petitioner saw Dr. Li on September, 29, 2017, Dr. Li noted that Petitioner was still weak and had some medial discomfort in his right knee, but it was better than before the surgery. Dr. Li indicated that the left knee has bothered him ever since before his right knee surgery. Dr. Li explained that Petitioner had to compensate and put a significant amount of weight on his left knee because he had to favor his right knee. He further stated

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that since Petitioner has recovered some of the right knee function, the pain in the left knee still persisted (PX 17, p. 88). Dr. Li testified that on Petitioner's September 29, 2017, he had right leg quad atrophy that would not allow Petitioner to fully use his right leg, causing his left leg to take more of the pressure (PX 1, p. 18). Dr. Li stated that during the exam, Petitioner had mild swelling in both knees and that he had a positive McMurray's in the left knee which indicated a likely meniscus tear (PX 1, p. 18).

Petitioner testified that he did not sustain any new injury to either knee after his May 8, 2017 accident through September 29, 2017. He had experienced increased pain in his left knee before his right knee surgery on August 25, 2017 as his gait was altered. He experienced pain the most using stairs and also noticed his left knee pain while doing physical therapy for the right knee.

On November 9, 2017, Dr. Li's records indicate that Petitioner's right knee and calf was feeling better, but that he still required significant strengthening. Dr. Li indicated that Petitioner's left knee was quite bothersome from having to overcompensate for his gait. (PX 17, p. 119) Dr. Li prescribed ongoing physical therapy and an MRI if the left knee continued to bother Petitioner. (PX 17, p. 121) The November 20, 2017 MRI of Petitioner's left knee showed an oblique tear of the posterior horn of the medial meniscus contacting the inferior articular surface; medial compartment degenerative joint disease with a region of high grade chondral loss along the medial aspect of the medial tibial plateau; multi focal chondromalacia in the lateral and patellofemoral compartments; and multi septated insinuating ganglion cyst in the proximal and lateral aspect of the lower leg. (PX 10, PX 17, p. 125) Dr. Li scheduled Petitioner's left knee surgery on December 1, 2017.

Petitioner was examined by Dr. Anderson at the Respondent's request for a second time on October 22, 2018. During this exam, Petitioner informed Dr. Anderson that sometime in November 2017, he was coming down some stairs at home when his left knee gave way and he fell. Petitioner said that this occurred after the MRI was done, but before the surgery on December 1, 2017. Petitioner said that this incident did not change the overall pain level in his left knee.

On December 1, 2017, Petitioner underwent surgery to his left knee consisting of a left knee arthroscopy with partial medial meniscectomy and abrasion chondroplasty of the patella. Dr. Li's post-operative diagnosis was left knee medial meniscus tear and Grade III chondral injury to the patella. (PX 11; PX 17, p. 131) Although Petitioner returned to work at Destihl after the surgery, he was not released to work for Respondent. On December 13, 2017, Dr. Li took Petitioner off work from both jobs until January 24, 2018. (PX 12)

Petitioner testified that Destihl terminated his employment in December of 2017.

Petitioner continued with physical therapy for his knees through January 18, 2018. At that time, the therapist stated that Petitioner still had stiffness and pain especially with prolonged immobility. The therapist stated that Petitioner's pain was 2/10 with 5/10 at the worst. The therapist stated that Petitioner has increased pain with prolonged walking, but was able to walk for 2 plus hours at a time. The therapist prescribed a home exercise program. (PX 17, p.p. 209, 210, 215) Dr. Li released Petitioner from therapy on February 15, 2018 after noting that he was doing well overall, with only mild quad atrophy in the right knee. Dr. Li recommended that Petitioner continue his home exercise program and advance activities as tolerated. (PX 17, p.p. 217-219)

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Petitioner testified that Dr. O'Leary performed surgery on his low back on January 24, 2018. Petitioner treated with physical therapy through Dr. Li's office for the low back after the surgery. (PX 17)

Dr. David Anderson, Respondent's Section 12 examiner, testified by deposition on April 1, 2019. Dr. Anderson reviewed Dr. Li's records and physical therapy records when he examined Petitioner at Respondent's request on July 31, 2017 and on October 22, 2018. (RX 1, p.p. 7, 9, 22-24) He testified that the records reflect that Petitioner started complaining of left knee pain in either August or September of 2017, however Petitioner's left knee complaints were intermittent (RX 1, p. 24). Dr. Anderson stated that Petitioner's DVT in his right leg was a known complication from surgery and that it would delay Petitioner's post-surgical recovery. (RX 1, p.p. 25, 26) Dr. Anderson stated that he took a history that Petitioner had injured his left knee while walking down stairs at home in November of 2017, in which Petitioner had a twisting injury while going downstairs and had acute medial knee pain (RX 1, p. 22).

Dr. Anderson examined Petitioner on October 22, 2018 and found that Petitioner had approximately 2 ½ cm of right quadriceps muscle atrophy as compared to the left leg with some patellofemoral crepitus. (RX 1, p. 26) Petitioner still had limitations with his right knee with prolonged walking as well as limited ability to negotiate stairs, kneel and squat. He noted that Petitioner had some pre-existing degenerative changes, but that his diagnosis for the right knee work accident was status post right knee arthroscopy and debridement which required the home exercise program and over the counter use of medication. (RX 1, p. 30) Dr. Anderson opined that Petitioner's left knee condition was caused from a twisting injury at home going down stairs and that the left knee was not related to the May, 2017 work accident. (RX 1, p. 30) Dr. Anderson opined that as a result of Petitioner's work accident in May of 2017, he should avoid squatting, kneeling and bending, as well as climbing stairs and ladders and lifting over 25 pounds. Dr. Anderson opined that Petitioner had sustained a knee injury, which required a meniscal debridement from his work accident. (RX 1, p. 32) Dr. Anderson further opined that Petitioner had an AMA impairment rating under the 6th Edition of 13% of the lower extremity and 5% person as a whole as it related to his work accident. (RX 1, p.p. 33, 34)

On cross examination, Dr. Anderson stated that Petitioner had informed him that on two occasions since his work accident, his right knee gave out. Dr. Anderson stated that it is a common phenomenon with a knee injury that it would give out. (RX 1, p. 40) On cross, Dr. Anderson stated that going downstairs can place a greater force or strain on the knees as the person is fighting gravity. (RX 1, p. 42)

Dr. Li testified at his February 18, 2019 deposition that Petitioner's diagnosis for his work accident to the right knee is medial and lateral meniscus tears with a chondral injury to the patella and medial femoral condyle. Dr. Li opined that as a direct result of the May 8, 2017 work accident, Petitioner had a direct blow to his knee which led to the chondral injury and that he twisted his knee causing the meniscus tear. Dr. Li testified that Petitioner lost a lot of meniscus from the work accident and that over time he has a higher risk of developing arthritis at an earlier age than he normally would. (PX 1, p.p. 24, 25) Dr. Li further opined that as a result of the May 8, 2017 accident, Petitioner was forced to compensate for the loss of use and function in his right knee, which put additional force and stress on his left knee for several months. (PX 1, p.p. 23, 24) Dr. Li stated that the right knee was complicated by a DVT, which further prolonged the increased stress on Petitioner's left knee causing a meniscus injury. He explained that mechanically, when a person walks, there is always some medial lateral shifting, and that using crutches in the perioperative period caused increased stress on the left knee. There was also additional stress on the left knee getting in and out of the car and going up and down stairs as these activities place a sheer and rotational stress on the meniscus. Dr. Li stated that when Petitioner compensated for

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the right knee, it put more pounds of force on the left knee doubling the force. (PX 1, p.p. 27, 28)

On cross-examination, Dr. Li testified that Petitioner had not informed him of a fall at home descending stairs. Dr. Li testified that if Petitioner had fallen in November, it might have been at the point where they had already decided to proceed with the surgery and that Petitioner may have not told him because the decision had been made. (PX 1, p.p. 31, 32)

Petitioner testified that he had previously injured both his right and his left knee in 2006 requiring surgery. The surgery relieved the pain in both of his knees and he did not treat for either knee from 2006 until he injured his right knee at work on May 8, 2017. Petitioner did not experience any pain in either one of his knees in the decade preceding his May 8, 2017 accident and he had no physical limitations with his knees. Petitioner said that he played hockey 2 to 3 times a week and worked out without pain prior to the May 8, 2017 accident.

Petitioner produced a settlement contract for a January 24, 2006 injury to the left knee for a torn medial meniscus, reflecting permanency of 27.5% loss of use of the left leg. (PX 20) Petitioner produced a settlement contract for an accident on March 11, 2006 for a right leg torn medial meniscus, which settled for $12,883.80 representing a disputed payment for temporary compensation, medical expenses, and permanent disability, with no percentage indicated for permanency. (PX 21)

Petitioner testified that at the time of arbitration, he experienced pain in both of his knees walking long distances and walking on uneven ground. He experienced stiffness in his knees when he sits long periods of time and he has pain in his knees going up and down stairs. Petitioner wears knee sleeves every day on both knees and uses Lanacane ointment at night. He takes approximately 6 Ibuprofen every day to help control pain. Petitioner no longer plays hockey because of knee pain. He described the pain in his knees is an achy, sore, dull pain that is sharper going up and down stairs.

CONCLUSIONS OF LAW

1. With regard to the issue of causation, the Arbitrator finds that the Petitioner has met his burden of proof. In support of this finding, the Arbitrator relies on the Petitioner's credible testimony and the medical evidence from Petitioner's medical providers. The Arbitrator notes that the primary focus of this issue is on the question of causality relating to Petitioner's left leg condition. Petitioner's initial accident on May 8, 2017 involved an impact and twisting injury to the right knee and the medical evidence is unanimous in supporting the causation between the Petitioner's right knee condition and the work accident. However, Petitioner's left knee condition was not medically noted until the September 29, 2017 visit with Dr. Li. To further complicate this issue, the Petitioner had an incident at home in November, 2017 wherein his knee gave out, causing him to fall down and twist the left knee. This incident at home became the basis of Respondent's IME physician, Dr. Anderson's opinion that the Petitioner's left knee condition was not work related. In reviewing the medical evidence and Petitioner's unrebutted testimony, the Arbitrator finds persuasive the explanation and testimony of Petitioner's treating physician Dr Li: Petitioner's right knee injury from May 8, 2017 lead to the Petitioner overcompensating with the left leg, which ultimately caused the left knee condition and the need for surgery on that leg as well. Petitioner's testimony that his knees gave him problems prior to his fall at home are completely plausible given his complaints of pain in both knees following his undisputed right knee surgery. It is not unreasonable to conclude that the fall at home was due to the problems stemming from his right knee condition. Accordingly, the Arbitrator finds that the Petitioner's current condition of ill-being in both his knees are causally related to his May 8, 2017 work accident.

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2. Based on the Arbitrator's conclusion on the issue of causation, the Arbitrator further finds that the Petitioner's medical treatment for both his knees have been reasonable and necessary in treating his work-related condition. Accordingly, the Respondent shall pay any and all medical expenses relating to the treatment of both of Petitioner's knees, subject to the fee schedule, as set forth in Petitioner's Exhibit 25 and 26: $25,010.17 – Orthopedic and Shoulder Center; $4,509.67 – Prescription Partners; $97.00 – Bloomington Radiology; $28.00 – Advocate Medical Group; $16,153.83 – Ireland Grove Center for Surgery; and $543.20 – Ambulatory Anesthesia. Respondent shall receive a credit for any medical expenses it has already paid.

3. Consistent with the Arbitrator's conclusions above, the Arbitrator also finds that the Petitioner is entitled to both temporary total disability and temporary partial disability. The parties stipulated that Petitioner was temporarily partially disabled from June 1, 2017 through November 11, 2017 as he was unable to return to his work for Respondent, but was able to return to work for Destihl. Petitioner underwent surgery for his left knee on December 1, 2017 and remained temporarily partially disabled from returning to work until December 12, 2017. During this time, Petitioner returned to work at Destihl, but not for Respondent. Dr. Li took Petitioner off work completely from December 13, 2017 through January 24, 2018. At that time, Dr. Li released Petitioner to the back surgeon, Dr. O'Leary. Based on this information, the Arbitrator awards Petitioner temporary partial disability benefits from June 1, 2017 through November 11, 2017 and from December 1, 2017 through December 12, 2017, representing 25-2/7 weeks at a rate of $155.59. The Arbitrator further orders Respondent to pay temporary total disability benefits of $1,063.33/week for 7-1/7 weeks, from December 13, 2017 through January 24, 2018. The parties agreed that all TPD benefits had been paid and that there was a $2,549.98 TPD overpayment, which will be applied against the temporary total disability benefits, awarded.

4. With regard to the issue of nature and extent, the Arbitrator notes that pursuant to Section 8.1b of the Act, for accidental injuries occurring after September 1, 2011, permanent partial disability shall be established using five enumerated criteria, with no single factor being the sole determinant of disability. Per 820 ILCS 305/8.1b(b), the criteria to be considered are as follows: (i) the reported level of impairment pursuant to subsection (a) [AMA "Guides to the Evaluation of Permanent Impairment"]; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. Applying this standard to this claim, the Arbitrator makes the following findings listed below.

(i) Impairment. The level of impairment reported by Dr. Anderson pursuant to the American Medical Association's Guide to the Evaluation of Permanent Impairment, 6th Edition, is 13% of the right lower extremity and 5% person as a whole as it relates to the work accident. No impairment rating was given for the left leg. The Arbitrator gives considered weight to this factor.

(ii) Occupation. Petitioner was employed by the Respondent in a job that required him to perform medium to heavy work, including stocking plumbing products. Petitioner was concurrently employed in a sedentary position as a director of purchasing for Destihl. Petitioner is no longer working at either job and now works in another state as a truck driver. The evidence does not show that Petitioner's injury is the reason behind his change in occupation. The Arbitrator gives great weight to this factor.

(iii) Age. Petitioner was 53 years old at the time of the injury. The Arbitrator gives some weight to this factor.

(iv) Future earning capacity. There was no direct evidence presented regarding Petitioner's future earning capacity, and therefore, the Arbitrator gives little weight to this factor.

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(v) Evidence of disability. There was evidence of disability corroborated by the medical records, which show that Petitioner suffered an injury to both his legs resulting in: right knee medial and lateral meniscus tears, Grade II chondral injuries to the medial femoral condyle, and Grade II and III chondral injuries to the patella; and left knee medial meniscus tear and Grade III chondral injury to the patella. Petitioner underwent surgical intervention involving a right knee arthroscopy, partial medial and lateral meniscectomy, and abrasion chondroplasty of the medial femoral condyle and patella; and left knee arthroscopy with partial medial meniscectomy and abrasion chondroplasty of the patella. He underwent post-surgical physical therapy. The evidence shows that Petitioner continues to have complaints of knee pain, difficulty with stairs, difficulty walking long distances or over rough terrain, and general aches and stiffness for which he takes over the counter medication and uses compression support. Based on the evidence introduced at trial, the Arbitrator gives significant weight to this factor.

Based on the factors above, the Arbitrator concludes the injuries sustained by Petitioner caused a 35% loss of each leg, as provided in Section 8(e) of the Act. Respondent shall receive a credit of 27.5% of the left leg from Petitioner's prior settlement.

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

Robert Musselman,

Petitioner,

vs. NO: 13 WC 7742

Shelter Builders,

Respondent.

20IWCC0396

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, and medical expenses, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator with the changes made below, which is attached hereto and made a part hereof.

While affirming and adopting the Decision of the Arbitrator, the Commission writes additionally on the issue of temporary disability due to the unusual situation presented where, as here, the Petitioner was also the owner of Respondent. The Arbitrator awarded Petitioner temporary total disability benefits for the period from July 16, 2012 through October 18, 2017. Respondent argues the award is in error because the medical records and Petitioner's testimony indicate Petitioner was working during this period. Respondent adds that Petitioner's testimony described many tasks which involved little to no physical activity. Respondent concludes that temporary total disability benefits should terminate on May 24, 2013, when Petitioner's treating physician, Dr. Phillips, confirmed that Petitioner was at MMI.

"To establish entitlement to TTD benefits, a claimant must demonstrate not only that he or she did not work, but also that the claimant was unable to work." *Mechanical Devices v. Industrial Comm'n*, 344 Ill. App. 3d 752, 759 (2003). "The dispositive test is whether the claimant's condition has stabilized, that is, whether the claimant has reached maximum medical improvement." *Id.* "The 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." *Id.* at 760 (citing *Beuse v. Industrial Comm'n*, 299 Ill. App. 3d 180, 183 (1998)).

"[T]he fact that an employee can do some light duty work or other useful tasks does not mean that [he] is ineligible to receive TTD benefits." *Shafer v. Illinois Workers' Compensation Comm'n*, 2011 IL App (4th) 100505WC, ¶ 47. A claimant's earning of occasional wages does not necessarily preclude a finding of temporary total disability. See, *e.g.*, *Zenith Co. v. Industrial Comm'n*, 91 Ill. 2d 278, 286-87 (1982) (working approximately a few hours daily as a hot dog vendor did not preclude a TTD award); *J.M. Jones Co. v. Industrial Comm'n*, 71 Ill. 2d 368, 373 (1978) (driving a school bus for three hours daily for seven months did not preclude a TTD award); *Mechanical Devices*, 344 Ill. App. 3d at 761-62 (driving a YWCA shuttle bus for three hours daily did not preclude a TTD award); *cf. Dolce v. Industrial Comm'n*, 286 Ill. App. 3d 117, 121-22 (1996) (consistent work selling real estate precluded claimant from a TTD award).

In this case, Petitioner was placed at MMI by Dr. Phillips in May 2013. During this same month, Petitioner was treating with Dr. Nho and underwent a functional capacity evaluation (FCE) to determine permanent limitations. The FCE results were valid and fell below that which would be required of a carpenter. Petitioner's condition also necessitated continued treatment with Dr. Nho and Dr. McLaughlin which is framed by strong evidence that Petitioner was not at MMI and entitled to further temporary total disability benefits contrary to that which Respondent avers.

After Dr. Phillips' MMI finding, Petitioner underwent an EMG study showing his pain was not secondary to diabetic neuropathy but was coming from his back. Shortly thereafter, Petitioner reported to another treating physician, Dr. McLaughlin, that his back pain continued to prevent him from working, that he occasionally tried to work, but generally had to lie down after an hour. Moreover, Petitioner had rated his pain at 9/10 (on June 4, 2012) and 8/10 (on September 19, 2013), compared to the degree to which Petitioner's condition subsequently improved under the care of Drs. Ross and Lee (rating his pain as 2/10 on June 1, 2017 and 3/10 on June 19, 2018). Even then, Petitioner was only cleared to work within the light to medium physical demand level. Petitioner's ongoing subjective complaints, which were corroborated by objective evidence and ameliorated by the different and additional treatment offered by Drs. Ross and Lee undercut the assertion that Petitioner's condition had, in fact, stabilized.

The medical records Respondent identifies generally refer to Petitioner attempting to work intermittently or periodically. Petitioner gave similar testimony at the hearing. Petitioner testified that his job duties had included lifting doors, windows, hot water heaters, and roofing materials. He also stated that his job included bending and stooping, especially when working in spaces like boiler rooms. He testified that after the accident, when he was first released, there was little he could do, particularly given that jobs were ticketed in terms of time and materials for each employee. Petitioner attempted to return to work while treating with Dr. McLaughlin, but it just made him hurt more. He would carry a bucket to avoid kneeling. He was very careful about lifting and generally sought assistance with lifting. Petitioner further testified that his

medication affected his balance and concentration, and that he would spend an hour or two on tasks like adjusting a door closure or re-screwing a hinge.

As owner of Respondent, part of Petitioner's job also involved setting salaries and job assignments. Some of those job duties were not strenuous, *e.g.*, making estimates, drawing blueprints, obtaining figures from subcontractors and delivering plans to clients. It would be expected that Petitioner would engage in the activities that he could in light of his ongoing condition and physicians' recommendations, just as any other injured worker would submit a light duty request to his employer who would look for work to accommodate it and expect him to participate in his employment as much as his condition allowed. Petitioner's testimony about his job duties was uncontroverted and withstood cross-examination, which failed to ask key questions that may have undermined Petitioner's credibility. Petitioner's unrebutted testimony established that he no longer performed a number of tasks he had performed before the accident.

Moreover, this testimony was corroborated by a former employee, Mr. Stricklin, who testified that while others did most of the work, Petitioner had been working full duty prior to December 1, 2011, including working on roofs and ladders, helping out with tile and working in boiler rooms. Mr. Stricklin testified that after the incident, it seemed that Petitioner was no longer able to do any work and seemingly in pain even sitting at a table talking to other workers. This testimony supports Petitioner's testimony about his pain levels contemporaneous with the accident and thereafter.

Petitioner also testified that he received a salary for only a few months after the December 2011 incident, which appears to have terminated prior to the period for which temporary total disability benefits were awarded. Moreover, Petitioner not taking a salary seems to have kept Respondent solvent to sustain its other employees for years after Petitioner's injury. Petitioner further testified that since the 2011 accident, he has largely relied on his wife's income (at least part of which came from Respondent) and on his personal savings. Respondent's cross-examination did not attempt to prove that Petitioner used his position as Respondent's owner to enrich himself during the period for which he was minimally working and temporary total disability benefits were awarded.

In sum, the weight of the evidence indicates that after May 2013, Petitioner remained incapable of working more than one or two hours a day on an intermittent or periodic basis. Petitioner's condition had not stabilized. Moreover, the record does not establish that Petitioner manipulated his position as an owner of Respondent to obtain benefits in a manner that would be unavailable to a typical employee. Given the unusual facts and circumstances presented in this case, the Commission affirms the award of temporary total disability benefits.

In all other respects, the Commission affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE FOUND BY THE COMMISSION that Petitioner proved his current condition of ill-being is causally connected to the accident in this case.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay Petitioner's reasonable and necessary medical bills of: Adventist Hinsdale Hospital, Athletico,

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ATI Physical Therapy, Midwest Orthopedics at Rush, Rush Oak Park Hospital, Rush University Hospital, DuPage Medical Group, Dr. John Hong, Advocate Good Samaritan, Dr. Patrick Sugrue, Advocate Good Samaritan Radiology, Mobile Anesthesiologists, Osco Pharmacy, and Athletico FCE (September 17, 2017), if previously unpaid and not written off, pursuant to the fee schedule and §§8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall receive a credit for payments made by the workers' compensation carrier in the amount of $63,991.91.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $657.69 per week for the period of July 16, 2012 through October 18, 2017, a period of 274 and 3/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is awarded a credit of $165,370.27 for temporary total disability benefits already paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner maintenance benefits of $657.69 per week for the period of October 19, 2017 through January 17, 2019, a period of 65 and 1/7 weeks, as provided in Section 8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner permanent and total disability benefits of $657.69 per week for life, commencing January 18, 2019, as provided in §8(f) of the Act, because the injury sustained caused the complete disability of the Petitioner rendering him wholly and permanently incapable of work.

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

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall pay Petitioner compensation that has accrued from December 1, 2011 through January 19, 2019 and shall pay the remainder of the award, if any, in weekly payments.

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

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

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

JUL 14 2020

DATED:
d: 6/24/20
BNF/kcb
045

Barbara N. Flores

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MUSSELMAN, ROBERT Case# **13WC007742**

Employee/Petitioner

SHELTER BUILDERS

Employer/Respondent

20IWCC0396

On 4/8/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.38% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1938 ALEKSY BELCHER
MATTHEW B WALKER
350 N LASALLE ST SUITE 750
CHICAGO, IL 60654

0560 WIEDNER & McAULIFFE LTD
JASON T STELLMACH
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF DuPage)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Robert Musselman
Employee/Petitioner

v.

Shelter Builders
Employer/Respondent

Case # 13 WC 7742

Consolidated cases: N/A

20IWCC0396

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Frank Soto**, Arbitrator of the Commission, in the city of **Wheaton**, on **January 18, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

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FINDINGS

On **12-1-11**, 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 $**51,300.08**; the average weekly wage was $**986.54**.

On the date of accident, Petitioner was **58** years of age, ***married*** with **0** dependent children.

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

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

Respondent shall be given a credit of $**165,370.27** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**165,370.27**.

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 $657.69/week for 274 2/7 weeks, commencing July 16, 2012 thru October 18, 2017, as provided in Section 8(a) of the Act. Respondent shall be given a credit of $165,370.27 for temporary total disability benefits that have been paid, as set forth in the Conclusions of Law attached hereto.

Respondent shall pay Petitioner maintenance benefits of $657.69/week for 65 2/7 weeks, commencing October 19, 2017 thru January 17, 2019, as set forth in the Conclusions of Law attached hereto,

Respondent shall pay reasonable and necessary medical services of $415,404.94 pursuant to Sections 8 and 8.2 of the Illinois Workers' Compensation Act. Respondent shall receive a credit for medical payments made by the workers' compensation insurance carrier in the amount of $63,991.91. When issuing payment for the above medical charges to Petitioner, Respondent shall provide Petitioner with any fee schedule or negotiated rate calculations used to determine the final amount owed to Petitioner, as set forth in the Conclusions of Law attached hereto,

Respondent shall pay Petitioner permanent and total disability benefits of $657.69/week for life, commencing on January 18, 2019, as provided in Section 8(f) of the Act. Commencing on the second July 15th after the entry of this award, Petitioner may become eligible for cost-of-living adjustments, paid by the Rate Adjustment Fund, as provided in Section 8(g) of the Act.

Respondent shall pay Petitioner compensation that has accrued from December 1, 2011 through January 19, 2019 and shall pay the remainder of the award, if any, in weekly payments.

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

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

Signature of Arbitrator

APR 8 - 2019

4/5/19
Date

20IWCC0396

Procedural History

This case was tried on January 18, 2019. The disputed issues are whether Petitioner's current condition of ill-being is causally connected to this injury, whether Respondent is liable for unpaid medical bills, whether Petitioner is entitled to TTD and maintenance benefits and the nature and extend of Petitioner's injury. Petitioner claims he is permanently totally disable, under an odd-lot theory, pursuant to Section 8(f) of the Act. Respondent is seeking a credit of TTD benefits paid in the amount of $165,370.27. (Arb. Ex. #1).

Findings of Fact

Robert Musselman (hereinafter referred to as "Petitioner") testified that, on December 1, 2011, he owned and worked at Shelter Builders (hereinafter referred to as "Respondent"). Respondent builds homes and remodels kitchens, bathrooms and basements. In addition, Respondent has a maintenance contract with an apartment complex. Petitioner testified that, in addition to his position as president of the company he also performs carpentry, electrical, plumbing and repairman duties. Petitioner testified that he would lift items such as windows, doors, roofing materials, water heaters and furnaces. Petitioner testified that also had to work stooped over while working in boiler rooms in the apartment buildings.

Petitioner testified that he graduated from Leo High School in 1971 and, after high school, he took courses in blue print reading and technology classes but did not earn a degree. Petitioner's prior work experience consists of working as a laborer in the construction industry.

Description of Accident

Petitioner testified that, on December 1, 2011, he received a call from Jim Stricklin who was at a job site in Glenn Ellyn. Petitioner drove to the job in Glen Ellyn. Petitioner and Mr. Stricklin discussed options on reinstalling tile. The customer advised Petitioner that there might be some tile in the basement. As Petitioner was walking down the basement stairs he fell. Petitioner testified that,

> *"I fell forward trying to catch my balance and twisting and turning, hit the table, caught my elbow on it and then I came down, my left knee banged and I – after that I just remember Jim picking me up. Or helping me up I should say." (T. pg.* 33).

Petitioner testified after his fall, his knees was hurting, and his back was stiff and progressively worsened throughout the day.

Mr. Stricklin testified that he was behind Petitioner on the stairs and it was dark. Petitioner was walking down the stairs when he missed the last step causing him to fall to the ground.

Petitioner's Pre-Accident Condition

In April of 2009, Petitioner treated with Dr. Frank Phillips at Midwest Orthopedics at Rush for back pain. (PX 2, pg. 10). Dr. Phillips performed surgery on July 1, 2009, consisting of a posterior spinal laminectomy – foraminotomy at L2-L3, L3-L4, L4-L5, and L5-S1; with posterior spinal instrumentation, L5 and S1 pedicle screws; posterolateral spinal fusion with local autograft and bone morphogenic protein infuse; and use of intraoperative neurophysiologic monitoring using the intraoperative fluoroscopy. (PX *23*, pgs. 11-13.).

On February 9, 2010, Dr. Phillips records state that *"[Petitioner] is actually doing quite well. He describes being 75 percent improved from preoperatively. He still has some discomfort in the buttocks and posterior thighs bilaterally, somewhat worse on the left. This is not positional and actually with walking distances he feels relief. He is walking a mile a day at his health club. He has some back discomfort. He has no pain really distal to the knee. He denies paresthesias or weakness."* (PX 23, Pgs. 11-13).

On March 2, 2010, a record from Athletico indicates that Petitioner returned to work performing light duty work. (PX 23, pg. 79). A follow up record dated August 20, 2010, states that Petitioner was "doing better and better" and had resumed "some" work. (PX 23, pg. 27). Petitioner testified that he returned to full duty work "sometime in 2010". (T. 27).

On February 17, 2012, after his work accident of December 1, 2011, Petitioner returned to Dr. Frank Phillips, the surgeon who performed Petitioner's 2009 surgery. In his records, Dr. Phillips described Petitioner's pre-accident condition as follows:

> *"Mr. Musselman is about three years out from a prior L3 to sacrum decompression, with L5 to S1 fusion for spondylolisthesis. He did quite well after that, suffering from only occasional intermittent back pain. He had returned to his work." (PX 2).*

Petitioner testified that he resumed remodeling kitchens, basements and performing building maintenance. Petitioner testified that he would occasionally see his pain doctor, Dr. McLaughlin, for palliative care and pain medication, which he would take after

returning home from work. (T. 28-29). Petitioner testified that prior to December 1, 2011, he had no issues involving his left shoulder or knees. (T. pgs. 29-30).

James Stricklin testified that he worked for Respondent for 13 or14 years. Mr. Stricklin was with Petitioner when Petitioner was injured on December 1, 2011. Mr. Stricklin testified that prior to December 1, 2011, Petitioner was working full duty. Mr. Stricklin further testified that after, December 1, 2011, he observed a change in Petitioner's physical condition and Petitioner was unable to work and it was even difficult for Petitioner to sit at a table.

Medical Treatment

On December 2, 2011, Petitioner sought care and treatment at Advocate Good Samaritan Hospital. The medical records contain the following history:

> *"This 58-year-old male presents to the emergency department with complaint of left posterior chest wall pain, low back and tailbone pain, bilateral knee pain and right ankle pain. The patient states yesterday afternoon that he missed 2 stairs and stumbled into a table. He states that he never fell to the ground. He believes he twisted and wrenched himself as he stumbled. He denies head injury or loss of consciousness. He denies neck pain. The patient took 2 Norco last night and 2 this morning with partial relief of his pain." (PX 1).*

The nursing triage notes identifies Petitioner's chief complaint as:

> *"Pt states he fell yesterday, tripped on stairs. Pt denies hitting head, loc. PT has pain to thoracic spine, left posterior ribs and flank, tailbone, bilateral knees and right ankle. PT was ambulatory upon arrival with altered gait. Hx spinal fusion." (PX 1).*

A CT of the lumbar spine was performed the same day. The radiologist, Dr. Geoffrey Chun, impression is as follows:

> *"No acute fracture is identified. Interval surgery. Interval development of restrolisthesis of L3 on L4 is subluxation at the L3-L4 facet joints. Old fracture of the left L3 inferior articular the fact with nonunion. Interval development of moderate to severe bilateral L3-L4 foraminal narrowing. Narrowing of the L4-L5 neural foramina which has increased since the previous study." (PX 1).*

On December 29, 2011, Petitioner was examined by his physician, Dr. Russell McLaughlin whose records state:

> *"53 year-old-male who reports he fell while working approximately a month ago and underwent MRI evaluation and since has had an exacerbation of his low thoracic pain and tailbone pain. He has been taking his medication with some limited improvement. He continues to work full time. He presents for a prescription refill. He denies any new numbness, weakness, changes in bowel or bladder function, depression or other complaints."*

Dr. McLaughlin noted the MRI showed no new significant findings. Dr. McLaughlin assessed *"multifactorial back pain, gradually improving on the regimen since recent fall. We will continue current treatment, but number of Norco tablets was increased up to six per day for his presumably transient increased pain."*

On February 17, 2012 Petitioner returned to Dr. Frank Phillips, the surgeon who performed Petitioner's 2009 back surgery, and reported the following history:

> *"On December 1st he fell down stairs, going down towards his knee and grabbing onto a table with his hand. He describes twisting his back and developing back pain since that time. Mr. Musselman describes primarily low back pain which does radiate up toward the thoracic spine. He also has pain over the coccyx. He did not specifically land on the coccyx. He has occasional lateral thigh pain to the level of the knee on the left." (PX 2).*

In his records, Dr. Phillips described Petitioner's pre-accident condition as follows:

> *"Mr. Musselman is about three years out from a prior L3 to sacrum decompression, with L5 to S1 fusion for spondylolisthesis. He did quite well after that, suffering from only occasional intermittent back pain. He had returned to his work." (PX 2).*

Dr. Phillips diagnosed a "thoracolumbar sprain / strain type injury" and he recommended a "more formal conservative program" consisting of medications and physical therapy. Dr. Phillips noted that "if he does not respond I would probably at that point proceed with an MRI to assess the integrity of the discs." At that time, Dr. Phillips issued 20-pound lifting restrictions.

Dr. Phillips also referred Petitioner to Dr. Shane Nho to address the bilateral knee pain. Petitioner saw Dr. Nho on February 20, 2012. Petitioner reported a history to Dr. Nho consisting of the following:

> *"The patient was going down a set of stairs. The patient said the basement was not well lit. The patient was able to walk on level ground, but there was actually two additional steps. The patient caught himself on a table, but at that point injured his back, tailbone, right ankle and bilateral knees."*

Dr. Nho's records state a 58-year–old male with a work-related injury occurring on December 1, 2011 complaining of bilateral knee pain. Dr. Nho administered an injection to the left knee and recommended a course of physical therapy. (PX 2).

On March 19, 2012, Petitioner returned to Dr. Nho. The records indicate that Petitioner was making good progress after the injection to his left knee. Dr. Nho recommended discontinuation of therapy for the knees, noting that Petitioner was also undergoing therapy for his back.

On March 30, 2012, Petitioner returned to Dr. Phillips for his back condition. Dr. Phillips noted that Petitioner was doing poorly, and his progress was slow. At that time, Dr. Phillips recommended a lumbar MRI and additional physical therapy. (PX 2).

The MRI was performed on April 9, 2012 at High Tech Medical Park in Palos Heights. After reviewing the MRI, Dr. Phillips stated, in his records, that:

> *"I have reviewed Mr. Musselman's lumbar MRI from April 9, 2012. This confirms the L5-S1 fusion construct across the grade 1 spondylolisthesis. All appears appropriate. At this level there has been good decompression. Disc height and signal intensity is well maintained at L4-5. At L3-4 there is subtle retrolisthesis and a disc protrusion. There does not appear to be any frank neural compressive pathology." (PX 2).*

Dr. Phillips noted that Petitioner continues to struggle with a "thoracolumbar muscle sprain/strain type injury", and that the MRI did not show any acute structural lumbar pathology. Dr. Phillips recommended work conditioning followed by an FCE, and he placed Petitioner on light duty. Dr. Phillips also prescribed a Medrol Dosepak.

On May 18, 2012, Petitioner returned to Dr. Phillips indicated that Petitioner was doing poorly and work conditioning was discontinued due to Petitioner's lack of progress. Dr. Phillips further noted that Petitioner was complaining of both thoracic spine and shoulder pain. At that time, Dr. Phillips referred Petitioner to Dr. Nho for evaluation of the shoulder and he prescribed a thoracic MRI. Dr. Phillips noted that Petitioner would "require ongoing pain management for his pain complaints."

On June 4, 2014, Petitioner returned to Dr. Nho reporting left shoulder, neck and finger numbness which started a month ago while Petitioner was in physical therapy. Petitioner had been engaged in overhead activity, lifting and pulling of heavy objects when he developed pain in the anterior and lateral aspects of the shoulder. Physical therapy had been discontinued due to

Petitioner's pain complaints. Dr. Nho diagnosed left shoulder rotator cuff, biceps tendonitis and he prescribed an MRI of the left shoulder.

The MRI of the thoracic spine was completed on June 19, 2012. Petitioner returned to Dr. Phillips on June 29, 2012. Dr. Phillips reviewed the MRI and noted a small midline disc protrusion at T6-T7 causing mild canal stenosis. At T7-8, there was a left paramedian disc protrusion causing mild to moderate left-sided stenosis with mild flattening of the left ventral cord with diffuse thoracic disc degeneration. Dr. Phillips recommended pain management. (PX 2).

On July 6, 2012, Petitioner underwent the MRI of the left shoulder and, on July 12, 2012, Petitioner returned to Dr. McLaughlin administered a thoracic epidural steroid injection at T7-8. (PX 1).

On July 16, 2012, Petitioner followed up with Dr. Nho who reviewed the left shoulder MRI. Dr. Nho noted the left shoulder MRI shows a full-thickness rotator cuff tear and biceps tendinitis. Dr. Nho recommended a left shoulder arthroscopic rotator cuff repair with possible subacromial decompression and biceps tenodesis. At that time, Petitioner was taken completely off work.

On August 2, 2012, Petitioner returned to Dr. McLaughlin for another thoracic ESI. (PX 1). On August 17, 2012, Petitioner followed up with Dr. Phillips who noted that Petitioner had undergone two thoracic ESI's with relief after the second injection. (PX 2). Dr. Phillips opined that Petitioner was "not a likely surgical candidate for his thoracio-lumbar spine" and commented that although Petitioner was off work for his shoulder, his spine injury limited him to no more than light duty work. Dr. Phillips recommended deferring the FCE until after Petitioner recovered from his left shoulder surgery.

Dr. Nho referred Petitioner to Dr. Labotka for pre-op evaluation. Surgery was attempted on October 11, 2012 but was aborted due to hypotension that developed after intubation. (PX 3). On November 13, 2012, Dr. Nho wrote a letter to Judy Zajac at Triune, stating that Mr. Musselman was suffering with left shoulder rotator cuff tendinitis and bicep tendinitis and the recent exacerbation of knee pain was not likely work related. (PX 2).

After another round of pre-op testing, the shoulder was performed on November 28, 2012. The preoperative diagnosis was "left shoulder rotator cuff tendinitis and biceps tendinitis". (PX 2, PX 5). After surgery, Petitioner underwent therapy for his left shoulder and continued to follow up with Dr. McLaughlin for pain management for his back.

On May 3, 2013, Dr. Phillips prescribed an FCE which was performed at ATI on May 3, 2013. (PX 7). On May 20, 2013, Dr. Phillips issued permanent restrictions of light to medium physical demand level, with the occasional lifting to 25.8 pounds chair to floor, 43.4 pounds bed to chair, and 19.2 pounds above the shoulder. (PX 2).

On May 24, 2013, Dr. Phillips readdressed the FCE restrictions, in that he would defer to pain management regarding whether or not Mr. Musselman could perform commercial driving due to the adverse effects of narcotic medications. (PX 2).

Petitioner continued treating with Dr. McLaughlin who noted that Petitioner's thoracic and lumbar pain had worsened, and that Petitioner was having difficulty with prolonged sitting, walking and had issues getting himself dressed.

On June 24, 2013, Petitioner underwent an EMG of the left lower extremity at DuPage Medical group per the request of Dr. Labotka. The EMG impression stated "[the] *Study is abnormal. Evidence for the presence of a left sided moderate chronic L5 radiculopathy with chronic denervation. No ongoing denervation is noted. No electrical evidence for any neuropathy noted.*

On August 22, 2013, Petitioner returned to Dr. McLaughlin. At that time, it was noted that Petitioner's leg pain had increased, the EMG revealed Petitioner's symptoms were coming from his back and that Petitioner's symptoms were not secondary to diabetic neuropathy. (PX 1).

On November 13, 2013 Petitioner sought a second opinion with neurosurgeon Matthew Ross at Midwest Neurosurgery & Spine Specialists. (PX 12). Dr. Ross noted Petitioner's pre-accident history of treatment for back pain. Dr. Ross also noted that Petitioner returned to work postoperatively. In his records, Dr. Ross stated that:

> *"In December 2011, he was going down the stairs at a job site. There was no light. He fell down the last 2 steps landing on his knee. States that he grabbed a table to help break his fall. After the fall, everything started hurting.".*

After examining the Petitioner and reviewing the records, Dr. Ross stated:

> *"The etiology of Mr. Musselman's ongoing back and leg symptoms are probably multifactorial. It is possible that a component of his pain is originating from the foraminal stenosis at the L3-4, L4-5 and / or L5-S1 levels. He does not have localizing neurologic signs to say this with certainty. As a result, I would recommend selective nerve root blocks and transforaminal cortisone injections to help identify what contribution of his pain is caused by foraminal stenosis at each of these levels. A component of*

his knee pain is undoubtedly coming from the knees themselves rather than being referred from the back. I would defer the evaluation and management of the knee symptoms to a qualified orthopedic specialist. I am concerned by the patient's high dose of narcotic analgesic medication. He is at risk for developing, if he has not already, narcotic hyperalgesic syndrome. The patient is concerned that the medications significantly impact his ability to think and remember. I would strongly recommend gradually weaning him down and off these drugs.".

Injections were performed on the following dates:

- January 16, 2014: Thoracic ESI at T6-7 performed by Dr. Russel McLaughlin. (PX 1).
- February 4, 2014: Transforaminal lumbar ESI at L4-5, left performed by Dr. Kwang Hwang. *(PX. 8).*
- February 18, 2014: Transforaminal ESI at L3-4, left by Dr. Kwang Hwang. (PX 8).
- February 26, 2014: Transforaminal ESI at L3-4, right by Dr. Kwang Hwang. (PX 8).
- March 10, 2014: Thoracic ESI at T10-11 by Dr. Kwang Hwang. (PX 8).
- April 7, 2014: Thoracic ESI at T10-11 by Dr. Kwang Hwang. (PX 8).

On April 21, 2014 Petitioner returned to Dr. Ross. At that time, Dr. Ross stated *"the lumbar selective nerve root blocks strongly suggest that a major component of [Petitioner's] pain is coming from the L3-4 and L4-5 levels. We know radiographically that these levels have foraminal stenosis." (PX 12).* Dr. Ross recommended surgical re-exploration with bilateral hemilaminotomies and foraminotomies at the L3-4 and L4-5 levels. Dr. Ross also discussed alternatives to surgery, including management strategies such as a spinal cord stimulator or chronic medication management. (PX 12).

On May 5, 2014, after falling, Petitioner was seen at Advocate Good Samaritan Hospital. (PX 4). At a follow up appointment with Dr. Labotka Petitioner said that loses his balance easily due to the medications. Dr. Labotka recommended a second opinion with Dr. Mather regarding the need for back surgery. Petitioner opted not to treat with Dr. Mather.

On June 26, 2014, Petitioner returned to Dr. McLaughlin and noted that Petitioner had not obtained imaging because "his work has recently become busy" and "he did not feel it was absolutely necessary". (PX 1). On July 24, 2014, Dr. McLaughlin noted that Petitioner "continues to work intermittently but is unable to have any sustained employment and typically realizes he is

done for the day after only an hour or two because of his significant worsening back pain." (PX 1).

On August 21, 2014, Dr. McLaughlin noted that Petitioner was not interested in further surgery but was interested in increasing his medication. Dr. McLaughlin also noted that the opioids enabled Petitioner to "continue working periodically" which he would otherwise be unable to do at all. (PX 1).

On September 4, 2014, Petitioner followed up with Dr. Ross who noted that Petitioner had ongoing back and leg symptoms and his use of OxyContin had also increased. Dr. Ross also noted that Petitioner lost 25 lbs. which, he said, shows a genuine commitment to his future health. In his records, Dr. Ross indicated that Petitioner was seriously considering surgery, and wanted to wean off narcotics before undergoing surgery. Dr. Ross recommended treatment from a formal detox or addiction specialist and he placed Petitioner on light duty with a 20-pound lifting limit. Dr. Ross also recommended against driving while on narcotic medication. (PX 12).

At Petitioner's next visit. Dr. Ross noted that Petitioner had reduced his OxyContin usage from 40 mg b.i.d. to 10 mg b.i.d. and had cut his oxycodone usage from 5mg 6 times per day to only 3 times per day. (PX 12). Dr. Ross ordered a lumbar myelogram and postmyelogram CT scan to assess the lumbar spine for evidence of nerve compression and he placed Petitioner on light duty with no lifting more than 20 pounds and sit/stand as needed. (PX 12).

The CT scan was performed on March 31, 2015. Dr. Ross reviewed the study and noted that he was not sure whether the L5 root symptoms were significant enough to justify surgery noting that the foraminal stenosis was most likely a contributing factor to Petitioner's ongoing symptoms. Dr. Ross further noted that Petitioner's thoracic pain was worse than the low back pain and leg symptoms. Dr. Ross recommended injections and pain management.

On May 21, 2015, Petitioner was seen by Dr. John Hong who performed transforaminal epidural steroid injections. (PX 9). On August 31, 2015, Petitioner returned to Dr. Ross who noted that, after the injections, Petitioner experienced almost 100% relief of pain for approximately 2 weeks, after which the pain returned. (PX 12). Dr. Ross recommend additional injections.

On September 16, 2015, Dr. Hong administered additional injections. On January 8, 2016, Petitioner returned to Dr. Ross who noted that Petitioner experienced pain relief after the injections but that the pain returned. Dr. Ross recommended surgery and took Petitioner off work. (PX 12).

On March 14, 2016, Petitioner was seen by Dr. Avi Bernstein, pursuant to Section 12 of the Act. Dr. Bernstein noted Petitioner's occupation as a carpenter and a contractor. Dr. Bernstein recorded the following history:

> *"The patient reports that he was involved in a work-related injury on December 1, 2011. The patient works as a maintenance carpenter and contractor. He reports that on the date of injury, he missed a step and went flying. He went down to his knee and left shoulder suffering a rotator cuff injury on the left shoulder. He subsequently had his left rotator cuff repaired on November 28, 2012."*

Dr. Bernstein acknowledged Petitioner's prior back problems, dating back to 2006, and reviewed the records with Petitioner. Dr. Bernstein opined that Petitioner suffered with severe subjective complaints of low back pain and bilateral lower extremity radiating pain with the left side being much worse than the right. Dr. Bernstein opined that Petitioner's medical treatment had been reasonable and necessary. As to causation, Dr. Bernstein opined as follows:

> *"[w]ith respect to causation, it appears that this patient has a chronic progressive degenerative condition of the lumbar spine. It is clear that he suffered a shoulder injury as a result of his work incident, but it is not clear that he suffered a low back injury as a result of the incident."*

On July 7, 2016, Petitioner underwent a lumbar MRI at Cadence Health. The MRI showed multilevel spondylotic and postsurgical changes throughout the lumbar spine. (PX 12).

On July 11, 2016, Petitioner saw Dr. Peter Lee at Northwestern. Petitioner was referred to Dr. Lee by Dr. Ross and Dr. Lee recommended an EMG of the bilateral lower extremities, physical therapy injections and evaluation for radio frequency ablation. Dr. Lee also noted that a spinal cord stimulator might be in order. (PX 10).

The EMG was performed on August 26, 2016. Dr. Lee noted the EMG showed chronic bilateral S1 radiculopathy. Dr. Lee recommended a pain management consult for spinal cord stimulator and/or a pain pump. (PX 10). The Spinal Cord Stimulator Trial was done on December 4, 2016. (PX 9).

On December 5, 2016, Petitioner returned to Dr. Bernstein, pursuant to Section 12 of the Act. Dr. Bernstein opined that because of Petitioner's chronic, persistent, subjective pain

complaints surgery was a reasonable option. Dr. Bernstein noted that Petitioner was uninterested in spinal fusion surgery and was pursuing spinal cord stimulation. (RX 2).

On January 23, 2017, Petitioner returned to Dr. Hong who noted that Petitioner experienced a substantial reduction in his pain level during the spinal cord stimulator trial. Dr. Hong recommended proceeding with the spinal cord stimulator. (PX 9).

Dr. Bernstein authored an addendum dated February 3, 2017. Dr. Bernstein limited Petitioner to a sedentary light physical demand level with a 15-pound lifting restriction with the ability to change position as required. Dr. Bernstein also recommended avoidance of repetitive bending, lifting or twisting. Dr. Bernstein opined that with respect to causation, there was "*not clear evidence that this patient suffered a low back injury as a result of his work-related incident. He has a significant pre-existing condition of the lumbar spine.*" (RX 4).

On February 8, 2017, the spinal cord stimulator was implanted. (PX 11). Petitioner developed a post-operative infection. (PX 9). By March 9, 2017, Petitioner's pain levels improved by 50%. (PX 9).

Thereafter, Petitioner was started on medical cannabis. (PX 20). Petitioner's Medical Cannabis Registered Qualifying Patient ID card was issued on June 10, 2017. (PX 19). Petitioner was utilizing both the spinal cord stimulator and medical cannabis with benefit. (PX 9).

On June 19, 2017, Petitioner underwent an MRI of the thoracic spine, at the request of Dr. Hong. The MRI showed thoracic spondylosis with posterior focal disc protrusion at T6-T7 and T7-T8.

On September 11, 2017, Petitioner underwent an FCE at Athletico. Petitioner was placed at the light physical demand level. (PX 17). On October 19, 2017, Dr. Hong placed Petitioner on permanent restrictions at the light physical demand level. Dr. Hong also continued to administer injections. (PX 9).

On February 13, 2018, Petitioner met with Dr. Patrick Sugrue who recommended multiple thoracic facet blocks. (PX 22). On April 5, 2018, Petitioner underwent a facet injection.

On June 19, 2018, Petitioner returned to Dr. Hong who noted that Petitioner was doing well on his medications, and Petitioner was advised to continue to use the spinal cord stimulator. (PX 9).

Deposition of Dr. Matthew Ross

Dr. Matthew Ross testified on September 1, 2017 via evidence deposition. Dr. Ross testified that Petitioner's spine related conditions of ill-being consisted of lumbar spondylosis with foraminal stenosis and radiculopathy. Dr. Ross opined that although the spondylosis and foraminal stenosis were not caused by the work accident, *"[t]he work accident caused the preexisting condition to become symptomatic."* Dr. Ross characterized this as an aggravation of a pre-existing condition. Dr. Ross testified as follows:

> *A. He has lumbar spondylosis with foraminal stenosis and some radiculopathy.*
>
> *Q. And, Doctor, were those conditions of ill-being causally related to the work accident of December 1st, 2011?*
>
> *A. The spondylosis and foraminal stenosis were not. Those predated the work accident. The work accident caused the preexisting condition to become symptomatic.*
>
> *Q. So would that be an aggravation of a preexisting condition, Doctor?*
>
> *A. I think you could accurately describe it as such.*
>
> *Q. And what is the basis for that opinion?*
>
> *A. You know, spondylosis is a degenerative arthritic condition that takes years to develop, so when we see that, you know, after an accident, we know the accident didn't cause it. So then the question is was it causing symptoms that predated the accident. He had had an excellent operation with Dr. Phillips addressing one consequence of the condition, which was spinal stenosis, and he was functioning reasonably well with, you know manageable back pain, low dose narcotic treatment occasionally, and after the work injury he was dramatically worse.*

On cross-examination, Dr. Ross further explained the basis for his opinion that the Petitioner had suffered an aggravation of a pre-existing condition:

> *Q. What do you look for when you're defining whether or not a condition has been aggravated?*

A. Well, we look at obviously subjective symptoms. We use pain medication as a yard stick, functionality as a yardstick, so if somebody, you know, to exaggerate the point, is managing pain with aspirin and now they are taking morphine, obviously you assume that's substantial aggravation. Mr. Musselman's ramp up of pain medication wasn't quite that extreme, but pretty close.

See Petitioner's Exhibit #13, pp. 52-53.

Dr. Ross also opined that Petitioner's need for treatment was accelerated as a result of the work accident:

Q. You talked about that condition and how it was aggravated by the work accident. How do you define an acceleration if I were to ask you whether or not the condition was accelerated by the work accident?

A. Well, that one's tougher, because there is, you know, natural progression of arthritis in the spine, which tends to be a slow process. If there is an abrupt change, that's not a natural, you know, progression of the aging process. Slow worsening is more consistent with natural aging.

Q. Would you say that the fact that this condition - - so the fact the condition was aggravated by the work accident does not exactly correlate to the condition being accelerated?

A. Well, it's - -

Q. Or the need for treatment would be accelerated?

A. It's the need for treatment would be accelerated.

Q. Was that the case with Mr. Musselman?

A. Correct.

Q. So it was aggravated - - the condition was aggravated as a result of the work accident?

A. Correct.

Q. And his need for additional treatment was therefore accelerated?

A. Correct.

See Petitioner's Exhibit # 13 at pp. 55-56.

Deposition of Dr. Avi Bernstein

Dr. Bernstein examined the Petitioner on 2 occasions. On March 14, 2016, Dr. Bernstein diagnosed Petitioner as follows:

> *"I felt that the patient had diffuse severe subjective complaints of low back pain and bilateral radiating leg pain, with the left side being worse than the right, due to multilevel degenerative change in the lumbar spine status post a fusion at L5-S1." (RX 5).*

When asked about the issue of causation, Dr. Bernstein testified as follows:

> *"I could not find causation in terms of a work injury being responsible for this patient's clinical condition." (PX 5).*

The bases for Bernstein's opinion on causation were as follows:

> *Q. And what was the basis for your finding on the issue of causation?*
>
> *A. The basis of my finding is a chronic pre-existing symptomatic condition of the lumbar spine, an admitted history of an inability to work full days following his low back surgery, and the expected progression of the degenerative condition leading to further chronic complaints of pain.*

On cross examination, Dr. Bernstein testified:

> *"Well, it's to a reasonable degree of medical certainty, right? So, I think it's more likely than not that he didn't have a permanent aggravation."*
>
> *Q. When did it end?*
>
> *A. I can't tell you that it ended on a particular date. (RX 5. Pgs. 41,42).*

Dr. Bernstein further testified:

> *"I believe that he would have had progression of his symptoms based on his degenerate changes in the absence of the fall." (RX. 5. Pgs. 43,44).*

Q. How long after the 12/1, in the absence of the fall?

A. I can't tell you. I'd have to analyze the record to see when he really started to have the diffused back pain and radiating leg pain. (RX 5, pg. 44).

Deposition of Ed Pagella

Ed Pagella testified that he has been vocational rehabilitation consultant for over 25 years and he is a certified rehabilitation counselor and a licensed clinical professional counselor. Mr. Pagella opined that Petitioner could not return to his prior occupation. (PX 14, pg. 20, 21). As to whether Petitioner could return to his prior occupation, Mr. Pagella testified as follows:

Q. Were you able to form an opinion to a reasonable degree of professional certainty as to whether or not Mr. Musselman was capable of returning to work as a maintenance repairman?

A. Yes.

Q. What was that opinion?

A. That he would be unable to return back to work as a maintenance repair person because his past relevant work did require him to do some heavy lifting, as I indicated; and whether you are repairing doors, or you are replacing windows, these items weigh over 50 pounds easily, sometimes over 100 pounds. So just in regarding the weight that he would be required to lift, both physicians - - the treating and the IME physicians, have limited him to sedentary to light physical tolerance. So first off, you have to take a look at the hierarchy of vocational rehab. What is the first thing you look at is whether or not he could return back to his previous occupation, performing his same job; and no, he couldn't based upon his physical limitations.

When asked whether or not Petitioner was a candidate for vocational rehabilitation, Mr. Pagella opined as follows:

"Mr. Musselman would be employable if I took away – I am not going to say it is possible for him to become employable. If I would take away the medicine, the marijuana, the fact that he is in chronic pain, if you just take that away and just give me the restrictions obviously of a 64 year old individual who is limited to these physical restrictions as outlined by the doctors, I would say okay. Give me a chance to try to find him alternative work. It may be possible." (PX 14, pgs. 26-27).

Mr. Pagella further testified that Petitioner was not a good candidate for job placement:

> *"My opinion in this case is that he is unemployable based upon all the medications that he is currently taking, that employers are not going to hire somebody that is – that gives all the reasons to his downside, and I would have to go through those reasons again. So those would be my reasons, not just that he shouldn't go out there and look for work. An employer is not going to hire somebody based upon the factors he currently has." (PX 14,* pg. 42).

Deposition of Diamond Warren

Diamond Warren testified that he has been a vocational consultant for approximately 9 years. Ms. Warren opined that Petitioner could secure employment as a building supply salesman, a construction salesman, or as a subcontracting clerk. (RX 7, pg. 19). When asked whether or not Petitioner was a good candidate for job placement services, Ms. Warren responded:

> *"Based on–one, based on, you know, he presented himself. And then, two, his restrictions. You know, he also was already looking for work, so he kind of had a head start on what to do. He just probably needs help, you know, maybe creating a resume, cover letter and how to interview and fill out applications." (RX 7, pg..22).*

Ms. Warren noted that Petitioner was of advanced age and that Petitioner's medications could adversely affect his ability to remain on task. Ms. Warren acknowledged that although Petitioner was a high school graduate, his graduation certificate from 1971 would not allow for direct entry into the modern job force. (RX 7, pg. 27).

Petitioner testified that he closed this business in November of 2016 and he has not worked after the business closed. Petitioner testified that he tried to look for work and his daughter helped him make a resume. Petitioner testified that he looked for work in a supervisory capacity and in the areas of nursing homes, building maintenance and as a factory worker. Petitioner testified that he received only one call back and he called that individual back leaving a phone message. That individual did not return Petitioner's call. Petitioner testified that he also contracted Aflack Insurance company seeking work. Petitioner testified that he was not provided any assistance to find work from Ms. Warren.

Petitioner testified that he still experiences back pain that travels into his left leg. Petitioner testified that his pain worsens if he is sitting for long periods of time or walks too much. Petitioner

testified that he can only walk for about 10 minutes. Petitioner testified his pain levels improved with the stimulator.

Petitioner testified that it is difficult dressing himself and he must put his belt on his paints before putting on his pants and he must sit down to put on his pants. Petitioner testified that he is unable to do things he did such as landscaping and going to the grocery store. Petitioner testified that when he goes to the grocery store he needs to sit down on a bench. Petitioner testified that he has problems reaching overhead and picking things off the floor. Petitioner still takes pain medication including oxycodone and cannabis. Petitioner testified the last check he received was on October 23, 2018.

The Arbitrator found the testimony of Petitioner and Mr. Stricklin to be credible.

Conclusions of Law

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law as set forth below. The claimant bears the burden of proving every aspect of her claim by a preponderance of the evidence. *Hutson v. Industrial Commission*, 223 Ill App. 3d 706 (1992).

With Respect to Issue (F) Is Petitioner's Current Condition of Ill-being Causally Related To The Injury, The Arbitrator finds as follows:

In preexisting conditions cases, recovery will depend on the employee's ability to show that a work-related accidental injury aggravated or accelerated the preexisting disease such that the employee's current condition of ill-being can be said to have been casually-connected to the work-related injury and not simply the result of a normal degenerative process of the preexisting condition. *Caterpillar Tractor Co. v. Industrial Comm'n*, 92 Ill2d 30, 36-37. When a workers' physical structures, diseased or not, give way under the stress of their usual tasks, the law views it as an accident arising out of and in the course of employment. *General Electric Co. v. Industrial Comm'n*, 89 Ill.2d 432, 60 Ill. Dec. 629, 433 N.E.2d 671 (1982). If a pre-existing condition is aggravated, exacerbated or accelerated by an accidental injury, the employee is entitled to benefits. *Rock Road Construction v. Industrial Commission*, 227 N.E.2d 2d 65, 67, 68 (1967), see also *Illinois Valley Irrigation v. Industrial Commission*, 362 N.E.2d 339 (1977). When a pre-existing condition is present, a claimant must show that a work-related accidental injury aggravated or accelerated the pre-existing condition such that the employee's current condition of ill-being can be said to have been causally connected to the work-related injury. *St. Elizabeth Hospital v.*

Workers' Compensation Commission, 864 N.E.2d 266, 272, 273 (5th Dist. 2007). 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' injury. *International Harvester v. Industrial Commission,* 93 Ill.2d 59, 63-64 (1982). Causal connection between work duties and an injured condition may be established by a claim of events including claimant's ability to perform duties before the date of an accident and inability to perform same duties following date of accident. *Darling v. Industrial Commission,* 176 Ill.App.3d 186, 530 N.E.2d 1135 (1988). A claimant's prior condition need not be a of good health prior to the accident, 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 and the salient factor is not the precise previous condition, it is the resulting deterioration from whatever the previous condition had been. *Schroeder v. Illinois Worker's Compensation Comm'n,* 4-16-0192WC (Fourth Dist. 2017). In fact, a claimant with a preexisting condition may recover where employment aggravates or accelerates that condition. *Caterpillar Tractor Co. v. Industrial Commission,* 92 Ill. 2d 30, 36 (1982).

The Arbitrator has carefully reviewed and considered all medical evidence along with all testimony. The Arbitrator concludes that Petitioner has proven by the preponderance of the credible evidence that a causal connection exists between Petitioner's current back condition and his work accident of December 1, 2011 which aggravated Petitioner's pre-existing low back condition and accelerated the need for medical treatment, and his work accident of December 1, 2011 also caused the injury to Petitioner's left shoulder, thoracic spine, bilateral knees and right ankle, as more fully set forth below.

There are conflicting medical opinions regarding causation of Petitioner's lower back condition. Petitioner had a preexisting back condition. The Arbitrator finds that prior to his work accident of December 1, 2011, Petitioner had returned to work and was able to perform his job duties. The Arbitrator further finds that after his work accident of December 1, 2011, Petitioner's ability to perform his job duties significantly deteriorated, caused a significant increase of pain medication usage, and necessitating the imposition of permanent work restrictions which did not exist prior to the December 1, 2011 work accident.

The Arbitrator finds the opinions of Dr. Ross to be more persuasive than the opinions of Dr. Bernstein regarding the issue of whether Petitioner's current low back condition being causally

related to his work accident of December 1, 2011. It is for the Commission to decide which medical view is to be accepted, and it may attach greater weight to the opinion of the treating physician. *International Vermiculite Co. v. Industrial Commission,* 77 Ill. 2d. 14 (1979). Treating physicians acquire their facts and opinions, not in anticipation of trial, but as actors and viewers of the subject matter that gives rise to the litigation. *See Tzystuck v. Chicago Transit Authority,* 124 Ill. 2d 226, 235 (1988). It may be said that the connection between a medical expert who is "retained to render an opinion at trial" and the party to the suit may be litigation-related, rather than treatment-related. *Id.* at 234. Treating physicians, on the other hand, typically are not "retained to render an opinion at trial" but are consulted, whether or not litigation is pending or contemplated, to treat a patient's physical or mental problem. *Id.* While treating physicians may give opinions at trial, those opinions are developed in the course of treating the patient and are completely apart from any litigation. *Id.*

As set forth in the Statement of Facts, Dr. Ross addressed both the Petitioner's clinical presentation, but he also considered the significant deterioration of Petitioner's condition after is work accident of December 1, 2011. Dr. Bernstein opined that Petitioner's back condition was the result of an ongoing degenerative process. Dr. Bernstein testified that he "could not find evidence that [Petitioner] suffered a back injury on the job" which, the Arbitrator finds, inconsistent with the testimony of the Petitioner, Mr. Stricklin and the medical records. Dr. Bernstein failed to sufficiently address the various medical records which documented a deterioration of Petitioner's condition after December 1, 2011. Further, Dr. Bernstein's causation opinion regarding Petitioner's back condition was based, in part, upon his belief that Petitioner never returned to full time work after his fusion surgery in 2009. The Arbitrator finds that Dr. Bernstein's understanding of Petitioner's work activities prior to December 1, 2011 to be contrary to the evidence.

Dr. Bernstein disputed only that Petitioner's low back injury was related to Petitioner's work accident of December 1, 201. Dr. Bernstein did testify that Petitioner's shoulder condition and thoracic spine injury were related to his work accident of December 1, 2011.

The Arbitrator finds that the Petitioner's medical records and testimony of Petitioner and Mr. Stricklin confirm that Petitioner's low back condition significantly worsen after his work accident of December 1, 2011. The Arbitrator notes that Dr. Ross provided a detailed basis for his opinion that Petitioner's back condition was aggravated by the accident.

The Arbitrator further notes that Dr. Bernstein acknowledge that Petitioner may have had an aggravation of his back condition but not a permanent aggravation. However, Dr. Bernstein was unable to tell when the aggravation resolved, if at all. Dr. Bernstein opined that Petitioner would have had a progression of his symptoms based upon his degenerative changes in absence of Petitioner's December 1, 2011 fall. However, Dr. Bernstein was unable to provide and opinion as to when Petitioner's symptoms progressed due to degenerative changes. When asked this question Dr. Bernstein testified that he couldn't answer the question and he would need to analyze the record to see when Petitioner started to have diffused back pain and radiating leg pain. (RX 5, pg. 44). The Arbitrator finds that Dr. Bernstein's inability to identify the onset of the symptoms due to degenerative changes undermines his opinion that Petitioner's symptoms were not aggravated or accelerated by the work accident of December 1, 2011.

The Workers' Compensation Act is a humane law of remedial nature, and wherever construction is permissible its language is to be liberally construed to affect the purpose of the Act. The purpose of the Act is that the burdens of caring for the casualties of industry should be borne by industry and not by the individuals whose misfortunes arise out of the industry, nor by the public. Every injury sustained in the course of the employee's employment, which causes a loss to the employee, should be compensable. *Shell Oil v. Industrial Commission,* 2 Ill. 2d 590, 596 (1954). It is well established that an accident need not be the sole or primary cause – as long as employment is a cause – of a claimant's condition. *See Sisbro, Inc. v. Industrial Commission,* 207 Ill. 2d 93, 205 (2003).

With Respect to Issue (J), Whether the Medical Services Provided to Petitioner Were Reasonable and Necessary and Whether Respondent Paid all Appropriate Charges, the Arbitrator Finds as Follows:

Petitioner initially sought treatment at the Advocate Good Samaritan Emergency Room on December 1, 2011. (PX 1). He next followed up with his pain management physician, Dr. McLaughlin. McLaughlin would constitute Petitioner's first choice of physician. Dr. Hong took over treatment of patients for Dr. McLaughlin when McLaughlin left his practice. As a result, Dr. Hong is within the chain of referral as required by the two-physician rule. Dr. Hong referred Petitioner to Dr. Sugrue, keeping Dr. Sugrue within the two-physician rule.

On February 17, 2012, Petitioner opted to see Dr. Frank Phillips, with whom Petitioner had treated for back issues in the past. The Arbitrator finds that Dr. Phillips is Petitioner's second

choice of physician. Dr. Phillips referred Petitioner to Dr. Shane Nho and, as such, Dr. Nho is also within the chain of referrals. Dr. Nho referred Petitioner to his family physician, Dr. Labotka, for pre-surgical clearance which keeps Dr. Labotka is also within the chain of referrals.

Petitioner testified, and the medical records support that Petitioner sought care and treatment with Dr. Ross without a referral from any physician within the chains of referral. As such, the Arbitrator finds that Dr. Ross would be considered a third choice of physician, outside of the two physicians allowed under the Illinois Workers' Compensation Act, as well as Drs. Hwang and Lee who were both referred by Dr. Ross.

The Arbitrator finds that Petitioner's treatment has been reasonable, necessary and related to his work injury. The Arbitrator notes that Dr. Bernstein also opined that Petitioner's treatment was reasonable and necessary including the need for a spinal cord stimulator. Dr. Ross also testified that Petitioner's treatment was reasonable, necessary and related to the work accident.

As such, the Arbitrator awards medical as follows:

Adventist Hinsdale Hospital: $117,356.02
Athletico: $13,212.00
ATI Physical Therapy: $2,679.30
Midwest Orthopedics at Rush: $41,107.25
Rush Oak Park Hospital: $22,260.84
Rush University Hospital: $42,218.57
DuPage Medical Group: $4,782.00
Dr. John Hong: $37,422.00
Advocate Good Samaritan: $79,875.93
Dr. Patrick Sugrue: $275.00
Advocate Good Samaritan Radiology: $4022.00
Mobile Anesthesiologists: $20,630.26
Osco Pharmacy: $27,988.77
Athletico FCE (9/11/17): $1,575.00

Respondent shall pay the above total amount of $415,404.94 pursuant to Sections 8 and 8.2 of the Illinois Workers' Compensation Act, subject to the fee schedule. Respondent shall receive a credit for payments made by the workers' compensation insurance carrier in the amount of $63,991.91. When issuing payment for the above medical charges to the Petitioner, the Respondent shall provide Petitioner with any fee schedule or negotiated rate calculations used to determine the final amount owed to the Petitioner.

With Respect to Issue (K), Whether Petitioner is entitled to TTD benefits, the Arbitrator finds as follows:

Petitioner claims to be entitled to TTD benefits from July 16, 2016 through October 18, 2017 representing 274 2/7 weeks. Respondent paid $165,370.27 in TTD benefits. (Arb. Ex. #1).

TTD is awarded for the period from the date of which the employee is incapacitated by injury to the date that his condition stabilizes, or he has recovered as far as the character of the injury will permit. *See Freeman United Coal Min. Co. v. Industrial Commission,* 318 Ill. App. 3d 170, 177 (2000). To be entitled to TTD benefits, the claimant must prove not only that he did not work but that he was unable to work. *Id.* The fact that a claimant may occasionally earn wages or perform useful services does not preclude an award of TTD. *See Zenith Co. v. Industrial Commission,* 91 Ill.2d 278, 286087 (1982).

TTD: 7/16/12 thru 10/18/17

On February 17, 2012, Dr. Phillips placed Petitioner on restrictions of no lifting more than 20 pounds. Petitioner testified that he tried to continue working within his restrictions. (T. pgs. 36-37). Petitioner continued to work through the early part of 2012. (T. pg. 111). Petitioner testified that he continued to work until being taken off work by Dr. Nho on July 16, 2012. Petitioner testified that he was off work per his doctor's recommendations from July 16, 2012 until Dr. Nho placed him on restricted work of no lifting in excess of 10 pounds at the sedentary level of work. (PX 2). Petitioner testified that there was "very little" he could do. Most of the work performed at Shelter Builders was "time and material". The only thing he would have been able to do was "hang around", but he wouldn't be paid for it. (T. 43).

Petitioner was placed at maximum medical improvement as of May 24, 2013, after the FCE, but that Dr. Phillips deferred to Petitioner's pain management physician as far as the need for restrictions due to Petitioner's usage of narcotic pain medication. (PX. 2).

On September 19, 2013, Dr. McLaughlin noted that Petitioner's back pain prevented him from working. On February 6, 2014, Dr. McLaughlin noted, again, that Petitioner was unable to work. In July of 2014, Dr. McLaughlin noted that Petitioner was only able to work intermittently and was unable to perform sustained employment. Dr. McLaughlin further commented that Petitioner was limited to an hour or two of work per day because of his significant back pain. On August 21, 2014 Dr. McLaughlin noted that the only reason Petitioner was able to work periodically was due to the use of opioid analgesics.

On September 4, 2014, Dr. Ross imposed light duty restrictions. (PX 12). The restrictions continued to exist until Dr. Ross took Petitioner off work on January 8, 2016. (PX 12). On March 14, 2016, Respondent's Section 12 examining physician, Dr. Bernstein, placed Petitioner on a sedentary work restriction. (RX 1).

Respondent dissolved in November of 2016. (T. pg. 102).

On February 3, 2017, Dr. Bernstein noted, again, that Petitioner was limited to a sedentary light physical demand level, with 15 pounds lifting restrictions and that Petitioner should be able to change his position as required and was to avoid any repetitive bending, lifting or twisting. These restrictions continued until Dr. Hong placed Petitioner on permanent restrictions as of October 19, 2017.

Although Petitioner made attempts to return to some level of work between July 16, 2012 and October 19, 2017, it is apparent from both Petitioner's testimony and the medical records that Petitioner was not capable of engaging in substantial gainful activity between July 16, 2012 and the closing of the business in November of 2016. This is further substantiated by the testimony of James Stricklin, who testified that after the work accident on December 1, 2011, Petitioner was no longer performing his job duties. (T. pg. 11).

As such, the Arbitrator awards TTD benefits from July 16, 2012 through October 18, 2017 representing 274 2/7 weeks. The Arbitrator finds that Respondent is entitled to a credit of $165,370.27 for TTD benefits Respondent paid.

Maintenance: 10/19/17 thru 1/17/19

On October 19, 2017, Dr. Hong placed Petitioner at maximum, medical improvement and imposed permanent restrictions at the light physical demand level. Respondent failed to offer Petitioner any assistance in finding alternative employment or vocational training. Petitioner engaged in a self-directed job search. Petitioner's daughter helped him to prepare a resume and helped him to create an account on indeed.com. (T. pgs. 65-66). Petitioner testified that he looked for jobs related to condominium and apartment building maintenance, looking specifically for supervisory roles. Petitioner testified that he looked for jobs at nursing homes and factories. Petitioner submitted into evidence over 100 pages of documented job search logs. (PX 16).

Petitioner networked with friends, including a friend who worked for a management company and another friend who worked as a mill supplier, but there were no positions available. Petitioner received only one phone call form an apartment complex in Homewood, but never heard

back from them after providing them with his information. (T. 67). Petitioner testified that as of the date of the hearing, he continues to look for work.

Petitioner testified that he met with vocational experts Ed Pagella and Diamond Warren. Petitioner confirmed that despite meeting with Ms. Warren, the Respondent never offered any job placement assistance. (T. pg. 69).

The Arbitrator finds that Petitioner has put forth a reasonable effort to find suitable employment within his restrictions. Petitioner has continued to look for work despite the fact that Ed Pagella has deemed Petitioner unemployable, and Respondent's own expert stated that Petitioner would require assistance to find suitable alternative employment. As such, the Arbitrator awards maintenance benefits from October 19, 2017 through January 17, 2019 representing 65 2/7 weeks.

With Respect to Issue (L) the Nature and Extent of Petitioner's Injury, the Arbitrator Finds as Follows:

The Arbitrator finds that Petitioner is permanently and totally disabled under the odd lot theory as of the date of hearing, January 18, 2019. A person is permanently and totally disabled when he cannot perform any services except those for which no reasonably stable labor market exists. *A.M.T.C. of Illinois v. Industrial Commission,* 77 Ill.2d 482, 487 (1979). He need not show he has been reduced to total physical incapacity before being entitled to a permanent and total disability award. *Interlake, Inc. v. Industrial Commission,* 86 Ill. 2d 168, 176 (1981). In addition, where any employee's disability is limited in nature so that he is not obviously unemployable or if there is no medical evidence to support a claim of permanent total disability, the burden is on the employee to establish by a preponderance of the evidence that he falls into the "odd lot" category, "that is, one who, although not altogether incapacitated to work, is so handicapped that he will not be employed regularly in any well-known branch of the labor market." *Westin Hotel v. Illinois Workers' Compensation Commission,* 372 Ill. App. 3d 527, 544 (2007).

A claimant may establish he is permanently and totally disabled under the odd lot theory by showing that: (1) considering his age, education, skills, training, physical limitations and work history he would not be regularly employable in any well-known branch of the labor market or (2) following a diligent job search, he was unable to find gainful employment.

When a claimant makes a *prima facie* showing that he falls into the odd lot category, the burden shifts to the employer to show that a reasonably stable job market nevertheless exists for that employee. *See Kula v. A.E.R.O Special Education Cooperative,* 18 I.W.C.C. 0705 (November 19, 2018).

The Arbitrator finds that Petitioner established by a preponderance of the credible evidence that he falls within the odd lot category. Petitioner has permanent restrictions as a result of his conditions of ill being. Both vocational experts agree that these permanent restrictions prevent Petitioner from returning to his usual and customary employment.

As to the first prong of the "odd-lot" analysis, vocational expert Ed Pagella credibly explained that Petitioner was not an ideal candidate for vocational services. There existed negative factors contributing to the overall conclusion that Petitioner was not a good candidate for such services. Mr. Pagella explained that Petitioner's advanced age, significant gap in employment, need for ongoing narcotic medication and medical marijuana would be considered a liability to prospective employers. Mr. Pagella concluded Petitioner would not be suitable for any stable employment and that Petitioner's restrictions impede any transferability of past relevant skill sets, and that Petitioner's use of prescribed narcotic medication and medical marijuana are significant obstacles that impeding Petitioner's ability to secure alternative employment.

As to the second prong of the odd-lot analysis, Petitioner's efforts to obtain employment via his job search logs demonstrate a reasonable effort on his part to look for work but also demonstrate Petitioner's inability to secure employment given his overall vocational state. It should be noted that Petitioner was never provided with any vocational assistance by the Respondent, despite the recommendations of their own vocational expert. The Arbitrator concludes that Petitioner has satisfied his burden meeting both prongs of the analysis.

Petitioner having met his burden of a prima facie case of permanent total disability, the burden shifts to Respondent to show that a reasonably stable job market nevertheless exists for the Petitioner.

Respondent asserts that a suitable work which is regularly and continuously available to Petitioner exists. Respondent offered the report and testimony of their vocational expert, Diamond Warren. (RX 6 & 7). Ms. Warren testified that Petitioner could work in building supply sales, construction sales and as a subcontracting clerk. However, Ms. Warren admitted that she could not state for certainty exactly what jobs would be available absent the implementation of a formal

vocational plan. Ms. Warren opined that Petitioner would need additional training to get up to speed and she was not aware of the work restrictions imposed by Dr. Bernstein. (*RX 7, pg. 28*). Ms. Warren also acknowledged that Petitioner's medications could affect his ability to remain on task. (RX 7, pgs. 30). Ms. Warren testified that she was not familiar with the guidelines put forth in National Tea, despite referencing those guidelines in her report.

The Arbitrator finds the opinions of Mr. Pagella to be more persuasive than the opinions of Ms. Warren. The Arbitrator further finds that Respondent failed to show that a reasonable stable job market exists for the Petitioner. The Arbitrator specifically notes that Respondent's expert testified that Petitioner would require assistance in order to secure alternative employment which Respondent did not authorize or provide assistance. The Arbitrator further notes that Respondent's own Section 12 examining physician, Dr. Avi Bernstein, opined that Petitioner would be limited to sedentary work, which is even more restrictive than the restrictions imposed by Petitioner's treating physicians and that Ms. Warren acknowledged Petitioner's sedentary restriction would further erode the availability of unskilled jobs available to Petitioner. (RX 7, pgs. 45-46).

With Respect to Issue (O), is Respondent due any credits, the Arbitrator finds as follows:

As set forth above, The Arbitrator finds that Respondent is entitled to credit for TTD and for medical bills paid by the workers' compensation insurance carrier.

Submission Confirmation Receipt
Report Date/Time:07/14/2020 04:32:05 PM CST
Capture Type: Check

This Submission Confirmation receipt represents items submitted for transfer and is not a deposit confirmation. Please verify individual transaction status from Capture Search.

Lockbox Number	Lockbox Name	Group Number	Group Name	Batch Number	Captured By	Capture Date/Time	Remitter RT	Remitter DDA	Payment Number	Amount	Reference Text
1756535	RDC - IL WORKERS' COMPENSATION COMMISSION	2370101090	SELF-INSURER'S SECURITY FUND	Pending	Inez Gardner	07/14/2020 04:30:29 PM	061112788	3299919128	0244563	21,148.93	
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1756535	RDC - IL WORKERS' COMPENSATION COMMISSION	2370101090	SELF-INSURER'S SECURITY FUND	Pending	Inez Gardner	07/14/2020 04:30:29 PM	053101561	4759628092	0107628541	10,205.34	
1756535	RDC - IL WORKERS' COMPENSATION COMMISSION	2370101090	SELF-INSURER'S SECURITY FUND	Pending	Inez Gardner	07/14/2020 04:30:29 PM	043301627	1028940736	008611902	7,142.40	
1756535	RDC - IL WORKERS' COMPENSATION COMMISSION	2370101090	SELF-INSURER'S SECURITY FUND	Pending	Inez Gardner	07/14/2020 04:30:29 PM	043301627	1028940736	008611901	185.58	
1756535	RDC - IL WORKERS' COMPENSATION COMMISSION	2370101090	SELF-INSURER'S SECURITY FUND	Pending	Inez Gardner	07/14/2020 04:30:29 PM	031100209	38910165	100182574	9,672.00	

Total Number of Checks	7
Total Amount	55,239.03

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

Jose Luis Aparicio,

Petitioner,

vs.

NO: 12 WC 27457

20IWCC0397

Classic Party Rentals,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issue of 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.

Petitioner does not challenge the Arbitrator's conclusion that Petitioner attained maximum medical improvement ("MMI") on November 12, 2012; instead, he argues solely that the Arbitrator improperly found Petitioner's medical expenses for ongoing cervical treatment performed after the date of MMI were not reasonable, necessary, and causally related to the work accident. The Commission agrees with the Arbitrator's conclusion that Petitioner failed to meet his burden of proving the medical services he received regarding his cervical spine injury after November 12, 2012, were reasonable and causally related to the work accident.

Pursuant to Section 8(a) of the Act, an employer must pay for all necessary medical, surgical, and hospital services that are reasonably required to cure or relieve the effects of a compensable accidental work injury. The Appellate Court has held that an employer remains liable for expenses "...so long as the medical services are required to relieve the injured employee from the effects of the injury." *Elmhurst Memorial Hospital v. Indus. Comm'n*, 323 Ill. App. 3d 758, 164 (2001). However, "...the employee is only entitled to recover for those medical expenses which are reasonable and causally related to [the] industrial accident." *Id.* at 764-65. After reviewing the totality of the evidence, the Commission finds Petitioner did not meet his burden of proving the medical treatment he underwent after the date of MMI was reasonable and causally related to the work accident.

A careful review of the evidence, including Petitioner's testimony and the medical records,

20IWCC0397

reveals Petitioner's ongoing subjective complaints were inconsistent and unsupported by objective findings. Throughout his treatment, Petitioner repeatedly gave conflicting statements regarding his pre-accident cervical complaints. For example, there are conflicting reports regarding whether Petitioner's cervical complaints relating to his earlier July 6, 2011, work accident had resolved prior to his May 22, 2012, injury. Petitioner testified that his prior complaints resolved, and he returned to work full duty by February 10, 2012. He testified that he received no treatment between February 10, 2012, and the May 22, 2012, accident. However, on May 23, 2012, Petitioner told his doctor that following the July 2011 accident he returned to work full duty with "minimal" cervical pain. He then reported that after approximately a month of working full duty, Petitioner began experiencing increasing pain in his neck and mid-back.

Similarly, in August 2012, Petitioner told Dr. Henriquez, his primary care physician, that while physical therapy and medication helped improve his complaints, he continued to experience neck and back pain once he returned to work in February 2012. When Dr. McNally first examined Petitioner in January 2013, Petitioner again reported that while he returned to work full duty following the July 2011 injury, on the date of accident he continued to take pain medication and experience cervical pain relating to that previous injury. During the Section 12 examination performed by Dr. Mather, Petitioner again confirmed that prior to his injury on May 22, 2012, he had been working with cervical pain.

Perhaps the most glaring evidence of Petitioner's inconsistent reports of pain is seen in the results of the September 11, 2012, functional capacity evaluation ("FCE"). The evaluator wrote that the overall test findings, combined with his clinical observations, suggested the presence of minor inconsistencies regarding the reliability and accuracy of Petitioner's reports of pain. The evaluator wrote:

> "Also, according to the Neck Disability Index, the client perceived himself to experience moderate disability despite later testing to medium and heavy physical demand levels. During strength testing, [Petitioner] reported a fear of pain onset with lifting 50 lbs. prior to returning to work, but demonstrated the ability to lift 50 lbs. repeatedly. This indicated that at times, [he] may be able to do more than he perceives or reports."

(PX 3). The evaluator wrote that Petitioner refused to lift 50 lbs. because he was not ready to return to work. Petitioner ultimately participated in three FCEs. While a December 2013 FCE was deemed valid by the evaluator, the results indicated Petitioner could perform at a lower physical demand level than his known capabilities in September 2012. However, a third FCE conducted in June 2013 once again revealed several inconsistencies in Petitioner's reported capabilities and pain levels. Although the evaluator deemed the results valid, Petitioner only achieved a 75% consistency of effort.

Additional evidence of Petitioner's history of inconsistent complaints is seen in the results of the Section 12 examination Dr. Mather performed on behalf of Respondent on March 15, 2013. (RX 9). Dr. Mather performed a physical examination of Petitioner and determined there were no objective findings supporting Petitioner's ongoing complaints of pain and discomfort. He opined

20IWCC0397

that Petitioner had reached MMI and could return to working at a heavy-duty physical capacity without restrictions in relation to the work accident. His opinions were based on several factors including the absence of objective findings during his examination of Petitioner, inconsistencies regarding Petitioner's history of complaints both during the Section 12 examination and throughout the medical records, and the clear self-limiting performance during the September 2012 FCE. Dr. Mather also noted Petitioner's wide-ranging cervical, thoracic, and upper lumbar symptoms that the doctor could not explain given the benign physical examination and the cervical MRI findings. Dr. Mather credibly testified that no further treatment was medically necessary particularly given the evidence of symptom magnification by Petitioner during his Section 12 examination.

Petitioner continued to undergo conservative treatment through April 2014. Dr. Novosoletsky, a pain management doctor, performed several rounds of cervical steroid epidural injections and cervical prognostic medial branch blocks from April 2013 through January 2014. The doctor also performed a cervical radiofrequency neurotomy during this period. Petitioner reported very inconsistent results from the numerous injections and continued to report wide-ranging complaints. Petitioner testified that he received approximately one to two weeks of relief following his injections before his symptoms returned. He testified his pain returned when he returned to work after undergoing the injections. However, the contemporaneous records present a different story. For example, following a cervical medial branch block performed in May 2013, Petitioner initially reported 80% pain relief; however, a few days later, he reported his cervical pain had already returned to baseline. There was no mention of any aggravating activities triggering a return of his pain during the office visit. The medical records consistently belie Petitioner's testimony that he received any sustained relief from the extensive ongoing conservative treatment he underwent after November 12, 2012. Under cross-examination, Petitioner agreed that when Dr. Novosoletsky discharged him from care in April 2014, Petitioner was experiencing the same level of cervical pain as when he began treatment at the facility in January 2013.

With this well-documented history of self-limiting behavior, inconsistent complaints, and subjective complaints that are not supported by objective findings, the Commission finds Petitioner did not prove by a preponderance of the evidence that the medical treatment he underwent after November 12, 2012, was reasonable, necessary, and causally related to the May 22, 2012, work accident. Despite Petitioner's conflicting reports of symptoms and pain levels, Dr. Novosoletsky continued to prescribe conservative treatment including numerous injections and work conditioning with no clear rationale. It appears that Petitioner's treating doctors continued to prescribe extensive treatment solely based on Petitioner's subjective complaints with no consideration of the lack of correlating objective findings and Petitioner's constantly changing subjective complaints. The totality of the evidence reveals the ongoing medical treatment was not required to cure or relieve Petitioner of the effects of his work injury. Thus, the Commission finds Respondent is not liable for the expenses relating to medical services provided after November 12, 2012.

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

20IWCC0397

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 $9,100.00. 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: JUL 15 2020

o: 5/19/20
TJT/jds
51

Thomas J. Tyrrell

Maria E. Portela

Kathryn A. Doerries

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

APARICIO, JOSE LUIS
Employee/Petitioner

Case# **12WC027457**

CLASSIC PARTY RENTALS
Employer/Respondent

20IWCC0397

On 11/21/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.41% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0147 CULLEN HASKINS NICHOLSON ET AL
JOSE M RIVERO
10 S LASALLE ST SUITE 1250
CHICAGO, IL 60603

0075 POWER & CRONIN LTD
ANDREW LUTHER
900 COMMERCE DR SUITE 300
OAKBROOK, IL 60523

20IWCC0397

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
CORRECTED ARBITRATION DECISION

Jose Luis Aparicio
Employee/Petitioner
v.
Classic Party Rentals
Employer/Respondent

Case # **12 WC 27457**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Steven Fruth**, Arbitrator of the Commission, in the city of **Chicago**, on **June 24, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

20IWCC0397

FINDINGS

On **May 22, 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 in his cervical spine ***is*** causally related to the accident. Petitioner's current condition of ill-being in his lumbar spine ***is not*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**20,176.00**; the average weekly wage was $**388.00**.

On the date of accident, Petitioner was **38** years of age, ***married*** with **4** dependent children.

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

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

Respondent shall be given a credit of $**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 §8(j) of the Act.

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of **$330.00/week** for **25 weeks**, because the injuries sustained caused a **5% loss of the person-as-a-whole**, as provided in§8(d)2 of the Act.

Respondent shall pay **$740.00** to Progressive Medical Center (Dr. Henriquez), to be adjusted in accord with the fee schedule provided by §8.2 of the Act.

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

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

Signature of Arbitrator

November 21, 2017
Date

NOV 21 2017

20IWCC0397

INTRODUCTION

This matter proceeded to hearing before Arbitrator Steven Fruth. The disputed issues were: ***F:*** Is Petitioner's current condition of ill-being causally related to the accident?; ***J:*** Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?; ***L:*** What is the nature and extent of the injury?; ***O:*** What is Petitioner's dependent status?

FINDINGS OF FACTS

Petitioner Jose Aparicio worked for Respondent Classic Party Rentals at the time of his accident. His job involved setting up party equipment such as tables, chairs and tents. On May 22, 2012, Petitioner testified that he was setting up a job at the University of Illinois. He was helping set up a tarp, and as he was lifting a 60-gallon barrel of water he felt pain in his neck and low back. He immediately called his boss to report the accident.

Petitioner acknowledged that he had been hurt in a work accident July 6, 2011. He had no lost time from work but was treated at Advanced Occupational Specialists through February 2012. He had no therapy from February 12 through May 22, 2012 and had been working full duty.

Petitioner testified that he is married with 4 children.

The following day, May 23, Petitioner was sent to Advanced Occupational Medicine (Advanced Occupational) by his employer (PX #1). His history was noted: "Mr. Aparicio stated that while at work on May 22, 2012, at 6:00 p.m. he pulled a barrier [*sic*] at work and noted upper back pain." Petitioner clarified at hearing that in fact, he was lifting a barrel, not a barrier, and that any reference to the barrier in the medical records is incorrect. X-rays were negative for fracture. Petitioner was diagnosed with axial thoracic and upper back strain. He was placed on light duty and given medication. Petitioner continued to follow up with Advanced Occupational. On June 7, 2012, Petitioner complained about neck and upper back pain. He was referred for physical therapy 3 times a week for 2 weeks.

Petitioner testified that he received physical therapy at Advanced Occupational from June 12 through June 14 (PX #1). Records document Petitioner's complaints

about neck and upper back pain. Petitioner was seen again at Advanced Occupational in July 2012 with continued complaints of neck and upper back pain. Petitioner reported improvement with his symptoms on August 11, 2012. An FCE was ordered.

The FCE was performed September 11, 2012 at Advanced Occupational (PX #1). Inconsistencies were noted in Petitioner's efforts. It was noted that he "may be able to do more than he perceives or reports." Inconsistencies in effort and complaints were noted. Petitioner reported fear of re-injury when lifting 50 pounds but was able to do so on several occasions. He was found capable of performing the physical demands of his pre-injury job. It was recommended that he continue with home exercise. By November 12, 2012, Petitioner ended his physical therapy at Progressive Rehab.

Petitioner continued physical therapy at Wood Dale Chiropractic, Ltd. (Wood Dale) with Dr. Alfred Feinblatt, who treated him from June 5 through July 9, 2012 (PX #6). On June 5 Petitioner complained of back and neck pain from pulling a dolly at work. He gave a history of a neck injury in 2011. On examination Dr. Feinblatt noted reproduction of right-sided neck pain with cervical compression and cervical hyperextension. There were no notes documenting a lumbar spine examination. X-rays showed subluxations from T4 through T9. Kemp's, "Gainslen's" [*sic*], Yeoman's, and Valsalva were positive. Dr. Feinblatt noted Petitioner's gradual improvement through 12 chiropractic visits. Therapy notes document "full spine manipulation" and chiropractic modalities applied to the thoracic and lumbar spines.

Petitioner consulted Dr. Rolando Henriquez (Progressive Medical Center), his primary care physician, on August 3, 2012 (PX #2). Petitioner gave a history of a neck and back work injury in 2011. He returned to work after physical therapy and medication but with some persistent pain. He then suffered severe neck, thoracic, and lumbar pain on "May 22, 2011" [*sic*]. Petitioner had been working with restrictions. He had had physical therapy and medication with minimal improvement.

Dr. Henriquez's exam noted paraspinal tenderness throughout the spine. There were no neurological abnormalities. He diagnosed cervicalgia, cervical radiculitis, lumbosacral radiculitis, thoracic sprain, and lumbago. Dr. Henriquez prescribed Voltaren and methocarbamol and recommended physical therapy, which was provided at Progressive Medical Center and Rehabilitation. The initial physical therapy evaluation at Progressive Medical Rehabilitation on October 10, 2012, noted Petitioner had upper cervical and mid back pain only (PX #3). No lumbar pain or diagnosis was noted.

On September 1, 2012 Dr. Henriquez reviewed a thoracic MRI, which was unremarkable (PX #2). He noted that Petitioner's lumbar pain was resolving with physical therapy and that cervical pain was reduced. No neurological abnormalities

were noted. The only clinical signs were tenderness over the entire spine. His diagnoses remained the same. He ordered continued therapy and a cervical MRI. On October 4, 2012, reported improvement with his symptoms. His clinical presentation was unchanged. On November 12, 2012 Petitioner continued to improve but complained of cervical pain which radiated into his left forearm with paresthesias. Dr. Henriquez noted Petitioner had reached MMI.

On December 15, 2012 Dr. Henriquez noted Petitioner's December 2011 cervical MRI showing disc bulging from C3 through C7 with foraminal stenosis (PX #2). Petitioner complained of mild to moderate cervical pain into both shoulders and the left upper arm with paraesthesias. Dr. Henriquez also noted that Petitioner had completed physical therapy because he had reached MMI. Nonetheless, he ordered a cervical MRI because of persistent cervical symptoms. Dr. Henriquez reviewed the December 7, 2012 FCE and recommended work conditioning. There was no note indicating that Dr. Henriquez reviewed the September 11, 2012 FCE.

On February 22, 2013 Dr. Henriquez noted the cervical MRI showed "DJD, and bulging disc." He also noted that Petitioner had finished work conditioning and was working with restrictions. He further noted Petitioner was to follow up with Dr. McNally.

Dr. Henriquez noted resolution of lumbar pain on December 15. Mild lumbar discomfort was noted on He did not document complaints of lumbar pain on January 10, 2013. Mild lumbar discomfort was noted on February 22, 2013. On cross-examination Petitioner denied telling Dr. Henriquez in January or February 2013 that he no longer had low back pain.

On December 7, 2012, an FCE was performed at Elite Physical Therapy, which placed Petitioner at the lower end of MEDIUM demand level (PX #5). Work-hardening at Elite Physical Therapy was recommended, which he did.

On referral by Dr. Henriquez, Petitioner saw orthopedist Dr. Thomas McNally of Suburban Orthopedics on January 22, 2013 (PX #4). Petitioner gave a history of his work accident on May 22, 2012. He also gave the history of his July 6, 2011 work accident when he hurt neck and back. Petitioner reported that a cervical MRI December 28, 2011 showed bulging discs at C4-5, C5-6, and 6-7. Petitioner stated he was working full duty and pain free at the time of his May 22, 2012 injury. He presented with complaints of sharp neck pain which radiated into the mid-back and chest and occasionally into the left arm. He also complained of tingling in the middle and ring fingers. Neck pain radiated to the top of his head when turning his head to the left.

Petitioner complained of sharp low back pain which radiated into the back of his left leg down to the heel.

Dr. McNally found no abnormalities in cervical or lumbar motion. There weer no documented complaints of pain on assessment of cervical or lumbar motion. Muscle strength was normal in all areas. There were no noted neurological deficits. Striaght leg-raise was negative on both right and left. Dr. McNally reviewed reports of Petitioner's August 7, 2012 thoracic MRI and December 28, 2011 cervical MRI. Dr. McNally diagnosed low back pain, radiculopathy, and cervical spine stenosis. He recommended a cervical MRI, an EMG of the upper extremities, and a lumbar MRI. Petitioner was placed on light duty per the December 7, 2012 FCE.

Petitioner underwent an EMG on March 7, 2013 (noted as 3/7/12 in the report), which revealed evidence of chronic radiculopathy at C6 and C7, bilateral mild carpal tunnel syndrome, mild right cubital tunnel syndrome, and moderate left cubital tunnel syndrome (PX #4). The cervical MRI on February 13, 2013 (PX #4) showed mild progression of degenerative changes at C5-6 and C6-7, a diffuse posterior 2 mm bulge and peridiscal posterior osteophytes at C3-4, a diffuse 3.5 mm posterior bulge at C5-6 with left paracentral and foraminal protrusion of the disc abutting the cervical cord with osteophytes and indenting the left C6 nerve root , and a broad based 3 mm disc protrusion abutting the cervical cord at C6-7 with bilateral neural foraminal encroachment and abutting C7 nerve roots, more on the left. The radiologist did not appreciate a disc bulge at C3-4 as noted on a prior report.

Upon review of the studies, Dr. McNally referred Petitioner to Dr. Dmitry Novoseletsky, a pain specialist with Suburban Orthopedics (PX #4). Dr. McNally recommended that Petitioner restart physical therapy at Progressive Medical Center in the meantime (PX #29). Work restrictions were continued.

Dr. Novoseletsky evaluated Petitioner on March 28, 2013, at which time he reviewed the diagnostic studies and recommended that Petitioner undergo a cervical epidural steroid injection, citing the American Society of Interventional Pain Physicians (ASIPP) Guidelines (PX #4). Dr. Novoseletsky administered a cervical epidural steroid injection (ESI) at T1-T2 on April 17, 2013, at which time he experienced 30% relief (PX #4). At follow-up on May 1, 2013, Dr. Novoseletsky recommended a lumbar MRI to further evaluate lumbar pain.

The lumbar MRI was performed on May 6, 2013, and showed degenerative disc changes at L3-4 and L4-5 (PX #4). On May 14, 2013 Dr. Novoseletsky reviewed the lumbar MRI and diagnosed cervical and lumbosacral spondylosis and facet syndrome.

Based on the ASIPP (American Society of Interventional Pain Physicians) Guidelines, he recommended a lumbar epidural steroid injection.

A July 13, 2013 FCE released Petitioner to MEDIUM demand level work (PX #4).

Dr. Novoseletsky administered medial branch blocks at C3 through C5 on May 29, 2013 (PX #4). Petitioner followed up with Dr. Novoseletsky on May 31, 2013, who noted that Petitioner experienced 80% relief since the May 29 injection. Dr. Novoseletsky recommended another medial branch block and considered a lumbar epidural steroid injection. Medial branch blocks at C3 through C5 were performed yet again on June 19, 2013 (PX #4). On follow-up on June 20, 2013, Dr. Novoseletsky noted Petitioner experienced 75% relief after the injection but that the pain would come and go. Dr. Novoseletsky diagnosed cervical spondylosis/facet syndrome, cervical DDD/IDD, cervical radiculopathy, and lumbosacral spondylosis/facet syndrome. He then recommended C3 through C6 radiofrequency neurotomy (PX #4).

Dr. Novoseletsky performed cervical radiofrequency neurotomy at C3, C4, and C5, on the left, on July 8, 2013 (PX #4). Following that procedure underwent another functional capacity evaluation at Suburban Orthopedics on July 11, 2013. The FCE placed him at a 50lb. restriction at the medium physical demand level (PX #4). Petitioner followed up with Dr. Novoseletsky on July 19, 2013, who noted that Petitioner felt 60% improvement from the July 8 cervical radiofrequency

Dr. Novoseletsky, citing ASIPP Guidelines again, again performed cervical medial branch blocks at C3, C4, and C5 on August 14, 2013 (PX #4). At follow up on August 16, 2013 Petitioner reported 75% relief. Dr. Novoseletsky went on to recommend Petitioner undergo lumbar medial branch block for diagnostic and prognostic purposes.

Dr. Novoseletsky administered medial branch blocks at L3, L4, and L5, on the right, on September 4, 2013, and again on September 25, 2013 (PX #4). He performed a radiofrequency neurotomy at L3, L4, and L5, on the right, on October 7, 2013. Dr. Novoseletsky administered medial branch blocks at C3, C4, and C5, on the right, December 2, 2013, and a radiofrequency neurotomy on January 14, 2014. Petitioner was referred for work hardening, which was done at Suburban Orthopedics Physical Therapy facility from February 25 through March 27, 2014 (PX #4). According to the discharge report, Petitioner was then capable of returning to heavy work. On April 3, 2014, Dr. Novoseletsky released Petitioner to full duty (PX #4). Two work duty notes were signed by Dr. Novoseletsky on April 3, 2014: one released Petitioner to full duty work and the other placed work restrictions (PX #4).

Petitioner was seen for a §12 IME by Dr. Stephen Mather on March 19, 2013 (RX #9) with an interpreter. Dr. Mather is a board certified orthopedic surgeon. He testified at evidence deposition March 5, 2015 (RX #8). He refreshed his memory from his March 19 IME report, marked as deposition Exhibit #2.

At the examination, Petitioner reported that his entire spine hurt except just above the iliac crest. On exam, he was able to turn his head 80° without difficulty. Dr. Mather observed that Petitioner moved about the examination room without apparent pain. Petitioner could flex his neck forward 40°, but with pain at T1, T2, and T3. There was no cervical or thoracic radiculopathy. There was no cervical tenderness. Petitioner complained of pain throughout his entire spine and down the left leg with tingling with axial compression and simulated axial rotation. Petitioner could touch his toes with his knees straight, but with pain at T1, T2, and T3. Straight-leg testing was negative (RX #9).

Dr. Mather noted in his March 19, 2013 report that he found nothing objective in his examination. He noted that Petitioner's cervical spine had age-appropriate spondylosis and that the thoracic spine was radiologically normal. He could not correlate Petitioner's complaints of paresthesias with exam findings. He noted documented symptom magnification at the September 11, 2012 FCE. He commented that Dr. Henriquez found Petitioner at MMI on November 12, 2012. Dr. Mather further noted that Petitioner gave a history that was inconsistent with his medical records. Petitioner's radicular complaints could not be validated by the exam. Finally, given the physical examination and MRI findings, Dr. Mather found Petitioner's widespread cervical, thoracic, and lumbar symptoms could not be explained on an organic basis (RX #9).

Dr. Mather testified consistently with his March 19, 2013 IME report. Petitioner objected to Dr. Mather's testimony regarding the epidural steroid and medial branch block injections. The objections were sustained and that testimony was disregarded. Cross-examination on the injections was also disregarded due to Petitioner's preserved waiver.

Dr. Mather opined that Petitioner suffered a cervicothoracic strain on top of cervical spondylosis. He also found a psychogenic pain or functional overlay (RX #8). Dr. Mather made no diagnosis for the lumbar spine because Petitioner had no lumbar complaints.

Dr. Mather explained that the axial compression test and axial rotation test should not cause pain. These maneuvers do not actually cause spinal rotation because the movement comes from the hips. This raised a concern for secondary motive for the pain report. The entire examination by Dr. Mather only revealed spinal tenderness at

T1, T2, and T3. Dr. Mather's review of the cervical MRI scan noted very mild cervical spondylosis from C5-7, no nerve compression, and no cord compression. Nothing in the MRI scan was acute in nature. Dr. Mather opined that Petitioner was at MMI. Dr. Mather found no organic basis for any of the Petitioner's spinal complaints. He explained that patients such as Petitioner that are involved in litigation have secondary gain and tend to self-limit at functional capacity evaluations (RX #8).

On cross-examination, Dr. Mather testified that the ODG do not apply to pain management. He opined that Dr. Novoseletsky treated outside the guidelines of the American Pain Society (ASIPP) but had no opinion on whether his treatment was unreasonable. Dr. Mather clarified on cross-examination that he uses the study regarding workers' compensation patients and secondary gain to guide his treatment of workers' compensation patients. He testified that when an FCE demonstrates that Petitioner can perform more than he can, he hopes the insurance company sends him to an IME who should have a "come-to-Jesus talk with the patient." He agreed with the diagnoses of a cervical strain superimposed on cervical spondylosis (RX #8).

Respondent offered Utilization Review opinions regarding a variety of treatment modalities: RX #2, RX #3, RX #4, and RX #5.

Dr. Michael Skaredoff, a specialist in pain management, prepared a Utilization Review January 30, 2015 for Petitioner's request for authorization for 35 work conditioning sessions (RX #2). Dr. Skaredoff, based on ODG (Official Disability Guidelines), found 35 work conditioning sessions were not medically necessary. Dr. Skaredoff noted 10 sessions over 4 weeks was reasonable. Dr. Skaredoff prepared another Utilization Review January 30, 2015 relating to the C3, C4, C5, and occipital medial branch blocks performed May 29 and June 19, 2013 and relating to the C3, C4, and C5 neurotomy performed July 8, 2013 (RX #3). Dr. Skaredoff opined that these procedures were not medically necessary due to lack of conformance with ODG, specifically because evidence of radiculopathy ruled out such procedures.

RX #4 was Dr. Skaredoff's third Utilization Review on January 30, relating to C3, C4, and C5 medial branch blocks on August 14 and December 2, 2013 and the C3, C4, C5, and third occipital neurotomy performed January 14, 2014. Dr. Skaredoff opined that these procedures were not medically necessary due to lack of conformance with ODG, specifically because radiculopathy ruled out such procedures. RX #5 was Dr. Skaredoff's fourth Utilization Review on January 30 relating to Dr. Novoseletsky's lumbar medial branch blocks at L3, L4, and L5 on September 4 and September 25, 2913 and the neurotomy ay L3, L4, and L5 on October 7, 2013. Dr. Skaredoff found the medial branch blocks performed September 4, 2013 were reasonable but did not find

that other medial branch blocks or the neurotomy medically necessary. He again relied on ODG for his opinions.

Currently, Petitioner works for another employer, doing some lifting such as lifting barrels, tarps, and posts. He still has pain in his cervical and lumbar spine when he does heavy lifting. With respect to the medical treatment received Petitioner testified that the physical therapy he received at Wood Dale Chiropractic gave him with temporary relief for his cervical and lumbar pain. With respect to the injections performed by Dr. Novoseletsky, Petitioner testified that he had significant but temporary relief. His pain always returned within 2 or 3 weeks after the injections. Petitioner also testified that the work conditioning and the physical therapy helped him considerably, to the extent that he was to return to full duty work.

Dr. Michael Friberg testified by evidence deposition March 25, 2016 (RX #6). He is licensed to practice medicine in the State of Illinois and is board certified in physical medicine and rehabilitation. He trained in interventional pain management during his residency. Dr. Friberg testified he primarily uses the Official Disability Guidelines (ODG) and ASIPP guidelines. He testified that he believed the lumbar medial branch block and the later lumbar radiofrequency neurotomy were not medically necessary because Petitioner had evidence of radiculopathy. Dr. Friberg also opined that the cervical branch blocks and radiofrequency neurotomy were not medically necessary. Dr. Friberg noted where radiculopathy is present these types of procedures are not recommended. Dr. Friberg relied on the ODG and ASIPP in forming his opinions. These procedures were not in accord with accepted protocols for Petitioner's diagnoses.

On February 27, 2015 Dr. Friberg had prepared responses to appeals to Utilizations Reviews relating to cervical and lumbar branch blocks and neurotomies performed by Dr. Novoselsky, which were marked as Exhibits 2, 3, and 4 of the deposition and admitted without objection. In DepX #2 Dr. Friberg upheld the determination that lumbar branch blocks at L3, L4, and L5 on September 25, 2913, as well as the radiofrequency neurotomies at L3, L4, and L5 on October 7, 2013 were not medically necessary. In DepX #3 Dr. Friberg upheld the determination that cervical branch blocks performed May 29 and June 9, 2013 at C3, C4, C5, and the third occipital nerve, as well as the radiofrequency neurotomies performed July 8, 2013 at C3, C4, and C5 were not medically necessary. In DepX #4 Dr. Friberg upheld the determination that cervical branch blocks performed August 14, 2013 and December 2, 2013 at C3, C4, C5, and the third occipital nerve, as well as the radiofrequency neurotomies performed January 14, 2014 at C3, C4, and C5 were not medically necessary.

On cross-examination, Dr. Friberg acknowledged that he has not administered interventional branch block injections since 2004. He refers branch block and epidural

injections to anesthesiologists because they require fluoroscopic guidance. He admitted that some of the medial branch blocks gave Petitioner some relief, while others did not. He testified that ODG and ASIPP standards are identical regarding Petitioner's injections. He did note that clinical records indicated that Petitioner had both cervical and lumbar radiculopathy.

Dr. Friberg admitted that he did not author the entirety of each report. Dr. Friberg did not believe Petitioner was malingering. Dr. Friberg did not believe Dr. Novoseletsky deviated from the standard of care but did not follow guidelines.

The reports of Dr. Skaredoff and the report and subsequent March 24, 2016 evidence deposition of Dr. Cristian Struven indicate that the work conditioning from December 28, 2012 through February 13, 2013, were not reasonable or necessary (RX #2 & RX #7).

Dr. Christian Struven testified at evidence deposition March 24, 2016 (RX #7). He is licensed to practice medicine in Illinois, Texas, and California. He has certifications from the American Board of Internal Medicine and the American Association of MRO's. He testified from his February 27, 2015 report (DepX #2) upholding non-authorization for 35 work-hardening sessions. 10 work-hardening sessions were approved.

Dr. Struven testified he did not have medical records to review. He testified that to request 35 sessions of work conditioning initially was excessive. He relied on the ODG. On cross-examination, Dr. Struven admitted he does not use the ODG in his own practice and does deviate from them. At the most, Dr. Struven would have authorized 10 sessions, which conformed to ODG. On cross-examination, Dr. Struven admitted that he does not currently treat patients in the office. He confirmed that he did not physically examine Petitioner. He also testified that if the records were good and suggested that the patient needed work conditioning he would have authorized 10 sessions, which are the maximum recommended under ODG.

On further cross-examination Dr. Struven acknowledged that he did not generate the actual Utilization Review report, but that Genex created the report for him to review. He admitted that he did not review the medical records that are listed on the utilization review report. He also admitted that the "pertinent information" referenced on the sheet was not generated by him that another person puts that in the report. He did not review the prescription for the work conditioning (RX #7).

According to Dr. Struven, the Utilization Review process involved submitting his report and that they "retype it in a way that they think it's better." He testified that he,

"didn't have a history and physical examination, so I couldn't really say whether it was necessary based on that... and I would need to have that from the doctor documenting so that we follow and see there was improvement perhaps or just to see if there was deficient". He went on to testify that he would have preferred to review patient's job description since work conditioning affects his ability to return to work. He did not understand Petitioner's treatment and diagnosis prior to reaching those conclusions (RX #7).

A Utilization Review by Dr. John Obermiller, M.D. reviewed a request for physical therapy twice a week for 4 weeks was done September 10, 2012 (RX #12). The treatment was not authorized. A Utilization Review by Janet O'Brien, M.D. for physical therapy once a week for 33 weeks was done December 7, 2012 (RX #11). The treatment was not authorized.

CONCLUSIONS OF LAW

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

The Arbitrator finds that Petitioner proved that his condition of ill-being regarding his cervical spine is causally related to the incident of May 22, 2012. The Arbitrator notes Petitioner reported neck pain promptly and sought care within one day of the accident. The Arbitrator further finds that Petitioner had reached MMI with his cervical spine on November 11, 2012.

Petitioner complained of immediate neck pain following his accident. Petitioner went through a series of healthcare providers before coming under the care of Dr. Rolando Henriquez in August 2012. Petitioner reported that his prior care had not relieved in neck and back pain. Tenderness over the spine was the only clinical sign documented by Dr. Henriquez. After another course of therapy Dr. Henriquez noted Petitioner was at MMI on November 11, 2012. This is consistent with the findings on the September 11, 2012 FCE.

The Arbitrator notes that Dr. Henriquez continued his care of Petitioner, which included a referral to orthopedist Dr. Thomas McNally. The Arbitrator does not find this history rebuts a finding of MMI in November 2012. In fact, Dr. Henriquez also noted Petitioner's MMI status on December 15, 2012, a date on which the doctor recommended work-hardening. Dr. Henriquez's follow-up is based solely on highly subjective tenderness responses to palpation. The Arbitrator also notes the inconsistencies in Petitioner's effort and subjective complaints documented in the September 2012 FCE.

It is inconsistent and illogical for Dr. Henriquez to opine that Petitioner is at MMI and then recommend work-hardening and an orthopedic referral. Petitioner's presentation with subjective complaints only, coupled with effort and complaint inconsistencies at the September 2012 FCE, do not support a claim of complaints requiring medical care beyond November 2012. In fact, Dr. Mather's findings and opinions at the IME on March 19, 2013 were also supportive of finding that Petitioner had reached MMI.

The Arbitrator notes inconsistencies in Petitioner's history of his lumbar complaints. There were no initial complaints of low back pain. There were no lumbar complaints documented in the Advanced Occupational Medicine Specialists records. While the lumbar spine is listed as part of the initial diagnosis, the Arbitrator notes that no physical examination findings of the lumbar spine were documented throughout any of the Wood Dale Chiropractic records.

In addition, it was not until August 3, 2012, when Petitioner was seen at Progressive Medical Center, that he was diagnosed with a lumbar spine injury. However, in his physical therapy evaluation at Progressive Rehabilitation Petitioner complained of cervical and mid back pain only. No lumbar pain or diagnosis was noted. By November 11, 2012, Progressive Medical Center was noting all lumbar complaints had resolved. When Petitioner saw doctors at Suburban Orthopedics 8 months after the accident, he had a litany of problems involving his lumbar spine. However, Petitioner had full range of motion and no lumbar complaints when he saw Dr. Mather for the §12 IME March 19, 2013.

The Arbitrator finds the delay in documentation of lumbar complaints and the inconsistencies in Petitioner's clinical presentation, particularly at Dr. Mather's IME, demonstrate insufficient evidence to establish a causal relation between the work-related accident and any claimed lumbar injury. Accordingly, the Arbitrator finds that Petitioner failed to prove the lumbar portion of his claim is causally related to the accident.

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

Petitioner submitted outstanding bills in PX #7. The first bill is from Illinois Physician's Network for the cervical MRI Petitioner underwent on February 13, 2013. The Arbitrator notes this was prescribed after Petitioner had been found at MMI by Dr. Henriquez. It was prescribed after Petitioner self-terminated treatment with Dr.

Feinblatt and after he told Dr. Fienblatt he "felt better." It was prescribed after the September 2012 FCE, which noted Petitioner was able to perform his job at his pre-injury status. Based on this, the Arbitrator finds that the cervical MRI was not causally related to the accident and thereby not necessary to cure or relieve the effects of the work accident injury. The MRI bill is denied.

The second bill is from Progressive Medical Center (Dr. Henriquez). The Arbitrator notes payments made by Respondent in both PX #7 and RX #13. The Arbitrator notes that Respondent submitted a Utilization Review, RX #11, relating to the underlying physical therapy was not appealed. The Arbitrator finds that Petitioner failed to prove that billing for physical therapy was reasonable or necessary. However, the bill also contains charges for Dr. Henriquez's clinical care August 3, September 1, October 4, and November 12, 2012, totaling $740.00. Since Dr. Henriquez found Petitioner at MMI on November 12, charges for service thereafter are not allowed. The Arbitrator finds that charges for these four visits were not unreasonable and, therefore, approves $740.00 Progressive Medical Center bill.

The third bill is from Elite Physical Therapy for work-hardening from December 19, 2012 through February 1, 2013, 28 sessions. The Arbitrator has previously found that Petitioner had reached MMI November 12, 2012. Therefore, perforce, work-hardening would not be medically necessary. However, the Arbitrator notes payments were made by Respondent in both PX #7 and RX #13. The Arbitrator also notes Respondent submitted a Utilization Review, RX #2, which authorized only 10 sessions of work-hardening. In addition to finding that work-hardening was not reasonable or necessary, the Arbitrator finds that Petitioner failed to prove that the total amount of this bill is reasonable or necessary. The Arbitrator also notes that each work-hardening session had billing entries for $262.00 and $345.00. There were no clinical records relating to work-hardening sessions admitted in evidence. Therefore, the Arbitrator is unable to determine which, if either or both, billing amount is substantiated by the evidence.

Inasmuch as Petitioner has the burden of proof, the Arbitrator finds that the lesser amount, $262.00, based on approval of 10 sessions is reasonable. Petitioner failed to prove that both billing charges for each session were reasonable. Therefore, $2,620.00 of the bill from Elite Physical Therapy would be allowed if medically necessary.

The fourth bill is from Suburban Orthopedics for medical care after Petitioner reached MMI. As a preliminary matter, the Arbitrator has found that Petitioner failed to prove that his claimed lumbar injury was causally related to the accident. Therefore,

these charges are denied, particularly charges relating diagnosis and treatment of the lumbar spine.

With regard to the bills for cervical complaints, the Arbitrator notes that Petitioner never gained significant benefit from the extensive treatment offered at Suburban Orthopedics. The Arbitrator notes the IME doctor's and the Utilization Review doctors' opinions and finds them persuasive. The Arbitrator also notes there were some insufficiencies in the Utilization Review doctors' opinions. They did not always have an opportunity to review all of Petitioner's medical records. Nonetheless, the UR opinions are consistent and reasonable considering all the evidence.

Additionally, and perhaps most important, Petitioner went through extensive cervical interventions and, according to both Petitioner and the medical records, gained very little, if any, relief. The lack of improvement by Petitioner lends additional credibility to the Utilization Review and IME opinions in this case. Based on the lack of response from Petitioner to this treatment, the opinion of Dr. Mather that there was no organic basis for Petitioner's complaints, and the opinions of the UR doctors that the treatment from Suburban Orthopedics was not medically reasonable or necessary, the Arbitrator concludes these bills will not be awarded.

The fifth bill is from Windy City Anesthesia. For the same reasons noted regarding the bill from Suburban Orthopedics, the Arbitrator does not award this bill.

The sixth bill is from Wood Dale Chiropractic. The Arbitrator notes payments made by Respondent in both PX #7 and RX #13. The Arbitrator finds this bill reasonable and necessary. The Arbitrator notes PX #7 shows payment and a zero balance for this bill and therefore finds that Respondent has no obligation to pay Wood Dale Chiropractic.

The seventh bill is from 1800 McDonough Surgery Center. For the same reasons noted regarding the bill from Suburban Orthopedics, the Arbitrator does not award this bill.

The eighth bill is from Oakbrook Anesthesiologists. For the same reasons noted regarding the bill from Suburban Orthopedics, the Arbitrator does not award this bill.

The ninth bill is from Precision Diagnostics. This bill appears to relate to the EMG/NCV. For the same reasons noted regarding the bill from Suburban Orthopedics, the Arbitrator does not award this bill.

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

The Arbitrator finds that Petitioner proved he suffered a cervicothoracic strain. The evidence is that he is at MMI. Petitioner is not under active medical care and is not currently prescribed any medications.

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

(i) No AMA Impairment Rating was offered in evidence. The Arbitrator could not give this factor any weight.

(ii) Petitioner is employed as a driver and helps set up for Respondent. Petitioner has returned to his prior job. The evidence shows that Petitioner is able to continue in that capacity. The Arbitrator gives great weight to this factor.

(iii) Petitioner was 38 years old at the time of the accident. He had a statistical life expectancy of 33 years. No physician has recommended further treatment for his injuries. The Arbitrator gives great weight to this factor.

(iv) There was no evidence that Petitioner's earning capacity was affected by his injuries. The Arbitrator gives no weight to this factor.

(v) There is minimal evidence of disability in the medical records. Petitioner admitted he was released without restriction from every healthcare provider. The Arbitrator gives great weight to this factor.

Based on all the evidence, including the five factors outlined above, the Arbitrator concludes that Petitioner suffered 5% loss of use person-as-a-whole, 25 weeks.

O: What is Petitioner's dependent status?

This issue was not genuinely disputed. Petitioner testified that he is married with 4 dependent children. No evidence was introduced to rebut Petitioner's testimony.

Steven J. Fruth, Arbitrator

October 10, 2017

STATE OF ILLINOIS)
) SS.
COUNTY OF WILLIAMSON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

LATASHA BUFFKINS,

Petitioner,

vs.

NO: 18 WC 30623

20IWCC0398

BI-STATE DEVELOPMENT/METRO,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed under Section 19(b) of the Act by the Respondent and Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, prospective medical, and temporary total disability (TTD) benefits, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Indus. Comm'n*, 78 Ill. 2d 327 (1980).

So that the record is clear, and there is no mistake as to the intentions or actions of the Commission, we have considered the record in its entirety. We have reviewed the facts of the matter, both from a legal and a medical/legal perspective. The Commission has considered all the testimony, exhibits, pleadings, and arguments submitted by the parties. The Commission is not bound by the Arbitrator's findings. Our Supreme Court has long held that it is the Commission's province "to assess the credibility of witnesses, resolve conflicts in the evidence, assign weight to be accorded the evidence, and draw reasonable inferences from the evidence." *City of Springfield v. Indus. Comm'n*, 291 Ill. App. 3d 734, 740 (1997) (citing *Kirkwood v. Indus. Comm'n*, 84 Ill. 2d 14, 20 (1981)). Interpretation of medical testimony is particularly within the province of the Commission. *A. O. Smith Corp. v. Indus. Comm'n,* 51 Ill. 2d 533, 536-37 (1972).

20IWCC0398

The Commission modifies the Arbitrator's Decision with respect to Petitioner's alleged right knee injury. The Commission finds that Petitioner's right knee condition is not causally related to the September 28, 2018 work accident and reverses the Arbitrator's Decision with respect to the right knee.

Petitioner testified to first injuring her right knee after striking the under carriage of the meter box, and then falling on her right knee when her leg gave out as she stood for paramedics. "As I was getting out of my seat, proceeding to make a step, that's when I fell." (T.30-31). Petitioner testified that she reported the fall to the emergency room physician, as well as her treating physicians. The Commission notes, however, that the ambulance and emergency room record fail to note Petitioner's fall or any injury to the right knee.

Petitioner sought treatment from multiple physicians, but the record demonstrated that Petitioner reported falling on her right knee to two physicians. Dr. Matthew Bradley, Petitioner's principal treater for the right knee, documented on March 7, 2019 that Petitioner fell after calling for "backup" on September 28, 2018: "[S]he stood up from her chair when backup arrived she fell twisting her right knee." (PX12). Petitioner also reported a fall to Respondent's Section 12 examiner, Dr. Timothy Farley, who documented: "EMS was then sent to the site. She states then when they tried to get her on a stretcher, her leg gave way and she fell directly onto her knee . . ." (RX1, pg. 6). The Commission finds significant that Petitioner had specified to both Drs. Bradley and Farley that her complaints were due to falling on her right knee and no other mechanism on September 28, 2018.

Nevertheless, Dr. Farley did not find that Petitioner's current right knee condition was causally related to the September 28, 2018 work accident. Dr. Farley, as well as Dr. Bradley, had noted extensive degenerative findings in Petitioner's right knee, including a tear in the medial meniscus. However, Dr. Farley found no displacement of the meniscal tissue. He testified, "when you see complex tearing in a meniscus without displacement, that's kind of a Hallmark of a degenerative tear." (RX1, pg. 11). On the contrary, Dr. Bradley did find causal connection, but his opinion was based on Petitioner's history of a fall. The Commission finds that Dr. Bradley's opinion was based on facts not supported by the record.

In light of the foregoing, including the medical evidence, Petitioner's varying descriptions of how she injured her right knee, and Dr. Bradley's flawed causal connection opinion for the right knee, the Commission finds that Petitioner failed to prove by a preponderance of the evidence that her current condition of ill-being for the right knee is causally related to the September 28, 2018 work accident.

The Commission affirms the Arbitrator's Decision with respect to Petitioner's lumbar spine injury. The Arbitrator had found causal connection for Petitioner's low back, but determined that Petitioner had reached maximum medical improvement (MMI) for her low back on March 14, 2019. Petitioner's treating physician, Dr. Matthew Gornet, had released Petitioner from treatment on March 14, 2019. He also released Petitioner with a 25-pound restriction and no repetitive bending or lifting. Dr. Gornet testified that Petitioner was not a candidate beyond conservative care due to her size and obesity. By March 14, 2019, Petitioner had completed the prescribed

conservative treatment. Petitioner confirmed at the arbitration hearing that her lower back was fine and she was no longer receiving treatment for her low back.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, filed July 18, 2019, is hereby modified as stated above, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner temporary total disability benefits of $660.00 per week for 23 6/7 weeks, commencing September 29, 2018 through March 14, 2019, that being the period of temporary total incapacity for work under Section 8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is entitled to a credit of $10,224.76 for TTD previously paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall only pay for the reasonable, necessary, and causally related medical services pertaining to Petitioner's lumbar spine up to and including March 14, 2019, and as contained within Petitioner's Exhibit 1; any treatment and medical bills after March 14, 2019 are hereby denied. The awarded medical bills shall be paid in accordance with Sections 8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's request for prospective medical is denied.

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

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

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

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

20IWCC0398

DATED: JUL 15 2020

DDM/pm
O: 5/19/2020
052

D. Douglas McCarthy

Stephen J. Mathis

L. Elizabeth Coppoletti

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

BUFFKINS, LATASHA
Employee/Petitioner

Case# **18WC030623**

20IWCC0398

BI-STATE DEVELOPMENT/METRO
Employer/Respondent

On 7/18/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0969 RICH RICH & COOKSEY PC
THOMAS C RICH
6 EXECUTIVE DR SUITE 3
FAIRVIEW HTS, IL 62208

0180 EVANS & DIXON LLC
DAVID REYNOLDS
211 N BROADWAY SUITE 2500
ST LOUIS, MO 63102

20 IWCC0398

STATE OF ILLINOIS)
)SS.
COUNTY OF Williamson)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Latasha Buffkins
Employee/Petitioner

v.

Bi-State Development / Metro
Employer/Respondent

Case # **18** WC **30623**

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 **May 15, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [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, **09/28/2018**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$51,480.00**; the average weekly wage was **$990.00**.

On the date of accident, Petitioner was **43** years of age, ***married*** with **0** dependent children.

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

Respondent shall be given a credit of **$10,224.76**for TTD, **$N/A** for TPD, **$N/A** for maintenance, and **$N/A** for other benefits, for a total credit of **$10,224.76.**

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

ORDER

Respondent is ordered to pay Petitioner temporary total disability benefits pursuant to Section 8(b) of the Act for 32 4/7 weeks, from September 29, 2018 through May 15, 2019.

Respondent is ordered to pay the medical expenses contained in Petitioners group exhibit 1, (see decision) and shall have credit for any amounts paid through its group carrier. Respondent shall indemnify and hold Petitioner harmless from any claims arising out of the expenses for which it claims credit.

Respondent shall authorize and pay for the prospective treatment recommended by Dr. Bradley, but not Dr. Gornet.

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.

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

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

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

Edward Lee
Signature of Arbitrator

7/15/19
Date

ICArbDec19(b)

JUL 18 2019

FINDINGS OF FACT

At the time of the injury, Petitioner was a 43-year-old bus operator for Respondent, Metro. (T.10; AX1) She has been employed in said capacity for 18 years. (T.10) The parties stipulated that she sustained accidental injuries that arose out of and in the course of her employment on September 28, 2018, when she was driving down a street with massive potholes. (T.11) She testified that she was tightly gripping the steering column with both hands when a pothole "shook the steering wheel column" and "made the steering wheel jerk very hard," causing injury to her right arm, right shoulder, neck, and upper back. (T.11) Petitioner also hit a second pothole on the same street while she was applying the brakes, which caused her right knee to strike the meter box. (T.12) She immediately experienced significant pain to shoot from her back down her right leg. (T.12-13) Petitioner called Respondent's operating room, and an ambulance was called for Petitioner. (T.13, 27) When Petitioner attempted to stand and make her way to the paramedics, her right knee gave out from the pain and she fell. (T.13) She was then helped from the floor to the stretcher. (T.27-28, 30-31) Pictures of the potholes responsible for Petitioner's injuries and the subsequent repairs were entered into evidence as Petitioner's Exhibits 16 and 17. (PX16; PX17)

Petitioner was taken by MedStar Ambulance to Belleville Memorial Hospital, where it was noted that Petitioner sustained injury to her entire right side as a result of hitting potholes and her steering wheel jerking with pain "shooting up to her shoulder and down her thigh." (PX3; PX4) Claimant was diagnosed with a lumbar strain and instructed to follow up with her primary care provider. (PX4) Petitioner testified that she advised the emergency room of her neck pain, but they failed to note same and further failed to note her fall on her knee. (T.28-29)

Petitioner then reported to her primary care physician, Dr. Denise Jordan, with a chief complaint of right-sided body pain in her right arm, buttock, thigh, leg, knee, neck and back pain. (PX5, 10/2/18) The history of the present illness consistently reflected that Petitioner was driving a bus when she struck a pot hole and "got a jerk from right neck, right shoulder and lower back" for which she sought treatment in the emergency room." *Id.* Dr. Jordan described Petitioner's symptoms as "[R]ight neck, right shoulder and right lower back, pain shoots up neck and down right shoulder and right side of lower back..." Dr. Jordan diagnosed Petitioner with a strain/cervicalgia of her neck and pain in her right shoulder, thoracic spine, and low back, and Dr. Jordan recommended physical therapy and an orthopedic referral. *Id.*

Petitioner began physical therapy at Graham Medical Center/Christian Hospital, where it was noted that Petitioner was having difficulty turning her head to change lanes, looking downwards, or reaching out to the side or overhead with her right arm. (PX6, 10/22/18) Petitioner was noted to have decreased range of motion in her right shoulder and cervical spine with associated pain on physical examination rated 6 out of 10 at the current time, 5 out of 10 at best, and 10 out of 10 at worst . *Id.* Follow-up visits showed no substantial improvement in Petitioner's symptoms. (PX6)

On November 8, 2018, Petitioner came under the care of Dr. Matthew Gornet, who took a consistent history of the injury of Petitioner hitting two potholes and developing severe pain. (PX7, 11/8/18) He noted that Petitioner's predominant symptoms were in her low back, right buttock, right hip and right leg, and that she continued to have increased symptoms in her neck, right shoulder, and right arm despite undergoing physical therapy. *Id.* Dr. Gornet noted that he previously treated Petitioner briefly in 2016 for some neck pain, but that this was resolved. *Id.* He also noted that while Petitioner had a history of a *left* knee surgery, she had no history of *right* knee troubles prior to the September 2018 injury. *Id.* His physical examination showed motor weakness in Petitioner's right ankle with trace deep tendon reflexes. *Id.* After obtaining and reviewing x-rays of Petitioner's neck and back, Dr. Gornet believed Petitioner's symptoms were consistent with a disc injury and potentially L4-5 radiculopathy and that they were causally related to her work injury. *Id.* He took Petitioner off work, prescribed anti-inflammatory medication, recommended an MRI of the lumbar spine, and referred Petitioner to Multicare Specialists for physical therapy, where she came under the care of Dr. Mark Eavenson. *Id.*

The MRI of Petitioner's lumbar spine was completed on November 12, 2018, and revealed a central broad-based protrusion at L5-S1 with facet ligamentum flavum hypertrophy resulting in bilateral foraminal stenosis, as well as an anterior right-sided L5 lower endplate Schmorl's node protrusion surrounded by edematous marrow signal change. (PX8, 11/12/18) Petitioner also began his care with Dr. Eavenson at the direction of Dr. Gornet on November 19, 2018. (PX9, 11/19/18)

Due to her persistent complaints of right knee pain, in addition to her low back symptoms, which were all supported by clinical examination findings of positive straight leg raise testing on the right, including persistent sensory loss throughout her right lower extremity and positive Valsalva testing despite conservative care, Dr. Eavenson also recommended an MRI of Petitioner's right knee, which was completed on November 27, 2018, and showed a complex tear of the posterior horn of the medial meniscus, an MCL sprain injury, grade II/III lateral tibiofemoral and midline patellofemoral chondrosis with moderate joint effusion, and patellar tendinosis with mild to moderate prepatellar bursitis. (PX9, 11/21/18-11/28/18; PX8, 11/27/18) Dr. Eavenson recommended an injection, which was performed the following day by Dr. Bell and slightly improved Petitioner's symptoms. (PX9, 11/28/18-12/3/18) Petitioner's progress, however, was minimal and she continued to have difficulty with her right knee and low back. (PX9, 12/11/18-3/4/19)

Dr. Gornet reviewed the results of Petitioner's cervical spine MRI on January 14, 2019, and noted his working diagnoses of disc injury at L5-S1, aggravation of some preexisting disc degeneration at L5-S1, and aggravation of some preexisting facet arthropathy at L4-5 and L5-S1. (PX7, 1/14/19) Dr. Gornet advised Petitioner that weight loss was paramount for treatment of her spine and stated his continued belief that Petitioner's condition was causally related to her September 28th work injury. *Id.* He referred Petitioner to Dr. Blake for epidural steroid injections at L5-S1 and medial branch blocks and facet rhizotomies at L4-5 and L5-S1. *Id.* He then noted

that Petitioner was still having knee pain because "when she got up, she fell onto her knee." *Id.* He referred Petitioner to Dr. Matthew Bradley for treatment of her right knee complaints. *Id.*

On January 4, 2019, Respondent had Petitioner examined by Dr. Peter Mirkin under § 12 with respect to Petitioner's neck, right upper arm, low back, and right hip. (RX6, 1/4/19) Petitioner advised Dr. Mirkin that her neck, shoulder, back and hip were completely fine before her work injury. *Id.* Dr. Mirkin noted Petitioner's chief complaints of pain in her neck, right shoulder, right arm, thoracic spine, lumbar spine, and right buttock down to her right thigh, as well as her right knee complaints. *Id.* In his physical examination findings, he characterized Petitioner's antalgic gait as "exaggerated" along with her pain response to palpation over her neck, back, or right thigh. *Id.* His straight leg raise test was negative and he felt that Petitioner's limited range of motion in her spine was due to her "girth." *Id.*

Although he indicated that he did not have the results of Petitioner's lumbar spine MRI, he stated: "It is my impression that this is a patient who has symptomatology out of proportion to her objective findings in regards to the parts of the body I was asked to evaluate. I would note that her mechanism of injury is not consistent with any significant injury to any part of her body, much less to the multiple areas that she complaints of." *Id.* He claimed Petitioner's condition was due to degenerative disc disease and her age and claimed that "she ha[d] no radicular findings in the upper extremities. *Id.* He concluded that he could not "fathom anybody that would consider surgical treatment at this time" and stated in parenthesis, "(I would certainly like to see the MRI myself if that could be made available)." His assessment was "pre-existing mild degenerative disease of her neck and back and a possible strain to her neck as well as symptoms magnification behavior." *Id.* With regard to his opinion on Petitioner's treatment, he again repeated, "(I would certainly like to see the MRI scan)" and believed that nothing more than a short course of physical therapy for Petitioner's complaints would have been warranted. *Id.*

Petitioner presented to Dr. Blake for the recommended injections at L5-S1 on January 29, 2019, and she also underwent right-sided medial branch blocks at L4-5 and L5-S1 on February 12, 2019, and left-sided medial branch blocks on February 19, 2019. (PX10; PX11) Petitioner also underwent radiofrequency ablation on her right side on February 26, 2019, and on her left side on March 5, 2019. *Id.* Petitioner reported improvement following same.

Respondent had Petitioner examined by Dr. Timothy Farley on February 5, 2019, who had previously examined Petitioner for an unrelated injury to her left knee. (RX1, Dep. Exh. 2; RX5) He noted that Petitioner was injured when she "hit a pothole and had immediate pain around the right shoulder, neck, and upper back." *Id.* He then noted that Petitioner hit another pot hole and developed unbearable pain. *Id.* His history reflects that Petitioner's employer set EMS, "but as they tried to get her up onto a stretcher her leg gave way" and Petitioner "fell directly on to her knee and her hip at that time." *Id.*

After noting Petitioner's treatment thus far, her persistent complaints, and her MRI findings of a complex tear of the medial meniscus, Dr. Farley concluded that Petitioner suffered from "[p]retibial patellar contusion right knee, right knee complex degenerative medial meniscus tear, right knee degenerative arthrosis." *Id.* He stated that: "The pretibial and prepatellar contusion is related to the described injury where her knee impacted the surface of the bus on September 28, 2018." However, he felt that the complex tear of the posterior horn of Petitioner's medial meniscus and the arthrosis was preexisting and degenerative in nature and unrelated to Petitioner's work accident. *Id.* He concluded that "[t]o this point" Petitioner's care had been reasonable and necessary, but he did not feel that any further formal care or restrictions were required for Petitioner's right knee with respect to the pathology he considered to be work-related. *Id.*

On March 7, 2019, Petitioner came under the care of Dr. Matthew Bradley for her right knee complaints, and he took the following history of the injury:

> Ms. Buffkins comes to clinic today with c/o medial right knee pain. She reports that on 9/28/18 while driving a bus she struck a pothole which caused her steering wheel to "kick." This caused a sharp burning sensation in her right shoulder and neck. She called for backup. When she stood up from her chair when backup arrived she fell twisting her right knee. She had immediate stabbing pain along her medial knee. She reports never having pain like this in er [sic] right knee prior to her fall. She denies interval trauma. Of note, she has been seeing and treating with Dr. Gornet for her shoulder/neck pain. She notes she sa [sic] Dr. Farley who told her she needed a knee replacement but never followed up with her. She has done therapy,. activity modification, NSAIDs and a "cortisone" injection with little sustained relief of pain. (PX12, 3/7/19)

Petitioner rated her current pain as 8 on a scale of 10 and stated that her symptoms were aggravated with mere activities of daily living. *Id.* After noting the findings on Petitioner's MRI and obtaining an ultrasound report of Petitioner's right knee, Dr. Bradley concluded that Petitioner would require a total knee replacement as opposed to arthroscopy. *Id.*

Dr. Bradley made personal notes in Petitioner's file consistent with his official treatment note on March 7, 2019, which reflected that Petitioner sustained an injury on September 28, 2018, as a result of striking a pothole while driving her bus, and that she fell and struck her knee when she attempted to stand up after help arrived. *Id.* The note also reflects that Petitioner clearly expressed that she had no such difficulty with her right knee prior to her fall. *Id.* However, a note from "Shanna" on April 11, 2019, stated that Petitioner had ongoing right knee complaints for many years. *Id.* Petitioner testified at Arbitration that this was a clear error, because she only had prior complaints and care with respect to her left knee. (T.19)

Petitioner returned to Dr. Gornet on March 14, 2019, and reported improvement in her symptoms following her course of injections with Dr. Blake. (PX14, 3/14/19) Dr. Gornet noted that only time would tell whether Petitioner's relief would be short lived. *Id.* He released

Petitioner back to work with a 25 pound lifting limit and prohibition on repetitive bending or lifting, but noted that Dr. Bradley likely had Petitioner off work pending her knee surgery. *Id.*

Respondent commissioned Dr. Mirkin for a second opinion, which he expressed in a report dated March 25, 2019. (RX6, 3/25/19) Dr. Mirkin was provided with the MRI showing that Petitioner suffered from a disc protrusion at L5-S1, as well as additional treatment records from Dr. Gornet and injection records from Dr. Blake. *Id.* He indicated that he reviewed an MRI of Petitioner's right knee showing a tearing of the meniscus. *Id.* He also noted the results of an MRI of Petitioner's cervical spine in July of 2016 prior to the injury taken for Petitioner's prior neck injury, which was negative. *Id.* After reviewing his prior opinion, Dr. Mirkin stated that he did not see any indication of a surgical lesion on Petitioner's lumbar spine MRI, because he did not appreciate any radicular symptoms on her examination or pain diagram. *Id.* He again made a report after reviewing additional records on April 15, 2019, cementing his opinion that Petitioner suffered from no significant injury and was not a surgical candidate. (RX6, 4/15/19)

On April 16, 2019, Dr. Bradley performed surgery on Petitioner's right knee consisting of right knee medial unicompartmental arthroplasty, right knee partial patellectomy, right knee prepatellar bursectomy, and right knee injection. (PX13) During Petitioner's follow-up on April 29, 2018, she reported that she was still having intermittent sharp, aching pain rated 5 out of 10 throughout her anterior knee that radiated down her leg with walking or movement of her leg. (PX12, 4/29/19) Dr. Bradley recommended oral and topical anti-inflammatory medication along with cold therapy, TENS stimulation, and physical therapy. *Id.*

Respondent also asked Dr. Farley to render a supplemental opinion shortly before Petitioner's right knee surgery, which he expressed in his supplemental report dated March 29, 2019. (RX1, Dep.Exh.3; RX5) Respondent provided Dr. Farley with additional records from Dr. Gornet and Dr. Bradley, which he commented did not change his opinion as to causation. *Id.* He stated again that he felt that Petitioner "had three injuries" as a result of her work accident. *Id.* He stated that the prepatellar contusion that Petitioner sustained from impacting her knee was related to her work accident, but was "transient in nature." *Id.* He maintained his belief that Petitioner's complex posterior horn tear of her medial meniscus was not related to the described injury, and that Petitioner's osteoarthritic condition was not caused by the injury. *Id.*

Respondent took the depositions of its Section 12 experts, and the depositions of Dr. Gornet and Dr. Bradley were also taken and the transcripts of same were received into evidence.

Dr. Farley testified on April 2, 2019, that since there was no displacement of Petitioner's complex meniscal tear and there was arthritis present in her knee, that Petitioner's tear was purely degenerative in nature. (RX1, p.9-10) He felt that the injection and anti-inflammatory medication was reasonable for Petitioner's right knee, but he didn't believe any additional care was required, and that "eventually those symptoms will go away." *Id.* at 11-12. He did not offer any opinions with respect to Petitioner's spine. *Id.* at 15.

On cross-examination, Dr. Farley admitted that he received no records from anyone confirming that Petitioner had been treated for any prior complaints of right knee pain before her work injury. *Id.* at 15. He acknowledged that Petitioner's MRI clearly showed substantial pathology, and when asked whether Petitioner's work accident could have aggravated her preexisting conditions, he stated, "I think they possibly could have been aggravated, yes." *Id.* at 16.

Respondent also deposed Dr. Mirkin on April 5, 2019. (RX2) He examined Petitioner just once on January 4, 2019, and rendered his subsequent opinions based solely on supplemental records provided by Respondent. *Id.* at 5-6. He felt that Petitioner's radicular complaints were in a non-dermatomal or circumferential distribution and therefore unrelated to and inconsistent with a disc abnormality. *Id.* at 9-10. He reiterated his belief that his examination of Petitioner was really normal with the exception of pain in her right knee with squatting. *Id.* at 13. He then, however, claimed that Petitioner had pain responses to his physical examination that were "signs of nonorganic pain behavior." *Id.* at 13. He stated, "[I]t's virtually impossible for someone who drives a bus to go over potholes, which I'm sure she's done thousands if not ten thousands of times over her life, and then claim major injuries to multiple parts of her body. It's just not conceivable to me." *Id.* at 14-15.

On cross-examination, Dr. Mirkin testified that he has been performing medical legal exams since 1990, and that over the last 5 years, 80% of those examinations in the context of workers' compensation have been on behalf of the employer. *Id.* at 22-23. His fee for an examination is $900.00 *per body part*, bringing his fee for just his initial examination in Petitioner's case to a total of $2,600.00. He charged $500.00 total for both of his supplemental reports, and $1,750.00 for an hour-long deposition. *Id.* at 23-24. He treats patients, but is not actively involved in research. *Id.* at 26. He has only occasionally contributed to research in the past when he was a fellow in 1994. *Id.* at 26. The closest he has come to participating in research has been assisting a German company in the design of a "hardware system." *Id.* at 26.

On further cross-examination, he acknowledged that Dr. Gornet appreciated Petitioner's symptoms as consistent with radiculopathy and acknowledged that Petitioner's physical therapist, Mr. Voss, documented a positive straight leg raise test in November of 2018. *Id.* at 29-30. He admitted that no other physician felt that Petitioner was exaggerating her symptoms. *Id.* at 30. When asked if it was fair for him to say that Petitioner was exaggerating her symptoms without having seen her MRI, he stated, "Oh, yes. In fact, an MRI wasn't even indicated in the absence of significant radicular findings on physical exam." *Id.* at 31. He admitted that Dr. Gornet's recommendations for conservative care through therapy and injections when therapy failed to produce improvement was reasonable, but he did not believe that radiofrequency ablations were an effective treatment. *Id.* at 32-33, 38.

Dr. Mirkin testified that he was not provided with the photographs of the potholes in question and therefore had no idea how big they were or what they looked like. *Id.* at 34. He

admitted that there was no evidence of Petitioner having any back problems prior to this incident. *Id.* at 34-35. He also acknowledged that there was no indication Dr. Gornet had recommended surgery for Petitioner's spine in any of the records he had reviewed at the time, although he commented on surgery in his report and stated his disbelief that anyone could recommend surgery for Petitioner's injury. *Id.* at 32, 36. Although he eventually was able to review the report of Petitioner's lumbar spine MRI, he did not review the actual films. *Id.* at 36.

When asked whether a disc protrusion at L5-S1 with foraminal stenosis could cause symptoms, he admitted, "Well, it could – any type of back condition can cause pain in the back, and that disc protrusion can be caused by a traumatic incident." *Id.* at 36-37. When asked if a preexisting disc protrusion could be made symptomatic by a traumatic incident, he stated, "Sure, if it's made larger or pushes against a nerve, it can cause what we call radiculopathy." *Id.* at 37. He admitted that he treats patients based on their symptoms, and not only findings on an MRI. *Id.* at 38. He further admitted that a patient can have an increase in symptoms without a change being evident on their MRI study. *Id.* at 38. He lastly acknowledged he had no current information as to the status of Petitioner's symptoms and complaints at the time of his deposition. *Id.* at 38.

Petitioner took the deposition of Dr. Matthew Gornet on February 11, 2019. (PX14) Dr. Gornet is a board certified orthopedic spine specialist who is heavily involved in clinical research, and particularly concerning treatment of low back pain and the latest techniques in surgery. (PX14, p. 5) Dr. Gornet testified that he performs one medical-exam per month, and, in Missouri, these are generally request of the request of Plaintiff's attorneys and in Illinois, they are generally at the request of the employer. (PX14, pp. 6, 7) He also testified that he has examined employees of Continental Tire and Metro East Industries at their employer's request. (PX14, p. 7)

Dr. Gornet acknowledged that Petitioner had been a prior patient of his, who he initially saw on 10/3/2016, in relation to neck and shoulder symptoms arising out of a work-related fall which occurred on 4/29/16. *Id.* Dr. Gornet confirmed at that time Petitioner had no symptoms in her low back, and that he did not see her again for these symptoms. *Id.*

Petitioner returned to Dr. Gornet on November 8, 2018, a year and a half later, with a history of low back pain into the right buttock, right hip and down the right leg after striking large potholes while operating a Metro bus. (PX14, p. 9) On exam, he noted subtle weakness and ankle dorsiflexion on the right at 4/5. (PX14, p. 10) Dr. Gornet believed that Petitioner had subtle nerve irritation, which correlated with her symptoms. (PX14, pp. 10, 11) Dr. Gornet reviewed plain x-rays which showed loss of disc height at L5-S1 and subtle translation at L4 and L5. (PX14, p. 11) Otherwise, he saw no significant degeneration. *Id.* He believed this was consistent with someone in their mid-forties. *Id.* He recommended physical therapy, anti-inflammatories and muscle relaxants and took Petitioner off work. (PX14, p. 12) Given the knowledge of Petitioner both before and after the accident, he stated that "...clearly, something

happened at the time of the accident. Whether or not that is an aggravation of some preexisting structure that was previously asymptomatic or a new injury, the only way to sort that out is with an MRI scan." (PX14, pp. 12, 13) That was done on the same day, and showed some preexisting disc degeneration at L5-S1 with the strong suggestion of a potential central disc protrusion. (PX14, p. 13) Dr. Gornet believed that Petitioner had facet arthropathy at L4-5 and L5-S1, which he believed was potentially preexisting but asymptomatic. *Id.* There also appeared to be some fluid in the joint which could indicate some irritation of those joints. (PX14, pp. 13, 14) Dr. Gornet actually viewed the potholes over which Petitioner was required to drive and stated that the pictures were consistent with Petitioner's history. (PX14, pp. 14 - 16) Following the MRI, Dr. Gornet referred Petitioner to Dr. Helen Blake for an epidural at L5-S1 along with medial branch blocks and facet rhizotomies for the facet pathology that he thought was aggravated. (PX14, pp. 16, 17) He also made a referral to Dr. Matthew Bradley for her knee symptoms; however, offered no opinions on the knee since that was not his area of expertise, nor did he treat her knee. (PX14, p. 33) The injections were performed at L5-S1 on 1/29/2019 and in addition, Petitioner underwent right-sided medial branch blocks at L4-5 and L5-S1 on 2/12/2019 and on the left on 2/19/2019. (PX11, 1/29/19, 2/12/19, 2/19/19) These were followed by radiofrequency ablations on the right side on 2/26/2019 and on the left on 3/5/2019. (PX11, 2/26/19, 3/5/19) Dr. Gornet reported in his note of 3/14/2019 that these have helped her. (PX7, 3/14/19) He released her to return to work with a 25 pound lifting limit and no repetitive bending or lifting. *Id.* He prescribed medication and noted that Petitioner had some restrictions per Dr. Bradley. *Id.*

Dr. Gornet also had the opportunity to review the report of Respondent's examining physician, Dr. Mirkin. (PX14, p. 18) When asked whether he agreed with Dr. Mirkin that she was exaggerating her symptoms, he stated:

> A. No, I would disagree with that. I think that she has clear objective pathology on her MRI both in her facet joints as well as her disc. Either of those could easily be aggravated or injured by the mechanism that she described. So from my standpoint, knowing this patient before and after, having her go back to work after she had a previous injury, there's nothing here that would be indicative of malingering tendencies, at least that I detected. *Id.*

Dr. Gornet also disagreed with Dr. Mirkin's conclusion that Petitioner's mechanism of injury was not consistent with any significant injury to her low back. (PX14, p. 19)

Dr. Gornet released Petitioner to return to work driving a bus; however, placed a 25 pound lifting restriction on her. (PX7, 3/14/19) He indicated that if her relief from the radiofrequency ablations and the branch blocks was only temporary, the next step in his treatment would be a discogram to evaluate her potential for surgery. (PX14, p. 17) On cross examination, Dr. Gornet testified that Petitioner's symptoms correlated with her objective diagnostic findings. (PX14, p. 32) Dr. Gornet acknowledged that while Petitioner was obese, there were no studies linking obesity with radicular back pain. Dr. Gornet acknowledged that

Petitioner's weight would have to be reduced from 290 to 250 pounds before he would consider surgery. (PX7, 3/14/19; PX14, pp. 28, 29) He testified that Petitioner was not at maximum medical improvement and he would follow her in the future. (PX14, pp. 40, 41)

Dr. Bradley also testified by way of deposition on April 19, 2019. (PX15) Dr. Bradley testified that his practice consists of 50% treatment of traumatic injuries and that the other 50% is spent doing joint replacement surgery, which is why Dr. Gornet referred Petitioner to him. (PX15, p. 5; PX14, p. 34) Dr. Bradley saw Petitioner for the first time on 3/7/2019. (PX12, 3/7/19) He took the consistent history of Petitioner's injury, and specifically, that when Petitioner attempted to stand up after help arrived, she fell, twisting in her right knee and had immediate stabbing pain along her medial knee. *Id.* He noted that she had seen Dr. Farley at Respondent's request, who advised her that she needed a knee replacement. *Id.* Prior to coming into his care, he noted that she had attempted conservative treatment in the form of therapy, activity modification, medication and an injection with little relief from her pain. *Id.* His examination showed pain to palpation, stable varus and valgus tests, normal anterior and posterior drawer signs, but a positive McMurry test, which caused pain without catching or locking. X-rays were consistent with significant narrowing of the medial tibiofemoral joint space consistent with osteoarthritis. *Id.* Dr. Bradley reviewed an MRI which was done on 11/28/18 which showed a large tear to Petitioner's medial meniscus with significant medial degenerative disease. *Id.* At the conclusion of the history, physical and review of the diagnostic studies, Dr. Bradley agreed with Dr. Farley that arthroscopy would not give Petitioner any kind of sustained pain relief and that a unicompartmental arthroplasty would be her best option. *Id.*

Dr. Bradley testified to the consistent history of Petitioner's injury, which occurred s she drove over large potholes and, specifically, with respect to her knee injury, that this occurred when she fell after attempting to stand up. (PX15, p. 6) He knew that Petitioner was placed on a stretcher and taken from the scene of the accident to the hospital. *Id.* In the course of his initial interview with Petitioner, he noted that she never had this type of pain in her knee prior to the accident. (PX15, p. 7) No medical records supported anything to the contrary. *Id.* He noted that he agreed with Dr. Farley in this respect:

> Q. And is there anything in Dr. Farley's report and/or deposition to indicate to you that Ms. Buffkins had any prior problems with her knee before this accident?
>
> A. No. In fact, Dr. Farley states, and I'll quote, Ms. Buffkins states she's never had any previous medical conditions as it relates to her right knee. She's also never seen a doctor for her right knee before. End quote. (PX15, p. 8)

Dr. Bradley reviewed multiple diagnostic studies, including the MRI, his own ultrasound and x-rays and testified that they were all consistent. (PX15, p. 8, 9) He believed they all showed that Petitioner had a degree of degenerative disease on the inside aspect of her knee, however, he also noted a large tear to her medial meniscus and the MRI scan showed some

pretibial and prepatellar edema, an indication that there was a direct impact or trauma directly related to the inside and front of her knee. (PX15, p. 9) Dr. Bradley testified that he uses ultrasounds to provide a good source of information immediately within his office. (PX15, p. 10) Dr. Bradley testified that ultrasounds help show infections and effusions, but most importantly, the ultrasound is a dynamic study which evaluates the knee throughout its range of motion, how it's moving and how it's functioning, whereas an MRI is a still picture of the patient laying down. *Id.* He noted that MRIs were thousands of dollars and ultrasounds were typically in the mid to upper hundreds of dollars so they are significantly less expensive. (PX15, p. 10, 11) His diagnosis was degenerative disease in Petitioner's knee, acute pretibia, prepatellar swelling and an exacerbation of her underlying degenerative disease. (PX15, p. 11) Dr. Bradley believed that Petitioner's injury caused an aggravation of her preexisting condition based upon all the available information. *Id.*

Dr. Bradley confirmed that he performed surgery in the form of a medial unicompartmental arthroplasty on 4/16/2019 in which he replaced the inside portion of Petitioner's right knee. (PX13; PX15, p. 17) Dr. Bradley explained that this procedure was performed because Petitioner did not have a significant amount of arthritis on the outside of her knee, but had more on the inside of her knee. (PX15, pp. 17, 18) In addition, Dr. Bradley noted that on the front part of Petitioner's femur toward the medial side there was a large flap of cartilage that was sheared off and was very likely to cause her pain. *Id.* Dr. Bradley opined that this was likely why Petitioner would have described stabbing pain since it was in an area where she would have to use that part of her knee to walk. *Id.* Dr. Bradley also testified that the flap was unstable and the edges of it were ragged and not rounded like one would expect as the result of a chronic condition. (PX15, p. 19) Dr. Bradley testified that chronic cartilage injuries typically appear very rounded and smooth, and that Petitioner's cartilage had sharp, unstable edges. *Id.* He testified it was difficult for him to imagine that these findings could have been present for years. *Id.* Dr. Bradley believed that the flap of cartilage was causing her pain since Petitioner was complaining of sharp and not dull pain. (PX15, p. 20)

With regard to causation, Dr. Bradley testified:

> A. I have no reports of her having this kind of pain prior to the accident, and she reported to multiple people this all started immediately after the accident, so I do believe that the accident caused this pain. (PX15, p. 21)

This opinion was based on Petitioner's intraoperative findings, her history, her review of records and her clinical examination. *Id.* Based on the type of procedure she had and her lack of arthritis in other portions of her knee, Dr. Bradley believed that Petitioner would have a "very, very normal life." (PX15, p. 22) He believed that Petitioner would be able to go back to doing her full duty bus driving job in between four and six months. (PX15, pp. 22, 23)

CONCLUSIONS OF LAW

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

Causal connection between accident and claimant's condition may be established by chain of events including claimant's ability to perform manual duties before accident, decreased ability to still perform immediately after accident, and other circumstantial evidence. *Pulliam Masonry v. Indus. Comm'n*, 77 Ill. 2d 469, 397 N.E.2d 834 (1979); *Shafer v. Illinois Workers' Comp. Comm'n*, 2011 IL App (4th) 100505WC, 976 N.E.2d 1 (2011). A claimant's testimony should not be expected to exactly mirror medical proofs due to the fact that the burden of proof is the preponderance of the evidence and inconsistency and error is inherent in the history taking process. *Jamie Blommaeet v. Ford Motor Co.*, 06 I.W.C.C. 0682 (2006); *Danny Farris v. Phoenix Corp. of Quad Cities*, 11 I.W.C.C. 0610 (2011), *aff'd by Farris v. Illinois Workers' Comp. Comm'n*, 2014 IL App (4th) 130767WC, 22 N.E.3d 54, reh'g denied (Nov. 26, 2014).

When a preexisting condition is present, a claimant must show that "a work-related accidental injury aggravated or accelerated the preexisting [condition] such that the employee's current condition of ill-being can be said to have been causally connected to the work-related injury and not simply the result of a normal degenerative process of the preexisting condition." *St. Elizabeth's Hospital v. Workers' Comp. Comm'n*, 864 N.E.2d 266, 272-273 (5th Dist. 2007). Accidental injury need only be a causative factor in the resulting condition of ill-being. *Sisbro, Inc. v. Indus. Comm'n*, 797 N.E.2d 665, 672 (Ill. 2003) (emphasis added). Even when a preexisting condition exists, recovery may be had if a claimant's employment is a causative factor in his or her current condition of ill-being. *Sisbro, Inc. v. Indus. Comm'n*, 797 N.E.2d 665 (Ill. 2003).

Allowing a claimant to recover under such circumstances is a corollary of the principle that employment need not be the sole or primary cause of a claimant's condition. *Land & Lakes Co. v. Indus. Comm'n*, 834 N.E.2d 583 (2d Dist. 2005). Employers are to take their employees as they find them. *A.C.& S. v. Industrial Comm'n*, 710 N.E.2d 837 (Ill. App. 1st Dist. 1999) citing *General Electric Co. v. Industrial Comm'n*, 433 N.E.2d 671, 672 (1982). The law is clear that if a preexisting condition is aggravated, exacerbated, or accelerated by an accidental injury, the employee is entitled to benefits. *Rock Road Constr. v. Indus. Comm'n*, 227 N.E.2d 65, 67-68 (Ill. 1967); see also *Illinois Valley Irrigation, Inc. v. Indus. Comm'n*, 362 N.E.2d 339 (Ill. 1977).

The Arbitrator had the opportunity to view Petitioner for 45 minutes and finds that she is a credible witness. The Arbitrator also finds the opinions of Dr. Bradley and Dr. Mirkin to be more persuasive than Dr. Gornet

Significantly, the Arbitrator notes that Petitioner had no documented complaints or treatment to her right knee. This was corroborated by all of the experts who testified, including Petitioner's treating physicians, as well as Respondent's examining physicians. The Arbitrator also finds it significant that Dr. Farley acknowledged that Petitioner's underlying degenerative

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conditions could have been aggravated by her work injury. Dr. Bradley also documented objective pathology which was causing Petitioner's symptoms.

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?

As for the treatment and medical bills up to the time Dr. Gornet released Petitioner to go back to work on March 14, 2019, the Arbitrator finds those bills within P EX. 1 up to that time to be reasonable and necessary. After that time, the Arbitrator finds only those medical bills in connection with Dr Bradley's treatment to be reasonable and necessary and therefore compensable.

Issue (K): Is Petitioner entitled to any prospective medical care?

With regard to prospective treatment, the Arbitrator finds that Petitioner is not at maximum medical improvement and is entitled to further care and treatment to cure and relieve the effects of her work-related injury. The Arbitrator therefore, orders Respondent to pay for the prospective treatment for Petitioner's right knee, if any, as outlined by Dr. Bradley.

Petitioner's claim for prospective medical treatment as recommended by Dr. Goernet is denied because the Arbitrator finds the opinions of Dr. Mirkin as to necessity of treatment to be more persuasive than those of Dr. Gornet, particularly in light of Dr. Gornet's references to subtle and mild findings.

Issue (L): Is Petitioner entitled to TTD?

The Arbitrator finds the Petitioner is entitled to receive temporary total disability benefits for a period of 32 4/7 weeks, representing benefits from September 29, 2018 to May 15, 2019 as recommended by the treating doctors including Dr. Gornet up to March 14, 2019 when he released her to go back to work and Dr. Bradley thereafter through May 15, 2019. The Respondent is entitled to a credit for any TTD paid.

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

DANIEL CUMMINGS,

Petitioner,

vs.

NO: 14 WC 40416

20IWCC0399

FUTURE ENVIRONMENTAL, INC.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident/occupational disease, causal connection, notice, temporary total disability, medical expenses, permanent partial disability, and penalties and attorney fees under Sections 19(k), 19(l), and 16, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 6, 2018 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the 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.

20IWCC0399

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: JUL 15 2020
o-5/19 /20
KAD/jsf

Kathryn A. Doerries

Maria E. Portela

DISSENT

I respectfully dissent from the opinion of the majority and would reverse the Arbitrator's Decision in its entirety. After considering the totality of the evidence, I believe Petitioner met his burden of proving by a preponderance of the evidence that he sustained an occupational disease due to an exposure arising out of and in the course of his employment on September 16, 2014.

As an initial matter, I must address the Arbitrator's gross abuse of discretion regarding the exclusion of or refusal to consider some of Petitioner's key exhibits. While the trier of fact is allowed a significant amount of discretion when determining the admissibility and the weight of evidence, the Arbitrator in this matter made evidentiary rulings that are contrary to the Illinois Rules of Evidence. The Arbitrator's inexplicable decision to refuse to even consider portions of medical records contained in Petitioner's Exhibit 2 is perhaps the most egregious example of this abuse of discretion. Respondent did not object to the entirety of Petitioner's Exhibit 2 going into evidence. Respondent raised no objections regarding the sufficiency or accuracy of the medical records contained in the exhibit. Therefore, it is mind-boggling that the Arbitrator would decide to essentially exclude the majority of the records. To make matters worse, the Arbitrator then criticized the sufficiency of Petitioner's medical evidence knowing he refused to consider a large amount of relevant treatment records.

The Arbitrator also erroneously rejected Petitioner's Exhibit 7. This exhibit contained photographs taken in 2007. Respondent properly identified the photographs and testified that they depicted the condition of his work site. He testified that his job duties remained generally consistent during his seven-year tenure at Respondent's facility. Respondent objected and argued the photographs were not relevant as they predated the alleged date of injury by several years. I believe the Arbitrator abused his discretion in excluding this exhibit as Petitioner laid a proper foundation for the photographs and credibly testified that they remained a true and accurate depiction of his work conditions on the date of accident.

Finally, the Arbitrator erred when he determined Petitioner's Exhibit 5 bore no relevance to this matter and granted no weight to the contents of the documents. This exhibit contains critical documents detailing an OSHA inspection of two tanks at different facilities operated by

Respondent in 2011. The documents provide critical historical context regarding Respondent's clear history of violations of OSHA safety standards regarding relevant issues such as the company's inadequate implementation of a respiratory protection program and its employees' documented inability to demonstrate proficiency in permit-required confined space entries. Respondent's own witnesses provided testimony regarding the contents of the documents included in Petitioner's Exhibit 5. I find it troubling the Arbitrator would deem these documents completely irrelevant and would grant no weight to them given the clear connection between Petitioner's alleged mechanism of injury and Respondent's undisputed history of OSHA violations regarding Respondent's inadequate protections and training for its employees engaged in job duties similar to those of Petitioner. This exhibit deserves to be given some weight and should be thoroughly considered when determining whether Petitioner met his burden of proving he sustained an occupational disease due to a compensable exposure a few years later. The Arbitrator failed to consider that Petitioner's occupational disease does not have to be linked to a single exposure.

Petitioner was a 31-year old hazardous materials technician on the date of accident who had worked in that position at Respondent's facility for seven years. He credibly testified that his regular work duties involved cleaning up hazardous materials such as jet fuel, pipeline leaks, and oil spills. Petitioner also cleaned out storage tanks for inspections and engaged in asbestos abatement and removal. Petitioner also spent several years working with ethylene dichloride and styrene while only wearing a face mask. Petitioner testified that while Respondent provided some personal protective gear while he worked around styrene, Respondent did not always provide oxygen for Petitioner. Beginning in June 2013, Petitioner began to complain of a fever, sore throat, and cough. He began to complain of trouble breathing by July 2014. By then, a chest exam was interpreted as showing an increase in density in the central right lung. Petitioner began treatment at Northwestern Medical Group on September 16, 2014, and was diagnosed with asthma due to the inhalation of fumes. In December 2014, Dr. Cohen diagnosed Petitioner with poorly controlled asthma relating to his occupational chemical exposure. Dr. Cohen credibly opined that Petitioner's several years of exposure to petroleum products, solvents, and other compounds with inadequate respiratory protection led to Petitioner's development of asthma.

After carefully considering the evidence, I believe Petitioner met his burden of proving he sustained an occupational disease due to a history of exposure arising out of and in the course of his employment as a hazardous materials technician. For the forgoing reasons, I would reverse the Arbitrator's Decision in its entirety and would award appropriate benefits.

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CUMMINGS, DANIEL
Employee/Petitioner

Case# **14WC040416**

FUTURE ENVIRONMENTAL INC
Employer/Respondent

20IWCC0399

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

If the Commission reviews this award, interest of 2.07% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0391 HEALY SCANLON
MATTHEW M GANNON
111 W WASHINGTON ST SUITE 1425
CHICAGO, IL 60602

0481 MACIOROWSKI SACKMANN & ULRICH
ROBERT B ULRICH
105 W ADAMS ST SUITE 2200
CHICAGO, IL 60603

20 IWCC0399

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

Daniel Cummings
Employee/Petitioner

v.

Future Environmental, Inc.
Employer/Respondent

Case # **14** WC **40416**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Thomas L. Ciecko**, Arbitrator of the Commission, in the city of **Chicago**, on **April 4, 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 or exposure 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 or exposure given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury or exposure?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident or exposure?
I. [ ] What was Petitioner's marital status at the time of the accident or exposure?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] What temporary benefits are in dispute?
   [ ] TPD [ ] Maintenance [x] TTD
L. [x] What is the nature and extent of the injury or exposure?
M. [x] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On **September 16, 2014**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident or exposure ***was not*** given to Respondent.

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

In the year preceding the injury, Petitioner earned $**46,063.16**; the average weekly wage was $**885.82**.

On the date of alleged accident or exposure, Petitioner was **31** years of age, ***single*** with **1** dependent child.

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

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

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

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

ORDER

Because Petitioner failed to prove he suffers from an occupational disease and that a causal connection exists between the disease and his employment, benefits are denied.

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

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

Signature of Arbitrator

June 6, 2018
Date

JUN 6 - 2018

Daniel Cummings v. Future Environmental, Inc., No. 14 WC 040416

Preface 20IWCC0399

At hearing, Petitioner offered into evidence Petitioner's Exhibit 7, nine photographs Petitioner testified he had a fellow employee take of a bag and himself, not all taken on the same day, depicting the condition of his worksite and the work he was doing on the job site. The photographs were taken in 2007. Respondent objected on grounds of relevance, saying they were taken in 2007. This Arbitrator took the matter under advisement. Daniel Cummings v. Future Environmental, Inc., No. 14 WC 40416 Transcript of Evidence on Arbitration at 115, 22-26, 60.

Still photographs may be admitted into evidence when properly authenticated and relevant to either illustrate or corroborate the testimony of a witness or to act as probative evidence of what the photograph depicts. A sufficient foundation is laid for a still photograph by the testimony of a person with personal knowledge of the photographed object, at a time relevant to the issues, that the photograph is a fair and accurate representation of the object at the time. Graham's Handbook of Illinois Evidence §401.8 (10th ed. 2010) Relevant evidence means evidence having any tendency to make the existence of any fact that is of consequence to the determination of the action more probable or less probable than it would be without the evidence. IRE 401.

Here, the foundation is lacking because the photographs purportedly depict a worksite and work seven years before the date of accident (exposure) alleged by Petitioner in both the Application for Adjustment of Claim (Application for Benefits) and the Request for Hearing, a time not relevant to the issues at hand. Thus, Petitioner's Exhibit 7 is excluded.

As to the matter of Petitioner's Exhibit 5, a response by the U.S Department of Labor, Occupational Safety and Health Administration to a Freedom of Information Request in 2015 seeking inspection documents for four OSHA inspections, the parties spent considerable time wrangling over the contents and response. Cummings at 50, 130-131, 135-150, 156-159, 165-166; Petitioner's Exhibit 5 at 165-166; Respondent's Exhibit 3 at 58. This Arbitrator admitted this exhibit into evidence over a nonspecific objection by Respondent, not having the opportunity to review or even be aware of its full contents and self-contained restrictions. Cummings at112-113.

Petitioner's Exhibit 5 contains documents concerning an OSHA inspection of two tanks, tank No. 6 and tank No. 10 at two different locations in 2011. The Department of Labor and Respondent settled matters concerning those inspections. That settlement specifically stated that the "...agreements, statements, findings and actions taken herein are made for the purpose of compromising and settling this matter economically and amicably, and they shall not be used for any other purpose whatsoever, except as herein stated." Petitioner's Exhibit 5 at 54, 174, 156.

Petitioner's Exhibit 5 is completely irrelevant to the issues in this case. It is the standard red herring, a misleading distraction, and irrelevant evidence. The inspections were done three years before the alleged date of accident (exposure). The inspections concerned two specific tanks at two specific locations. There was no testimony by Petitioner that he ever worked in those tanks or at those locations. There was no testimony the OSHA investigations were related to any jobs performed by Petitioner, or any equipment, clothing, or tools he had or was supposed to have. There was no testimony by Petitioner he ever worked with what was identified in those tanks. Petitioner's Exhibit 5 at 43, 163, 54, 174; Cummings at 7-90, 10, 13, 15-16, 18, 165-166. Petitioner's Exhibit 5 warrants no consideration and is given no weight.

Findings of Fact

Daniel Cummings (Petitioner) a 31 year old male, worked for Future Environmental (Respondent) since March 2007. Respondent is a special waste hauler and emergency responder for special waste and oil spills. Petitioner testified his job was hazmat technician and his duties consisted of cleaning up hazardous materials, oil spills, or tank cleaning. He said the majority of clean up for hazardous materials consisted of motor oil, hydraulic oil, and transformer oil. Kenneth Houston, the Industrial Coordinator for Respondent, testified he has known Petitioner for 10 years. Houston is responsible for making job assignments, ordering equipment, and making sure employees have necessary equipment including personal protection equipment. Petitioner, said Houston, was a laborer/ technician. Houston testified the host company gave Respondent a Safety Data Sheet, listing chemical compositions and hazards. Houston reviewed the Sheet with that job supervisor, determined the safety equipment needed, and made sure the employees had it. Tanks were monitored to view limitations and checked to see if it was explosive. Everyone on the crew was given a gas monitor. Cummings at 9, 119, 8-9, 11, 117-119, 121-125.

Petitioner testified, in vague generalities, about the cleaning of tanks, and few specific chemicals used in the cleaning process. He testified 70% of his daily job was using citrus degreasers to remove petroleum products from tanks. He testified he worked over 1000 times in an enclosed space. Petitioner was vague in his testimony regarding safety equipment and personal protection equipment saying he worked around Styrene without oxygen being provided; was not always provided an air supply in a closed space; and was not sure of the number of times he was provided an oxygen mask while working in an enclosed space. There was no testimony about the need for oxygen around Styrene, no testimony about the need for oxygen in a closed space, and no testimony he should have been provided an oxygen mask when working in an enclosed space. In short, there was no context to his testimony. Petitioner testified when he was provided personal protective gear, face masks, air cartridges, or oxygen, he used it. He said he got an air monitor supplied by Respondent and "...tried to keep it with me." Petitioner offered no specific dates, or jobs, or times, or locations, or circumstances in his testimony. Cummings at 11-21, 78-86.

Houston testified Petitioner had to go into a confined space on a regular basis, where he would have to contort his body for ingress and egress. He said a crew of four goes into a confined space and everyone is issued a gas monitor. Anyone, said Houston, can shut down a job if they do not feel safe. Employee's masks are fit tested to make sure they have a proper fit. Petitioner testified he had fit tests in 2011, and 2013. Houston testified employees got a pulmonary function test every two years and Petitioner never failed to pass his. He also testified to the extensive training employees received. Cummings at 122, 124-125, 81, 126, 128.

Petitioner failed to testify to, or recount, any single specific exposure or incident while working, setting in motion his claim of injury or exposure, seven years after beginning employment with Respondent.

Petitioner testified that prior to his employment, with Respondent he never had any problems with his lungs or breathing, or ever sought treatment. He testified that on June 3, 2013, he went to Tinley Primary Care complaining of fever, sore throat, and a cough. Although the records of Tinley Primary Care are largely illegible, Petitioner was given a Strep test which was negative. Petitioner was also given a chest x-ray. There was no sign of pleural effusion or pneumothorax. A possible infrahilar infiltrate was noted. There is no indication the visit or complaints were work related. The remainder of Petitioner's visits to Tinley Primary Care for the next year and a half appear to be for the conditions of life: allergies, cough, hematoma on the leg, food poisoning, diarrhea, and ear ache. Petitioner had two more chest x-rays, December 23, 2013, and July 21, 2014. Both appear inconclusive. Cummings at 26; Petitioner's Exhibit 1 at 12, 27, 15-16.

Petitioner testified he had a cough and trouble breathing and was told he needed to see a specialist, and so sought treatment at Northwestern Hospital. Cummings at 33-34. No medical records submitted support this.

Petitioner's medical records from Northwestern Medicine, submitted as purportedly received in response to subpoena, consist of 135 pages. However, the Certification of Medical Records by Northwestern indicates the documents sent in response to subpoena consist of 38 pages as requested. Petitioner fails to explain this discrepancy. Moreover, the handwritten notation of *9/16/14-12/1/2014* seems to correspond to the *Encounter date 12/1/14* on the upper right of certain pages in Petitioners Exhibit 2. Therefore, I will consider pages 1 through 26 of Exhibit 2. See 820 ILCS 305/16.

Petitioner was first seen at Northwestern September 16, 2014. The records indicate the reason for the visit was Dyspnea. Although Petitioner avoided any specific testimony as to the onset of his symptoms, or specifics as to a trigger, the history indicates that in August 2014, he was cleaning a site at a Styrene factory when he developed acute onset of a cough. Later that night he developed acute onset of chest tightness, dyspnea and wheezing. The history indicates he presented to urgent care and was given a nebulizer. There is no supporting evidence of such urgent care visit offered by Petitioner, and no testimony of it by Petitioner. There is no notation in the record of exposure to anything except Styrene. A diagnosis of Asthma due to inhalation of fumes was made. The treatment plan was: Prednisone; SABA PRN; spacer for inhaler. A sleep

study was considered once acute issues were resolved. The plan indicated it would be best if Petitioner could stop working as his symptoms are exacerbated at work. If not possible, the doctor encouraged Petitioner to take proper respiratory precautions. Petitioner's Exhibit 2 at 4-7.

Petitioner followed up at Northwestern September 23, 2014. At that time, he was diagnosed with Asthma and Rhinosinusitis. The record notes Petitioner has been using Prednisone for seven days and "avoidance of workplace." I take this to mean Petitioner stopped working rather than choosing to take proper respiratory precautions as suggested by the physician September 16th. The plan was to start Petitioner on a combination of budesonide-formoterol and albuterol prn. The impression of the physician was Asthma-possibly worsened by workplace exposure. Petitioner's Exhibit 2 at 10-15.

Petitioner testified he stopped working at Respondent September 26, 2014. He gave two different reasons. He said he was terminated. Then he said he stopped working at Respondent "...due to...doctor's orders." Cummings at 39-40. Petitioner sought to give the impression the termination was related to the doctor's advice. Cummings at 39. Petitioner lacks credibility. In an application for employment with Allstate Power Vac dated March 10, 2015, Petitioner certified as true he was terminated in *October 2014*. In a charge against Respondent, filed with the U.S. Department of Labor, Petitioner alleged termination on September 26, 2014, because of union support, protected concerted activity, and because he provided testimony concerning an unfair labor practices charge. There is no evidence, at this point, he was ordered to stop working at Respondent due to the "...chemicals that you were required to use." Cummings at 39-40; Respondent's Exhibit 3 at exhibit 4, exhibit 5.

There is no credible evidence that Petitioner ever told Respondent, either orally or in writing, he had an occupational disease related to his employment. There is no evidence Respondent was in a position of knowing of any such disease. This is especially problematic for Petitioner as he was warned during trial, and never addressed the notice issue. Cummings at 43-44.

Petitioner was referred for a consult to Dr. Robert Cohen at Northwestern. He first saw Cohen December 1, 2014. At that point he had ceased working for Respondent for over a month. In a curious bit of non-medical evaluation, Cohen read the "...website of 'Future Environmental LTD.'..." Cohen's recital of Respondent as a company and Petitioner's work activities seem far more expansive than the testimony offered at trial. Cohen testified, via evidence deposition. Petitioner's history was taken by Trevor Nicholson, someone working with Cohen. We do not know for sure who he is. The record recites Petitioner told Nicholson of "...a recent example of exposure to ethylene dichloride while not using respiratory precautions (September 2014). During this acute exposure, reports feeling unwell at the time...duration of this exposure was over two days with masks subsequently being worn during the second day." No such testimony was offered by Petitioner at trial. There was only one brief, vague, mention of ethylene dichloride by Petitioner at trial. Petitioner was diagnosed with asthma and dyspnea. Cohen's plan was a chest x-ray and pulmonary function test. He also requested Petitioner give details on specific chemical exposures and noted he would contact OSHA to obtain 10 years' worth of reports on Respondent. Petitioner never provided the details and OSHA never provided any records. In another non-medical entry, Cohen noted "Has an attorney Matt Gannon...to call him

also Independent Medical Report being provided." Petitioner's Exhibit 2 at 20-26; Petitioner's Exhibit 4 at 31, 43; Cummings at 13.

Cohen testified Petitioner had specific exposure to ethylene dioxide in September 2014; it sounded like a fairly significant one. However, Cohen testified to the wrong chemical and did not know the permissible exposure limits for ethylene dichloride, or whether Petitioner's exposure was above or below the limits. Cohen said the chemicals described by Petitioner were respiratory irritants and given the intensity of the exposure and Petitioner's symptoms, it is more likely than not they were contributory to Petitioner's respiratory symptoms. Cohen testified he felt Petitioner had a new onset of asthma and likely, if not entirely work caused, certainly work exacerbated. He did not think Petitioner had adequate protection. Petitioner's Exhibit 4 at 13-15, 34, 21-22.

Cohen said this despite: not knowing if Petitioner worked in a confined space, or used protective equipment; not knowing the permissible exposure limits for ethylene dichloride, or what Petitioner's exposure was; having only one example of working with ethylene dichloride; not knowing how often Petitioner worked with styrene, or used protective equipment; there being no indication how often Petitioner cleaned up, in his description, volatile organic compounds, or whether protective air breathing equipment was used; not knowing the permissible exposure limits for styrene or whether Petitioner's exposure exceeded permissible limits; never getting information from Petitioner on chemical exposures or documents from OSHA; not knowing what the actual intensity of any of Petitioner's exposures were, or its duration. Petitioner's Exhibit 4 at 13-15, 33-38, 43, 57.

Cohen testified his diagnosis was chronic obstructive pulmonary disease with an asthmatic component. He said he last saw Petitioner in October 2017. He said Petitioner cannot work in an environment where he would be exposed to vapors, gases, dust, or fumes and should not return to his work in his previous capacity at Respondent. Cohen admitted his diagnosis of chronic obstructive impairment or chronic obstructive pulmonary disease was not contained in any of his reports in 2015 or 2015, but was first mentioned in a report to Petitioner's attorney.

Petitioner testified he has since found other employment working out of a union hall with Local 150. He testified to more than doubling his wages from that of working for Respondent. He testified to at least five job/employers since leaving Respondent, driving trucks, being on a boring crew, laying pipe, running pumps, and spotting heavy equipment. Cummings at 74, 64, 66, 71, 75.

In January 2017, Petitioner submitted to an independent medical evaluation by Dr. David Fletcher. Fletcher, Board Certified in Occupational Medicine and Preventive Medicine, has been a doctor for almost 40 years and is a veteran of the United States Army Medical Corps. At the time of his deposition, Fletcher sat on the Illinois Workers' Compensation Medical Fee Advisory Board as the medical representative; was on the Illinois State Medical Society Workers' Compensation Task Force; and a member of the Illinois Workers' Compensation Research Institute as a peer reviewer on research studies. Eighty to ninety percent of his time was spent

actively treating patients. Fletcher testified by means of an evidence deposition. Respondent's Exhibit 3 at 6-7, exhibit 1.

Fletcher testified he had a strong independent recollection of his examination of Petitioner. He testified his expertise included treatment and rehabilitation of pulmonary conditions, which is a major aspect of his specialty. Fletcher does OSHA required examinations, and determines whether a patient can wear personal protective equipment. He does fit testing for respiratory compliance. Fletcher testified that although Petitioner talked about some of the things he was exposed to, the problem Fletcher had is the lack of industrial hygiene data. He had no assessment of Petitioner's workplace as far as what exposures Petitioner had, saying that's very important when deciding on causation. Fletcher was familiar with the two substances Petitioner mentioned, ethylene dichloride and styrene, but there was no data showing how much exposure Petitioner had. Fletcher testified Petitioner's CT scan showed no evidence of any active lung disease. Petitioner had some nodules, a density in the lungs he considered unremarkable, probably a benign process. That, said Fletcher, would not be work related. Respondent's Exhibit 3 at 10, 8-9, 13-14, 15, 17.

Fletcher testified the result of some of Petitioner's pulmonary function tests for Dr. Cohen showed a very mild obstructive component, with no way to date when it first occurred, and certainly not disabling. Fletcher testified Petitioner had some evidence of some extrinsic asthma that is not disabling. There is no evidence it is related to his employment. He said Petitioner's physical examination was completely normal, with no wheezing. Based on Petitioner's history, physical exam, pulmonary function tests and CT scans, Fletcher said Petitioner has no evidence of a disability. His diagnosis was extrinsic asthma that is controlled. He would place no work restrictions on Petitioner at all. Respondent's Exhibit 3 at 19, 20-21, 22, 23.

Fletcher further testified he disagreed with Dr. Cohen, saying he did not believe one could, with medical certainty, identify the manner of causation of Petitioner's condition without the industrial hygiene data and the exposure data. He testified there was not enough information for Cohen to formulate his opinion, and no documentation to support Cohen's saying Petitioner had many years of exposure to petroleum products, solvents, and VOC's with inadequate respiratory protection. Fletcher testified he would need to have specific documentation of Petitioner's exposures, when or when he didn't wear his respirator. Although Cohen diagnosed Petitioner with occupational chronic obstructive lung disease, Fletcher testified there was no evidence to support that diagnosis. Fletcher further testified he disagreed with Cohen's opinion as to causal connection because "...we don't have information to make a scientific medical certainty that [Petitioner's] exposures at work caused his condition. We don't know exactly what his exposures were." Fletcher believes he is in a better position to give an opinion on causal connection because that is what he does. Cohen focuses on treatment. Respondent's Exhibit 3 at 28, 35-36, 40, 54.

Conclusions of Law

The decision in this case begins and ends with disputed issue **C** did an accident or exposure occur that arose out of and in the course of Petitioner's employment by Respondent. To recover compensation under the Act, a claimant must prove that he suffers from an occupational disease and that a causal connection exists between the disease and his employment. An occupational disease is defined as a disease arising out of and in the course of the employment or which has become aggravated and rendered disabling as a result of the exposure of the employment. See Durbin v. Illinois Workers' Compensation Commission, 2016 Ill. App. (4th) 150088WC, P41.

I find, as a conclusion of law, Petitioner does not suffer from an occupational disease, and that Petitioner has not established a causal connection between his condition and his employment. I find the testimony of Dr. David Fletcher persuasive and credible over that of Dr. Robert Cohen. I rely on that testimony in support of this conclusion. I do so based on Fletcher's 40 years of practice; current practice and vast experience in this very area; certainty of opinion; focus on prevention, evolution, and causal connection in this area; and recognition of the lack of evidence critical to a diagnosis with medical certainty.

Fletcher diagnosed Petitioner with extrinsic, not irritant asthma, that is controlled. Fletcher recognized the problem with evaluating Petitioner was the lack of information or assessment as to what exposures he had, when the exposures took place, the circumstances of the exposures, how much was a given exposure, when did and when didn't Petitioner wear protective gear. A causation opinion, said Fletcher could not be given without industrial hygiene data and exposure data. Fletcher testified "...I'm left without any kind of definitive evidence of any environmental exposure specifically the intensity, duration or frequency of such exposure." Respondent's Exhibit 3 at 51. There is no evidence the extrinsic asthma is related to Petitioner's employment and no certainty as to how long he had it. Respondent's Exhibit 3 at 22.

Moreover, Petitioner repeatedly failed to give concrete testimony as to his exposures or instances of the lack of proper equipment, in short, any evidence that could be extrapolated into data necessary to support a diagnosis with medical certainty.

As to disputed issues **E** timely notice; **F** current condition; **J** medical services and payment; **K** temporary benefits; **L** nature and extent; and **M** the imposition of penalties, this Arbitrator makes the following conclusions of law: because Petitioner did not prove he suffers from an occupational disease or that a causal connection exists between a disease and his employment, he is not entitled to medical benefits, temporary total disability, or permanent partial disability. No benefits of any kind are awarded. In view of this decision Petitioner's Petition for Penalties and Fees is denied.

Arbitrator

June 6, 2018

Date

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JOHN BELDIN,

Petitioner,

vs.

NO: 13 WC 16992

20IWCC0400

VILLAGE OF HOFFMAN ESTATES,

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

The Commission modifies the Arbitrator's Decision solely with respect to the issue of Notice. The Respondent stipulated to Notice on the Request for Hearing form and Notice was never disputed at the Arbitration Hearing. (ArbX1, T, p. 4) Therefore, the Commission strikes the word "not" from the fourth line under the Findings section on page one of the Arbitrator's Decision, so the sentence reads, "Timely notice of the accident was given to Respondent."

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's Decision filed on January 23, 2018, is hereby modified for the reasons stated herein, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that after considering all testimony and evidence introduced, the Petitioner failed to prove that he suffered an accident which arose out of and in the course of the employment, therefore, all workers' compensation benefits are denied.

20IWCC0400

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 bond requirement in Section 19(f)(2) is applicable only when "the Commission shall have entered an award for the payment of money." *820 ILCS 305/19(f)(2) (West 2013)*. Based upon the denial of compensation herein, no bond is set by the Commission. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court. *820 ILCS 305/19(f)(1) (West 2013).*

DATED: JUL 15 2020
KAD/bsd
O5/19/20
42

Kathryn A. Doerries

Maria E. Portela

DISSENT

I respectfully dissent in part from the opinion of the majority and would reverse the Decision of the Arbitrator in its entirety. After a careful review of the evidence, I believe Petitioner met his burden of proving he sustained injuries due to an accident arising out of and in the course of his employment. Thus, I would find that a compensable accident occurred and would award benefits accordingly.

As an initial matter, I agree with the majority's reversal of the Arbitrator's conclusion that Petitioner failed to provide timely notice of the work injury. The parties stipulated that Petitioner did provide timely notice of the work accident.

Petitioner has worked as a full-time firefighter paramedic for Respondent for 12 years. There is no dispute that Petitioner spent his day at work on December 11, 2012, making room in the fire station for delivery of an ice machine and a new washing machine. As part of the project, Petitioner helped move a heavy hose rack and heavy hoses. Petitioner testified that while moving everything, he felt a tweak in his upper left shoulder blade as he twisted. He described that pain as feeling like something hit him in the shoulder. Later that day, Petitioner told his supervisor that he felt numbness or a tingling sensation down his left arm. The next day, he visited the ER and was unfortunately misdiagnosed with shingles. The medical records confirm that Petitioner complained of pain in his neck and upper left extremity during that visit. Almost one month after his

misdiagnosis, Petitioner returned to the ER and received a referral for a cervical spine MRI. Dr. Graf, Petitioner's treating physician, diagnosed Petitioner with a multilevel cervical disc protrusion with spinal stenosis and impingement on the thecal sac. Petitioner underwent conservative treatment including cervical epidural steroid injections.

After considering the totality of the evidence, I do not find the opinions of Dr. Salehi, Respondent's Section 12 examiner, persuasive. Instead, I find the opinions of Dr. Graf most credible. Dr. Graf credibly opined that Petitioner's cervical disc herniations were either caused or aggravated by his work injury. This opinion is fully supported by the totality of the evidence. Petitioner testified credibly regarding his mechanism of injury as well as his immediate onset of physical complaints. The medical records are consistent with Petitioner's testimony regarding his mechanism of injury and his subsequent cervical complaints. After undergoing six months of conservative treatment, including multiple cervical epidural steroid injections, Petitioner was able to return to his normal job as a firefighter paramedic without restrictions. Petitioner was taken off work from December 13, 2012, through December 31, 2012, and from January 2, 2013, through January 7, 2013, for a total of 4-4/7 weeks. He testified credibly that he continues to experience occasional discomfort and tingling down his left arm. He also continues to occasionally feel a knot in his neck. His chronic complaints are aggravated by certain activities such as carrying heavier objects on his back like an air pack. Petitioner testified that an air pack weighs approximately 30 lbs. He continues to take aspirin and uses a foam roller when his symptoms are aggravated.

For the forgoing reasons, I would reverse the Arbitrator's Decision and find that Petitioner sustained an injury due to an accident arising out of and in the course of his employment on December 11, 2012. I would find that Petitioner met his burden of proving his current condition of ill-being regarding his cervical spine is causally related to the work accident. Furthermore, I would find Petitioner met his burden of proving his medical expenses were for medical services that were reasonable and causally related to his work accident. Petitioner also met his burden of proving an entitlement to TTD benefits from December 13, 2012, through December 31, 2012, and from January 2, 2013, through January 7, 2013, for a total of 4-4/7 weeks. Finally, after carefully weighing the five factors pursuant to Section 8.1(b) of the Act, I would find that Petitioner sustained a loss of 10% of the whole person as a result of the work accident.

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BELDIN, JOHN
Employee/Petitioner

Case# **13WC016992**

VILLAGE OF HOFFMAN ESTATES
Employer/Respondent

20IWCC0400

On 1/23/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.61% 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:

2573 MARTAY LAW OFFICE LTD
DAVID W MARTAY
134 N LASALLE ST 9TH FL
CHICAGO, IL 60602

0445 RODDY LAW LTD
PAUL W SCHUMACHER
303 W MADISON ST SUITE 1900
CHICAGO, IL 60606-3394

20 IWCC0400

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

JOHN BELDIN
Employee/Petitioner

v.

VILLAGE OF HOFFMAN ESTATES
Employer/Respondent

Case # **13** WC **16992**

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 Kurt Carlson, Arbitrator of the Commission, in the city of **Chicago**, on **12-07-17**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **12/11/12**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident ***was 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 $**92,884.48**; the average weekly wage was $**1,786.24**.

On the date of accident, Petitioner was **47** years of age, ***married*** with **1** dependent children.

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

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

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

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

ORDER

After considering all testimony and evidence introduced, the Arbitrator finds that Petitioner failed to prove that he suffered an accident which arose out of and in the course of the employment.

The Arbitrator finds that Petitioner is denied workers' compensation benefits.

STATEMENT OF FACTS

The petitioner, a firefighter for the Village of Hoffman Estates, alleges to have suffered an accident at the work place on December 11, 2012. The claimant, a firefighter paramedic for the Village of Hoffman Estates, had been in that position with the Village for 12 years. The claimant did work as a firefighter paramedic full-time. Petitioner's job duties were to fight fires, provide necessary first-aid and medical care, answer calls. The claimant testified that on December 11, 2012 while moving hoses and a hose rack, and also putting in an ice machine and washing machine, the petitioner injured his upper back and neck. The claimant testified that it felt like something hit petitioner in the shoulder blade. The claimant proceeded to finish his shift and while driving that evening on a call, he told his lieutenant that his left arm was numb and tingling.

The claimant testified that he never provided a specific notice of accident on the day in question other than his reference to a numbness and tingling in the left upper extremity.

The claimant following this alleged date of accident was having a massage when the masseuse advised the petitioner that he had some type of rash or growth on his left shoulder. The claimant was extensively treated for what was thought to be Shingles. The claimant had multiple visits with his physician regarding the Shingles and ultimately in January of the next year it was determined that petitioner actually had an injury to his cervical region. It was not until January 14, 2013 that petitioner called his lieutenant and advised him that he had a cervical injury and that it must have happened at the work place.

Based upon the medical records, the petitioner had multiple visits to his physicians from December 12, 2012 at the Janesville Hospital where petitioner was diagnosed as suffering from Shingles through his follow-up visits on December 19, 2012 that petitioner never mentioned anything about a work related incident involving petitioner's cervical region. It was not until January 18, 2013 that petitioner was referred for a shoulder issue. The records are devoid of a work-related history.

Testifying on behalf of the Village was Lieutenant Christopher Lenczewski. Lieutenant Lenczewski testified that he worked with the petitioner on the alleged date of accident December 11, 2012 and at no time did petitioner ever inform him that he suffered an accident while moving the fire hose and racks and appliances. Lieutenant Lenczewski testified that it is the Village's policy to notify the Village immediately regarding an accident or illness. Lieutenant Leuczeuski testified that petitioner did not provide notice of any accident until January 14, 2013, when he contacted the Lieutenant by telephone.

The petitioner was treated conservatively with physical therapy and injections and was ultimately released to return to his full duties.

The Arbitrator finds that petitioner failed to prove that he sustained an accident, which arose out of and in the course of the employment and therefore petitioner's request for benefits pursuant to the Illinois Workers' Compensation Act are hereby denied. The Arbitrator relies on the credible testimony of Lieutenant Lenczewski, as well as, the opinions of Dr. Sean Salehi. Dr. Salehi opined and concluded that petitioner's cervical condition was not causally related to any activity or accident at the work place.

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

01-22-18
Date

JAN 23 2018

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Alan L. Johnsen,	)	
	)	
Petitioner,	)	
	)	
v.	)	NO: 16 WC 31032
	)	
DHL Express USA, Inc.,	)	
	)	
Respondent.	)	

ORDER

This matter comes before Commissioner Barbara N. Flores pursuant to the parties' joint request to amend the previously approved Settlement Contract Lump Sum Petition and Order with a "Medicare Set Aside Addendum to Settlement Addendum."

Pursuant to Section 9070.40(e) of the Rules Governing Practice Before the Illinois Workers' Compensation Commission, the parties may reserve the right to amend an approved Settlement Contract by stipulation and Order of a Commissioner to conform with regulatory requirements including, but not limited to, those of Social Security and Medicare. In no event may those amendments abridge the substantive rights of the parties as listed in the previously approved Settlement Contract.

By the terms of the Settlement Contract Lump Sum Petition and Order ("Settlement Contract") approved by Arbitrator Carolyn M. Doherty on November 7, 2017, the Respondent agreed to either fund a Medicare Set-Aside account ("MSA") as approved by the Centers for Medicare and Medicaid Services ("CMS"), or keep Petitioner's medical rights open under Section 8(a).

Petitioner's medical rights under Section 8(a) have remained open since approval of the Settlement Contract. Respondent had the claim reviewed and a proposed MSA in the amount of $14,010.00 was submitted to CMS and approved on April 16, 2020.

Respondent elects and is exercising the provisions of the Settlement Contract to terminate Petitioner's medical rights under Section 8(a) by funding the MSA. The parties agree that the

MSA will be self-administered by Petitioner as indicated in the "Medicare Set Aside Addendum to Settlement Addendum" per CMS rules and federal regulations, and Petitioner further agrees that all rights pursuant to Section 8(a) of the Illinois Workers' Compensation Act and Occupational Diseases Act upon entry of the Order by the Illinois Workers' Compensation Commission to amend the Settlement Contract shall be closed.

Therefore, the Commission having jurisdiction over said claim, it is hereby ordered:

1. That the Settlement Contract Lump Sum Petition and Order, approved by Arbitrator Carolyn M. Doherty on November 7, 2017, is hereby modified as per the parties' joint request;

2. That it is the further Order of the Commission that pursuant to the reference Settlement Contract and the parties' joint request, Petitioner's continuing rights under Section 8(a) are now closed; and,

3. That the heretofore approved Settlement Contract, as was approved by Arbitrator Carolyn M. Doherty on November 7, 2017, remains in full force and effect, and shall be read in concert with this Order and Joint Motion.

DATED: June 23, 2020

JUL 17 2020

Commissioner Barbara N. Flores

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Alan L. Johnsen, Petitioner,	)	
vs.	)	No. 16 WC 31032
DHL Express USA, Inc., Respondent.	)	

MEDICARE SET ASIDE ADDENDUM TO SETTLEMENT ADDENDUM

NOW COMES Alan Johnsen (Petitioner), DHL Express USA, Inc., (Respondent), and Sedgwick CMS (Carrier) and for valuable consideration, the receipt and sufficiency of which are hereby acknowledged to enter this addendum.

This Addendum is incorporated into the settlement of the Petitioner's Workers' Compensation claim against Respondent, and, whereas the Center for Medicare and Medicaid Services (CMS) has approved a Medicare Set Aside Allocation of $14,010.00 to pay for future services in relation to the Petitioner's right knee claim and his subsequent workers compensation claim involving the right shoulder the following agreement is presented. This MSA is also referenced in the settlement of 19 WC 05619. All terms related to the administration and disbursement of the funds are incorporated in the settlement contract for 19 WC 05619.

Whereas, the parties desire and intend to fully comply with the CMS approved MSA instructions, the parties agree as follows:

1. That a settlement amount of $34,892.03 was approved on November 7, 2017. That settlement allowed for Petitioner's future medical expenses under Section 8(a) of the Workers' Compensation Act to be addressed in a subsequent resolution or to remain open. A draft in the amount of $34,892.03 was issued to the Petitioner and his attorney in fulfillment of the agreement noted in the original approved contract. (See Exhibit 1 Approved Contract).

2. On April 16, 2020, CMS issued an approval of an MSA Set Aside allocation for the Petitioner. That allocation totals $14,010.00. (See Exhibit 2, CMS approval letter.)

3. Upon approval of this agreement, the carrier will issue a draft representative of seed money of $2,335.00 payable to the Petitioner to establish itself administered structured MSA account. The carrier also agrees to fund the annuity for the self administered MSA accounts. See settlement contract for 19 WC 05619 for details of the MSA.

4. The Petitioner shall self-administer the MSA funds and do so in full compliance with all directives or instructions as provided to Petitioner by CMS and its approval

letter or as may hereafter be required by CMS. Petitioner will receive an annual disbursement of $1,061.40 beginning on July 22, 2021. This disbursement will continue for 11 years or while living within that period of 11 years.

Pursuant to the approved settlement agreement, the approval of this addendum constitutes Respondent fulfilling their agreement to address Petitioner's future medical needs in accordance with Section 8(a) of the Act. The parties agree that as of the approval of this agreement, Petitioner Section 8(a) right to future medical treatment will be close.

So agreed and executed, this 27 nd date of May, 2020.

Respectfully Submitted,

HENNESSY & ROACH, P.C.

By: _____
Attorneys for Respondent

LAW OFFICES OF RAYMOND SIMARD

By: _____
Attorneys for Petitioner

APPROVED BY AUTHORITY OF THE
ILLINOIS WORKERS' COMPENSATION COMMISSION
pursuant to the provisions of the
Workers' Compensation and Workers'
Occupational Diseases Acts

JUN 23 2020

Commissioner Flores

By: Barbara N. Flores, Commissioner

ILLINOIS WORKERS' COMPENSATION COMMISSION
SETTLEMENT CONTRACT LUMP SUM PETITION AND ORDER

Attorney: Please type or print. Answer all questions. File four copies of this form. Attach a recent medical report.

Workers' Compensation Act ☒ Occupational Diseases Act ☐ Fatal case? No ☒ Yes ☐ Date of death _____

Alan L. Johnsen
Employee/Petitioner

Case # 18 WC 21032

Arbitrator Doherty

DHL Express USA, Inc.
Employer/Respondent

Setting Ottawa

To resolve this dispute regarding the benefits due the petitioner under the Illinois Workers' Compensation or Occupational Diseases Act, we offer the following statements. We understand these statements are not binding if this contract is not approved.

Alan L. Johnsen
Employee's name

695 Vermont Road
Street address

Frankfort, IL 60423
City, State, Zip code

DHL Express USA, Inc.
Employer's name

9401 W. 47th Street
Street address

McCook, IL 60525
City, State, Zip code

State Employee? Yes ☐ No ☒ Male ☒ Female ☐ Married ☒ Single ☐

Dependents under age 18 0 Birthdate 05/16/1961 Average weekly wage $ 1,429.44

Date of accident 5/03/2016

How did the accident occur? While working

What part of the body was affected? Right Leg

What is the nature of the injury? Arthroscopic repair of the right leg

The employer was notified of the accident orally ☒ In writing ☐ Return-to-work date 09/14/2016

Location of accident Grand Ridge, IL Did the employee return to his or her regular job? Yes ☒ No ☐

If not, explain below and describe the type of work the employee is doing, the wages earned, and the current employer's name and address.

TEMPORARY TOTAL DISABILITY BENEFITS: Compensation was paid for 12 and 6/7 weeks at the rate of $ 726.62/week.

The employee was temporarily totally disabled from 05/05/2016 through 06/01/2016
07/13/2016 through 09/13/2016.

MEDICAL EXPENSES: The employer has ☐ has not ☒ paid all medical bills. List unpaid bills in the space below.

Respondent agrees to process reasonable, necessary, and causally related medical expenses submitted in accordance with the Illinois Fee Schedule and accrued up to October 3, 2016.

PREVIOUS AGREEMENTS: Before the petitioner signed an Attorney Representation Agreement, the respondent or its agent offered in writing to pay the petitioner $ 0.00 as compensation for the permanent disability caused by this injury.

As arbitrator or commissioner of the Commission previously made an award on this case on: N/A regarding

PTD $ 0.00 Permanent disability: $ 0.00 Medical expenses: $ 0.00 Other: $ 0.00

EXHIBIT 1.

Terms of settlement: Respondent offers and Petitioner agrees to accept $34,892.03 in full and final settlement of any and all claims under the Workers' Compensation Act and Occupational Disease Act for any and all accidental injuries of any nature, kind, or description allegedly incurred as a result of the accident of May 3, 2016, including any and all results, development, or sequelae, fatal or non-fatal, allegedly resulting from such accidental injuries and whether or not such injuries are compensable. Issues exist between the parties as to whether Petitioner has incurred injuries to the degree alleged and whether or not such injuries are compensable, and this settlement is made to amicably settle all issues on a disputed basis. This settlement includes liability for temporary total compensation and disability resulting from said accidental injury for all of which Petitioner expressly assumes responsibility. All rights under Section 16 and Section 19, including but not limited to Section 19(h) of the Act are expressly waived by the parties. Petitioner and Respondent agree that this settlement is made with the intent to preserve all rights afforded to Respondent under Section 8(j) of the Act and is not any way are any rights under Section 8(j) waived by Respondent. Without limiting the generality of the foregoing release, this settlement represents 20% loss of use of the right leg or 43 weeks x 755.23; or a lump sum of $32,474.46; and $2,417.57 to address underpayment of TTD.

It is not the intention of the parties to shift the responsibility of any future medical benefits to the Federal Government. Pursuant to 42 U.S.C. 1395y (Laws, 42 C.F.R. Sec. 411.20 – Sec. 411.47, the Medicare Intermediary Manual, and certain Memorandums or FAQ's issued by CMS, the parties acknowledge their duty to adequately consider Medicare's interest in this workers' compensation settlement by not shifting the health care burden of this claim to Medicare. The parties have complied with their duties under the law in the following manner. The parties have considered Medicare's interests in this claim. Petitioner is a beneficiary of Medicare. The parties have agreed to leave petitioner's medical rights under Section 8(a) open and will address any requests for future medical care upon confirmation that the recommended care is reasonable, necessary, and related. Respondent reserves the right to secure a section 12 evaluation to assist ongoing discussion should future medical treatment be requested.

Total amount of settlement	$ 34,892.03
Deduction: Attorney's fees	$ 6,978.00
Deduction: Medical reports, X-rays	$ 79.00
Deduction: Other (explain)	$
Amount employee will receive	$ 27,839.03

PETITIONER'S SIGNATURE. *Attention, petitioner: Do not sign this contract unless you understand all of the following statements.*
I have read this document, understand its terms, and sign this contract voluntarily. I believe it is in my best interests for the Commission to approve this contract. I understand that I can present this settlement contract to the Commission in person. I understand that by signing this contract, I am giving up the following rights:

1. My right to a trial before an arbitrator;
2. My right to appeal the arbitrator's decision to the Commission;
3. My right to any additional benefits if any condition worsens as a result of this injury.

Signature of petitioner — Alan L. Johnson, Name of petitioner (please print) — Telephone number — Date

PETITIONER'S ATTORNEY. I attest that any fee petitions on file with the IWCC have been resolved. Based on the information reasonably available to me, I recommend this settlement contract be approved.

Signature of attorney — 11-1-17, Date

Raymond Simard
Attorney's name and IC code # (please print)

Law Offices of Raymond Simard
Firm name

203 W. Randolph, Ste. 916
Street address

Chicago, IL 60606
City, State, Zip code

(312)847-1270 — ray@raymondsimard.com
Telephone number — E-mail address

TAX ID No.: 36-384-1089

RESPONDENT'S ATTORNEY. I attest that any fee petitions on file with the IWCC have been resolved. The respondent agrees to this settlement and will pay the benefits to the petitioner or the petitioner's attorney, according to the terms of this contract, promptly after receiving a copy of the approved contract.

Signature of attorney or agent — 10/30/17, Date

Mitzi H. Westerhoff #762
Attorney's name and IC code # or agent (please print)

Hennessy & Roach, P.C.
Firm name

140 S. Dearborn St., Ste. 700
Street address

Chicago, IL 60603
City, State, Zip code

312-340-6310 — mwesterhoff@hennessyroach.com
Telephone number — E-mail address

Sedgwick CMS
Name of responsible party or third party administrator (please print)

APPROVED BY AUTHORITY OF THE
ILLINOIS WORKERS' COMPENSATION COMMISSION
Pursuant to the provisions of the
Workers' Compensation and Workers'
Occupational Diseases Acts

NOV 07 2017

By: Brooke Doherty, Arbitrator

Under penalties of perjury, the undersigned petitioner certifies that he/she has read the terms of this document, understands them, and signs this document voluntarily. In accordance with Section 8 of the Act, he/she certifies that he/she has received no benefits from any employer other than the respondent for the injuries sustained on the date(s) listed above. He/she further certifies that he/she has not received any benefits from any source, including but not limited to, group insurance, Medicare, Medicaid, or any other state or federal program, for the injuries sustained on the date(s) listed above.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DEREK HEINZ,

Petitioner,

vs. NO: 15 WC 27772

THOMAS COMBS d/b/a TEC BUILDERS,

20IWCC0401

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Respondent herein and notice given to all parties, the Commission, after considering the issues of temporary disability, including temporary total disability and maintenance, and medical expenses, and being advised of the facts and law, modifies the Decision of the Arbitrator as set forth below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

CONCLUSIONS OF LAW:

I. Temporary Disability

A. Temporary Total Disability

In challenging the award of Temporary Total Disability benefits, Respondent argues the appropriate periods are July 30, 2014 through June 12, 2015 and July 6, 2015 through September 11, 2015. Respondent's argument is predicated on Dr. Berry's releases on June 12, 2015 and September 11, 2015; specifically, Respondent posits Dr. Berry provided a "full duty release without restriction. The record is devoid of any reference to any work restrictions or off work slips by a physician until petitioner was seen by Dr. Rhode on 09/07/2016 and placed at MMI." The Commission begins its analysis with a review of the relevant medical records.

On May 22, 2015, Dr. Berry memorialized Petitioner's pain had improved and he was making functional gains: Petitioner "finally started to have some thumb function" and his "fingers are getting stronger." Observing Petitioner's strengthening efforts were self-directed

because further therapy was denied, Dr. Berry directed Petitioner to return in three to four weeks. PX4, RX7, RX9.

On June 12, 2015, Petitioner was re-evaluated by Dr. Berry. The doctor noted Petitioner reported resolution of his forearm pain, and her examination findings included extension of the IP joint of the thumb; independent motion of the index finger; full extension of the fingers; centralized extension of the wrist, with ability to deviate radially and ulnarly; flexion completely returned; and improved swelling. Dr. Berry directed Petitioner to try to use his hand normally so he could continue making functional gains:

> I have encouraged him to try to return to normal function as much as possible. He has been unable to throw a baseball with his son which this is a normal pastime. I have encouraged him to return to this activity as well. Hopefully return to normal life will continue to strengthen his hand. He has no restrictions to any activities at this point. I am pleased with his progress, and I feel like we have finally come to the point of normal function. I will continue to see him on a monthly basis. PX4, RX7, RX9.

The Commission notes Petitioner's increased use of his hand resulted in a precipitous worsening of his symptoms, and he returned to Dr. Berry for a re-evaluation shortly thereafter. The significance of Dr. Berry's encouragement to return to normal function in order to strengthen his hand will be discussed below.

When Petitioner presented for the July 6, 2015 follow-up appointment, Dr. Berry documented an appreciable regression in Petitioner's function following the increased use of his hand: "He continues to be significantly weaker on the right side. As instructed, he has been throwing a baseball with his son. He reports that he has had pain after some duration with this activity. His pain is wrist joint as well as just proximal to it." Dr. Berry ordered a strength evaluation, which revealed substantial discrepancies in grip strength on the right versus the left side, despite the right being Petitioner's dominant hand, as well as decreased circumference of Petitioner's right forearm muscles. Dr. Berry memorialized that overall Petitioner had improvement with each visit, and while the doctor had encouraged him to return to normal function as much as possible, Petitioner had increasing pain after some activities. Dr. Berry noted Petitioner would "significantly benefit" from work conditioning to increase his stamina and overall strength, however this was not an option because of the legal issues at the time. Dr. Berry released Petitioner to restricted duty and directed he return in two weeks. Dr. Berry subsequently authored an addendum:

> I have reviewed the patient's therapy notes after his severe discrepancy in his right and left arm. All of his muscles have been effected [SIC]. He has significant weakness of grip strength, wrist flexion and extension as well as the elbow flexion. I believe that he would benefit from significant therapy to get him back to normal function and final result at the point of maximum medical improvement. I am recommending therapy 3 x a day [SIC] to improve his current condition. PX4, RX7, RX9.

Dr. Berry's July 20, 2015 office note reflects Petitioner's wrist pain had resolved, though

he did not have much stamina. The doctor reiterated her recommendation for therapy, memorializing "we spent quite a bit of time on the phone with his insurance company trying to get him approved," and noted she would continue to monitor his strengthening. PX4, RX7, RX9. On July 31, 2015, Dr. Berry ordered a repeat strength evaluation and again recommended therapy. PX4, RX7, RX9.

Petitioner underwent a brief course of physical therapy in August. The therapist's September 4, 2015 note reflects Petitioner had made "slight gains" in strength when compared to a month prior and continued to have decreased strength on the right side. PX4, RX7, RX9.

On September 11, 2015, Petitioner was re-evaluated by Dr. Berry. Dr. Berry recorded Petitioner reported notable improvement in his symptoms overall but continued wrist pain after significant use: "For example, when he throws a ball with his son, he does have pain afterwards that he feels as if the wrist has been overused." The doctor further noted Petitioner's right hand strength evaluation demonstrated "significant deficits in his muscles. He has improved some strength in some aspects, but he continues to be significantly weaker compared to the left." Dr. Berry released Petitioner to full duty noting her hope this would lead to Petitioner regaining lost function: "Patient will hopefully continue to improve with all of this. I believe that anti-inflammatories may help this tendinitis-like picture. I will release him to full duty without any restrictions. Hopefully, the strengthening will come back as he continues to use his arm at a normal capacity." Petitioner was to be re-evaluated in one month. PX4, RX7, RX9.

An employee is temporarily totally incapacitated from the time an injury incapacitates him from work until such time as he is as far recovered or restored as the permanent character of injury will permit. To be entitled to TTD benefits, it is the claimant's burden to prove not only that he did not work but also that he was unable to work. *Shafer v. Illinois Workers' Compensation Commission*, 2011 IL App (4th) 100505WC, ¶ 45, 976 N.E.2d 1. A TTD award is proper when the claimant cannot perform any services except those for which no reasonably stable labor market exists. *Archer Daniels Midland Co. v. Industrial Commission*, 138 Ill. 2d 107, 118, 561 N.E.2d 623 (1990). "Therefore, when determining whether an employee is entitled to TTD benefits, the test is whether the employee remains temporarily totally disabled as a result of a work-related injury and whether the employee is capable of returning to the work force." *Holocker v. Illinois Workers' Compensation Commission*, 2017 IL App (3d) 160363WC, ¶34, quoting *Interstate Scaffolding, Inc. v. Illinois Workers' Compensation Commission*, 236 Ill. 2d 132, 923 N.E.2d 266 (2010).

The Commission agrees with Respondent that Dr. Berry's records do not contain any activity restriction slips after September 11, 2015. We observe, however, that neither Dr. Berry's June 12, 2015 note nor the September 11, 2015 note place Petitioner at maximum medical improvement and instead both acknowledge an ongoing severe strength deficit which Dr. Berry indicated she hopes to improve with Petitioner's use of the hand. The Commission finds it significant Petitioner found alternate employment in an office setting approximately three weeks after September 11, 2015, and his unrebutted testimony is his ongoing functional deficits led to him being terminated after only a month because of his inability to complete job duties which the Commission finds to be consistent with the sedentary to light level: "I never got a formal piece of paperwork, but I was called by the owner of the company and he said is your hand and arm still messed up? We had a discussion about exactly how he hired me knowing what was wrong

with my arm. He then let me go and said I shouldn't have hired you, I apologize; and that was about the extent of our conversation." T. 41-42. The Commission further emphasizes that over Petitioner's entire post-operative course, including well beyond September 11, 2015, the medical records consistently document substantial strength deficits.

On November 13, 2015, Dr. Berry noted Petitioner had "significant delay" in return to function and despite his attempt to return to normal use of his hand, it remained "significantly weaker." Dr. Berry again noted her belief Petitioner's "strength will come back with the use." Notably, while Dr. Berry indicated Petitioner had been released to full duty without any restrictions, she further referenced her hope Petitioner would do well with a new job search. PX4, RX9.

On January 6, 2016, Dr. Berry documented Petitioner's postoperative course was "very difficult for him with generalized muscle weakness which still persists in comparison to the other side" PX4, RX9.

On February 22, 2016, a valid FCE demonstrated an ongoing strength disparity between Petitioner's left and right hands. While Petitioner operated at the Medium Physical Demand Level with his left hand, his right hand only achieved Light Physical Demand Level. Petitioner's left hand maximum carry was 45 pounds, yet his dominant right hand maximum carry was only half that, 27 pounds. PX10, RX9.

On March 2, 2016, Dr. Berry noted Petitioner had subjective and objective weakness of his entire right upper extremity. PX4, RX9.

On April 4, 2016, Dr. Berry documented Petitioner had continued weakness and complained of wrist swelling and pain worse when using his hand. Noting she had encouraged him to continue to use his hand as much as possible, Dr. Berry concluded Petitioner was "doing limited better" and should continue "to work on his strengthening by using his hand and wrist." Dr. Berry further noted Petitioner was looking "for another employment" and did not have any restrictions from her standpoint. RX10.

On May 2, 2016, Dr. Berry documented Petitioner had persistent weakness of the arm. The doctor again recommended Petitioner continue to use his arm. RX10.

On June 10, 2016, Dr. Berry directed Petitioner to "continue to work on his strengthening with normal activities." RX10.

On June 27, 2016, Dr. Berry documented Petitioner's right side "is still significantly weaker than the left," this despite the fact Petitioner had "been working on strengthening by using the arm." Dr. Berry further noted Petitioner had been trying to increase his activities, but was limited due to pain. The doctor also memorialized Petitioner had not obtained new employment. RX10.

On September 7, 2016, Dr. Rhode performed an impairment rating evaluation. Dr. Rhode concluded Petitioner was at maximum medical improvement and had permanent right upper extremity restrictions: maximum lift and carry 20 pounds, frequent at 10 pounds; limited push

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and pull; limited repetitive grasp; and no vibratory tools. PX14, DepX1.

The Commission observes the question of what Dr. Berry intended by releasing Petitioner to unrestricted activity was addressed in her March 6, 2018 deposition:

> You know, he had this weakness overall and to tell him you have no restrictions, keep using your hand, the goal of that is to increase his strength. So most people improve their strength by using their hand. So you don't want to restrict the patient when they're in the healing phase and trying to gain their strength back. You encourage them to do more, do more, do more. You never tell the patient go and lift 200 pounds the first time you release them. You tell them to progressively increase. So that's the documentation that says use your hand, use your hand in hopes of increasing his strength and not restricting him from that standpoint. Then knowing that more activity produced more pain at some point halfway through that, well, let's not - - try not to do as much, as much activity. Let's see if we are able to control your pain and tenderness by limiting that activity, and yet even with that, he was not going so well. So certain time goes on, and then at the two-year mark, he still doesn't have the strength to do certain things. If he had to hold a heavy instrument or something that he would drop, he's not safe. So after this period of time not having significant improvement and getting the final this is what he can do, I think it's a permanent restriction prohibiting him. PX22, p. 50.

The Commission finds Dr. Berry's testimony is consistent with Petitioner's description of his discussions with Dr. Berry: "Correct; and no restrictions as in let's see what you can do. I was never released, it never said 100 percent or go back to your former job…What, I am telling you what I know is that she told me let's see what you can do. Let's go try and find a job, let's try and do this." T. 42.

Given Dr. Berry's testimony that the releases to activity were not intended to reflect Petitioner was capable of immediately resuming his pre-accident work activities but rather were in effect ongoing therapy to see if he could regain the lost strength and return to normal function, as well as the consistent documentation of significant strength deficits which preclude Petitioner from performing his usual carpentry duties, the Commission concludes Petitioner was entitled to Temporary Total Disability benefits. The Commission finds Petitioner was temporarily and totally disabled from July 30, 2014 through October 1, 2015, and November 1, 2015 through September 7, 2016. We correct the decision to reflect this represents 105 5/7 weeks.

B. Maintenance

On Review, Respondent claims no maintenance benefits should be awarded because Petitioner's job search was self-limited and in bad faith. The Commission disagrees.

Petitioner's job search logs cover September 12, 2016 through April 1, 2018; over that span, Petitioner applied for 325 jobs. PX17. Respondent argues Petitioner's search was insufficient in that he imposed an artificial requirement of 35 hours per week and applied for positions which failed to take advantage of his skill set. Certainly Petitioner's job logs include numerous applications to fast food restaurants and the like. However, the logs demonstrate

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Petitioner also applied for the types of jobs Respondent's vocational expert, Karen Kane, identified as appropriate for his transferable skills: watchman at CLWP; dispatcher/receiver for in-home/custom windows at JC Penney; patient access specialist at Memorial Medical Center; sales at Gordman's department store; sales at multiple automobile dealerships; loss prevention/security at Kmart; appliance sales at Sears; and sales at Menard's. PX17. The Commission finds Petitioner's job search was sufficiently diligent to justify the award of maintenance benefits. We further find, however, the period should be modified.

The Commission observes the job search logs reflect Petitioner's efforts dramatically waned after February 2018: while the logs demonstrate Petitioner applied for 42 positions in February 2018, over the months of March and April, only a total of 10 applications are documented. The Commission finds this does not evidence diligent job search efforts sufficient to justify payment of maintenance benefits. The Commission finds Petitioner's entitlement to maintenance benefits terminated on February 28, 2018. The award of maintenance benefits from March 1, 2018 through May 30, 2018 is hereby vacated.

II. Medical

Respondent argues all treatment rendered after September 11, 2015 is not causally related to the accident. The Commission disagrees.

While Petitioner developed tendinitis and was subsequently diagnosed with a TFCC tear, his treatment with Dr. Berry also addressed his ongoing strength deficits which resulted from his work injury. Therefore, the expenses associated with Petitioner's post-September 11, 2015 treatment are related to the accidental injury. The Commission finds the medical expenses contained in Petitioner's Exhibit 15 are reasonable, necessary, and causally related to the July 29, 2014 accident.

All else is affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 27, 2018, as modified above, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $310.28 per week for a period of 105 6/7 weeks, representing July 30, 2014 through Ocboter 1, 2015 and November 1, 2015 through September 7, 2016, that being the period of temporary total incapacity for work under §8(b) of the Act. Respondent shall be given a credit $6,162.50 for Temporary Total Disability benefits paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner maintenance benefits in the amount of $310.28 per week for a period of 77 weeks, representing September 8, 2016 through February 28, 2018, as provided in §8(a) of the Act. The award of maintenance benefits from March 1, 2018 through May 30, 2018 is vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay reasonable, necessary and related medical expenses of $57,318.62 as set forth in Petitioner's Exhibit 15, pursuant to §8(a), subject to the §8.2 of the Act. Respondent shall be given a credit for medical

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

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $286.00 per week for a period of 125 weeks, as provided in §8(d)2 of the Act, for the reason the injuries sustained caused the 25% loss of use of the person as a whole.

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

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

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.

Stephen J. Mathis

Stephen Mathis

D. Douglas McCarthy

D. Douglas McCarthy

SPECIAL CONCURRENCE/DISSENT

I concur with the majority's opinion in all aspects other than the award of temporary total disability benefits. As to this award, I respectfully dissent.

As the Majority correctly notes, Dr. Berry's medical records contain no off-work or restricted-work notes after September 11, 2015. Moreover, as the Majority notes, on June 12, 2015, Dr. Berry released Petitioner to return to normal function as much as possible. PX4. As the records indicate, Petitioner followed these instructions, and on July 6, 2015, he presented to Dr. Berry complaining of increased pain. Dr. Berry, thusly, restricted Petitioner's ability to work, and physical therapy was undertaken. *Id.* On September 11, 2015, Dr. Berry re-evaluated Petitioner who reported notable improvement in his symptoms. Accordingly, Dr. Berry released Petitioner to return to work full duty, without restrictions. PX4.

Thereafter, Dr. Berry continued to manage Petitioner's treatment with the belief Petitioner's function would return to normal with continued use of his hand. On February 22, 2016, an FCE was performed which evidenced strength deficits to Petitioner's right hand as well as decreased lifting abilities. PX10; RX9. Dr. Berry continued to note weakness and pain in Petitioner's right hand throughout her treatment in 2016 but declined to place any restrictions on Petitioner's activities, work or otherwise. On September 7, 2016, Dr. Rhode placed Petitioner at

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maximum medical improvement and released him to return to work with restrictions of lifting/carrying 20 lbs. and 10 lbs., frequently. PX14, DepX1. These restrictions are consistent with the findings of the FCE performed on February 22, 2016.

Based on the above, I find temporary total disability benefits are owed from July 30, 2014 through June 12, 2015; July 6, 2015 through September 11, 2015; and February 22, 2016 through September 7, 2016. During each of the above periods, Petitioner was restricted in his ability to return to work. Therefore, I respectfully dissent.

DATED: JUL 17 2020

L. Elizabeth Coppoletti

LEC/mck

O: 5/19/2020

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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HEINZ, DEREK
Employee/Petitioner

Case# **15WC027772**

THOMAS COMBS D/B/A TEC BUILDERS
Employer/Respondent

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On 11/27/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.47% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1824 STRONG LAW OFFICES
TODD A STRONG
3100 N KNOXVILLE AVE
PEORIA, IL 61603

2674 BRADY CONNOLLY & MASUDA PC
FARRAH L HAGAN
211 LANDMARK DR SUITE C-2
NORMAL, IL 61761

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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

Derek Heinz
Employee/Petitioner

v.

Thomas Combs d/b/a TEC Builders
Employer/Respondent

Case # **15** WC **27772**

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 **Springfield**, on **5/30/18**. 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 **7/29/14**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**4,188.75**; the average weekly wage was $**465.42**.

On the date of accident, Petitioner was **33** years of age, ***married*** with **1** dependent child.

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

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

Respondent shall be given a credit of $**6,162.50** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**6,162.50**.

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

ORDER

Respondent shall pay reasonable and necessary medical services of $**57,318.62**, as set forth in Petitioner's exhibit 15 , as provided in Sections 8(a) and 8.2 of the Act.

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

Respondent shall pay Petitioner temporary total disability benefits of $**310.28**/week for **105 4/7** weeks, commencing **7/30/14** through **10/1/15 (61 1/7)**, and **11/1/15** through **9/7/16 (44 3/7),** as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $**6,162.50** for temporary total disability benefits that have been paid.

Respondent shall pay Petitioner maintenance benefits of $**310.28**/week for **90 3/7** weeks, commencing **9/8/16** through **5/30/18**, as provided in Section 8(a) of the Act.

Based on the factors enumerated in §8.1b of the Act, which the Arbitrator addressed in the attached findings of fact and conclusions of law, and the record taken as a whole, Respondent shall pay Petitioner the sum of $**286.00**/week for a further period of **125** weeks, as provided in Section **8(d)2** of the Act, because the injuries sustained caused **25% loss of use of the person as a whole**.

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

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

Michael K. Nowak, Arbitrator — **11/13/18** Date

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FINDINGS OF FACT

As a procedural matter, this case was arbitrated under case number 15 WC 27772. The parties, at the time of arbitration, stipulated that there was a duplicate filing under case number 14 WC 41567 for which a motion to voluntarily dismiss was entered.

The Petitioner testified that he was 37 years of age, married with one child at the time of arbitration. The Petitioner acknowledged having two years of college classes, but was unable to obtain a degree. The Petitioner has described his primary occupation in his adult life as being a carpenter. He has worked for various entities and employers in his capacity as a carpenter. The Petitioner is a non-union carpenter who performs all aspects of carpentry, including finishing work as well as rough carpentry work. The Petitioner testified that he worked for the Respondent for approximately 1-1/2 years.

The Petitioner described his accidental injuries occurring on July 29, 2014 in great detail (TR, pp. 15-18). The Petitioner was working with plywood and utilizing an electric circular saw to cut sheets of plywood when a piece of plywood became stuck and the saw "jumped." The Petitioner described that the "saw pulled my hand around." The Petitioner jumped out of the way and his hand was struck. The Petitioner thought he had broken his wrist. The saw weighed somewhere between 5 and 7 pounds. The saw threw his whole body around when it jumped. (TR, p. 17). This Arbitrator noted during the course of testimony that the Petitioner was gesturing that his right extremity was pulled away from his body in a hyperextended motion. (TR., p. 17). The Petitioner described that he felt immediate shooting pains in his right wrist shooting down his elbow and felt a surging pain. He reported the incident to his supervisor, Tommy Combs, and Jason Mayol. (TR, p. 18). The Petitioner sought immediate medical treatment at Memorial Medical Center emergency room that day. The histories contained in the emergency room records corroborate the Petitioner's live testimony wherein the Memorial Medical Center emergency room physician recorded a history of "patient was using a circular saw and the saw became caught in the wood. Patient had immediate pain to the right forearm, hand, and elbow." The emergency room physician noted the Petitioner's pain, swelling, and numbness in his right upper extremity. The pain diagram as noted by the emergency room physician shows pain complaints and swelling in the right wrist, right forearm, as well as the right elbow. The emergency room physician noted limited range of motion, flexion and extension in the right upper extremity.

The Petitioner testified that he had not had any prior medical care or treatment or injuries to his right wrist, right forearm or right elbow. The Arbitrator notes in reviewing the exhibits that there is no evidence to the contrary.

The Petitioner sought follow-up medical care and treatment with Dr. Sims at SIU Family Practice. He was referred for an MRI, which took place on August 5, 2014. (PX6). The Petitioner was subsequently referred by his primary care physician to Dr. Berry, an orthopedic surgeon at SIU Physicians and Surgeons (PX4), who likewise referred the Petitioner for an EMG/NCV study with Dr. Edward Trudeau, which took place on October 2, 2014. (PX8). The EMG findings reveal ulnar neuropathy at the right elbow, posterior interosseous neuropathy on the right dorsal proximal forearm as well as median neuropathy on the right wrist.

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The Petitioner was prescribed and underwent surgical intervention for right carpal tunnel, right cubital tunnel, and right radial tunnel surgery with Dr. Berry on February 5, 2015 at the Baylis Building in Springfield, Illinois.

Petitioner testified that after the surgery he had problems with strength. He testified that he wasn't able to grip even simple things in the beginning. He also reported a tingling in his forearm region. He had sensation in his forearm which felt like hitting his funny bone.

Petitioner testified that prior to the work accident he had never had any medical care or treatment with respect to the right wrist, right forearm, or right elbow.

Petitioner testified that he eventually underwent a repeat MRI to the right wrist in November 2015. Petitioner testified that he had not sustained any accidents or falls between the accident and the second MRI..

Petitioner testified that he was involved in a motor vehicle accident in January 2016. Due to the accident he had left shoulder pain, back pain, and neck pain. He denied having any injury to his right wrist, right elbow, or right forearm.

Petitioner testified that he obtained a second opinion with Dr. Rhode. Petitioner underwent an FCE. He was given restrictions of no lifting greater than 20 pounds with respect to the right hand and arm. He was also given a restriction of no exposure to vibratory tools and limited repetitive work with respect to the right hand and arm.

Petitioner testified that he followed up with Dr. Berry in November 2017 to review the FCE. She agreed with the restrictions.

Petitioner testified that he was seen by Dr. David Brown on two occasions pursuant to section 12 of the Act.

Petitioner testified that his current complaints included having to rest after an hour to hour and a half after picking up around his house. He testified that his arm felt like it is in a vice. He testified that if he extends anything too long, he starts to get a tingling feeling down his fingers.

With respect to the tools he would normally use as a carpenter, he testified that he could not use vibratory tools. He testified that he could not even mow his yard; can't use a nail gun because of the kick back, and his grip strength is not very good. He testified that with these difficulties, he would not be able to perform his duties as a carpenter. He testified that the employer did not make any effort to provide accommodated or light duty work.

Petitioner testified that he requested vocational rehabilitation benefits, which were denied by the Respondent. He testified that he looked for work on his own with his current restrictions. Petitioner testified that he looked for a job for 90 weeks. He testified that he performed the job search through the internet and putting in applications.

Petitioner testified he was off work from July 29, 2014, through October 1, 2015. He stated he had a job in 2015 at Pioneer Industries in Decatur. He was an office assistant. His job duties consisted of making sure the

manager's paperwork was done, emptying small trash cans, printing off anything that needed to be printed, and looking through parts to make sure they were clean. Petitioner testified he was paid $15.00 an hour. He indicated that he was fired over his restrictions. At that time he was still having problems with his arm. He testified that Dr. Berry felt that since Petitioner was still having problems they needed to continue treatment. Petitioner testified he went on some restricted duties under Dr. Berry and his primary care physician. He was off work again November 1, 2015, through September 7, 2016, when he was ultimately placed at MMI by Dr. Rhode. He testified that he continued his job search from September 8, 2016, through the date of trial. He testified that he had not located employment within his physical restrictions. He testified that he continues to look for work.

Petitioner testified that his current activities include picking up his house and doing dishes.

Petitioner testified that he has been his son's baseball coach since his child was five. Petitioner testified that he can throw intermittently to his son.

Petitioner confirmed that on job application forms if asked about what he cannot do, he puts down his work restrictions. He also testified that he puts down that he has to have 35+ hours a week minimum. He testified that if he has an interview, he reports that he has a pending workers' compensation case.

Petitioner testified that he had 10-12 interviews. He testified he had no job offers. He testified that some of the jobs told him he could not give him 35 hours. The other job offers when he told them about his restrictions they were leery because of the repetitive work.

Petitioner testified he was offered jobs that had less than 30 hours a week, but he called his attorney who informed him that the jobs were supposed to be 35 hours a week. He was offered two jobs less than 35 hours a week. He did not take those jobs because as he understood it he was not supposed to take jobs unless it was 35 hours.

Petitioner testified that he had not gained any additional education in order to get a job. He had intended to go back to school, but he was not sure of his goals. He was waiting for his work comp claim to be completed.

Karen Kane-Thaler was called as a witness by the Respondent. She is a certified vocational rehabilitation counselor. She testified that based upon Petitioner's education, his work history, the provided medical records with delineated restrictions, and his geographic area; it was her opinion within a reasonable degree of medical certainty that he would be able to seek, accept, and maintain employment. She testified that when looking at his restrictions and education, work history, experience, knowledge, and transferrable skills, she did not believe he was seeking opportunities that would truly benefit from who he was or put him in a position that would allow him to earn a comparable or better wage rate. She testified that the job search logs did not reflect a sufficient type of search. She testified the job search log indicates there would have been a day that he applied for 15-20 jobs, but then there would be several weeks where he did not apply for anything.

Ms. Kane-Thaler testified that Petitioner had transferrable skills. He would fall into the US Department of Labor category of semi-skilled to skilled based on his work history. His transferrable skills would be from the equipment he operated or the knowledge to sell it. He had bookkeeping skills, doing sales, and self employment.

Ms. Kane-Thaler performed a labor market survey. The entry level jobs she came up with were on the low end $10.00-$14.00 per hour and the high end $30.00 per hour. She believed Petitioner would be able to obtain the types of jobs included within the labor market survey. Ms. Kane-Thaler testified that Petitioner did not require vocational rehabilitation.

The Arbitrator finds it significant that Respondent wholly refused to provide vocational assistance when requested, but then retained an expert on the eve of trial to attack Petitioner's efforts to find employment on his own.

Kevin Kennedy from PhotoFax testified on Respondent's behalf. A CD was entered into evidence showing the Petitioner engaged in throwing and catching a baseball with his child in July 2017. Petitioner did not appear to exceed his restrictions.

CONCLUSIONS

The issues of accident and notice were stipulated to by the parties.

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

The Arbitrator first notes that the medical histories contained in each and every medical record are consistent and corroborate the Petitioner's testimony as to the mechanism of injury that occurred with his accidental injuries on July 29, 2014. The Petitioner has been consistent throughout his medical care and treatment that he had complaints which were initiated on the date of accident to his right hand, right forearm and right elbow. The Arbitrator finds it significant that there is no history contained in any medical records of prior medical care or treatment to the Petitioner's right upper extremity.

The Arbitrator notes that the Respondent has alleged that either the mechanism of injury could not have caused nerve injuries to the wrist, elbow and forearm pursuant to the medical opinions of Dr. Brown or, in the alternative, that the Petitioner sustained an intervening accident or event in a motor vehicle accident that he was involved in in January of 2016. As to the alleged intervening motor vehicle accident in January 2016, the Petitioner, on direct examination, acknowledged the motor vehicle accident and he further acknowledged that he sought medical care for cervical complaints related to the motor vehicle accident in January, 2016, which occurred roughly 1-1/2 years subsequent to the work-related accident of July 29, 2014. The medical records from SIU Family Medical Center, and specifically Dr. Nolasco, note that Petitioner followed up just two times with his primary care physician. The medical records of SIU Physicians and Surgeons contain complaints of pain to the thoracic back and left shoulder, but do not suggest any increase of pain or increase in symptomatology with respect to his right wrist, right elbow, or right forearm that would sever the causal connection which was demonstrated in the medical records from July 29, 2014 up through January 2016.

The Arbitrator, therefore, finds that the motor vehicle accident which the Petitioner was involved in in January of 2016 did not intervene and supervene to sever any chain of causation with respect to the Petitioner's right upper extremity conditions.

The Arbitrator also notes that the Respondent during the course of evidentiary depositions of Dr. Berry, Dr. Rhode, and Dr. Brown have attempted to argue that a TFCC tear identified in an MRI study of November 11, 2015 was caused by some "unknown event" or alleged to have been caused by activities of daily living,

activities demonstrated on an alleged surveillance, and/or during the course of cross-examination of either Dr. Rhode or Dr. Berry or on direct examination of Dr. Brown that there was some other unknown hypothetical event or activities of daily living to account for the ongoing complaints of pain and/or subsequent surgical recommendations regarding the TFCC tear. The Arbitrator has reviewed all three depositions and found that the Respondent's alternative theories of denial are unsupported by the facts submitted at the time of arbitration either via Respondent's or Petitioner's medical exhibits and/or Petitioner's own testimony or testimony elicited by Respondent on cross-examination of the Petitioner. The theories of denial submitted by the Respondent during the course of the evidentiary depositions are unsupported by fact.

The Arbitrator finds that the Petitioner submitted unimpeached testimony that there was no other potential causes outside of the work related injury to account for his ongoing complaints of right wrist pain at or near the TFCC. More specifically, the Arbitrator has examined the treating medical records and testimony of Dr. Berry, the treating orthopedic surgeon and finds her testimony to be more persuasive than that of Dr. Brown. Specifically, this Arbitrator examines Petitioner's Exhibit No. 24, a December 1, 2017 treatment record whereby Dr. Berry was subjected to cross-examination and presented hypothetical facts which were unsupported at the time of trial. However, the Arbitrator finds Petitioner's Exhibit No. 24 to be compelling relative to the TFCC tear. Specifically, the Arbitrator notes that the TFCC tear was identified prior to the alleged intervening motor vehicle accident of January, 2016 and the testimony of the treating surgeon, Dr. Berry, wherein she provides and gives an opinion that the work-related incident of July 29, 2014 was causative to his wrist, forearm and elbow injury. At all times, Dr. Berry found the Petitioner to be credible and to give a truthful presentation of his symptomatology and complaints, which she relied upon for treatment purposes.

Furthermore, the Arbitrator has reviewed the complete testimony of Dr. Blair Rhode, the Petitioner's examining physician, wherein he also, after reviewing all of the pertinent medical evidence and being subjected to cross-examination, maintained that the Petitioner's right upper extremity condition with respect to his right wrist, right forearm and right elbow were causally related to the undisputed accident. Dr. Rhode relied upon the numerous medical records and histories which were presented to him on direct examination.

Moreover, the Arbitrator has reviewed the opinions of Dr. Brown, who agrees with the treatment protocol as outlined by Dr. Berry and contained in Petitioner's treating records as to the reasonableness and necessity of medical care and treatment. Dr. Brown simply could not find an explanation and gave a generalized opinion that he found it unusual that all three nerve entrapments could have been injured in one specific mechanism of injury.

In reviewing the totality of evidence contained in the record, the Arbitrator finds the testimony and opinions of Dr. Berry, who is more intimately familiar with, and saw the Petitioner on sequential examinations, to be more compelling than those of Dr. Brown.

The Arbitrator, therefore finds that Petitioner's right upper extremity condition with respect to his right wrist, right forearm and right elbow are causally connected to the undisputed accident that he sustained on July 29, 2014.

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

Petitioner submitted medical expenses totaling $57,318.62. (PX 15) The Arbitrator finds all of the above medical bills represented reasonable and necessary medical care and treatment rendered by Petitioner's treating physicians. The Arbitrator made previous findings as to the issue of causal connection and found that the Petitioner sustained injuries to his right wrist, right forearm and right elbow that were causally connected and related to the Petitioner's accident injuries occurring on July 29, 2014.

Respondent shall pay reasonable and necessary medical services of $57,318.62, as set forth in Petitioner's exhibit 15 , as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act. Medical benefits shall be paid directly to Petitioner.

Issue (K): What temporary benefits are in dispute?

TTD:

The Arbitrator finds that the Petitioner was temporarily and totally disabled from July 30, 2014 through October 1, 2015. The Petitioner acknowledged, and the Respondent did not rebut or refute and, in fact, the Respondent's own vocational rehabilitation assistant confirmed that the Respondent could not offer any type of light duty. The Petitioner testified that he was able to locate and secure light duty work from a subsequent employer for roughly four weeks, but, when his new employer found out the full work restrictions and inability to perform the full function of his job duties, he was no longer willing to accommodate the Petitioner. At no time was the Respondent ever able to provide any accommodative or light duty employment. The Petitioner then was back off work with no employment between November 1, 2015 through the date of maximum medical improvement as identified in the functional capacity evaluation and final opinion of Dr. Blair Rhode of September 7, 2016. Dr. Berry subsequently reviewed the medical opinion of Dr. Blair Rhode as well as the functional capacity evaluation results and furthermore declared Petitioner at maximum medical improvement at a later point in time.

Respondent shall pay Petitioner temporary total disability benefits of $310.28/week for 105 4/7 weeks, commencing 7/30/14 through 10/1/15 (61 1/7), and 11/1/15 through 9/7/16 (44 3/7), as provided in Section 8(b) of the Act. Respondent shall be given a credit of $6,162.50 for temporary total disability benefits that have been paid.

Maintenance:

Petitioner testified that he requested vocational rehabilitation benefits, which were denied by the Respondent. He testified that he looked for work on his own with his current restrictions. Petitioner testified that he looked for a job for 90 weeks. He testified that he performed the job search through the internet and putting in applications.

Petitioner testified he was off work from July 29, 2014, through October 1, 2015. He stated he had a job in 2015 at Pioneer Industries in Decatur. He was an office assistant. His job duties consisted of making sure the manager's paperwork was done, emptying small trash cans, printing off anything that needed to be printed, and looking through parts to make sure they were clean. Petitioner testified he was paid $15.00 an hour. He

indicated that he was fired over his restrictions. He was off work again November 1, 2015, through September 7, 2016, when he was ultimately placed at MMI by Dr. Rhode. He testified that he continued his job search from September 8, 2016, through the date of trial. He testified that he had not located employment within his physical restrictions. He testified that he continues to look for work.

Petitioner confirmed that on job application forms if asked about what he cannot do, he puts down his work restrictions. He also testified that he puts down that he has to have 35+ hours a week minimum. He testified that if he has an interview, he reports that he has a pending workers' compensation case.

Petitioner testified that he had 10-12 interviews. He testified he had no job offers. He testified that some of the jobs told him he could not give him 35 hours. The other job offers when he told them about his restrictions they were leery because of the repetitive work.

Petitioner testified he was offered jobs that had less than 30 hours a week, but he called his attorney who informed him that the jobs were supposed to be 35 hours a week. He was offered two jobs less than 35 hours a week. He did not take those jobs because as he understood it he was not supposed to take jobs unless it was 35 hours.

Petitioner testified that he had not gained any additional education in order to get a job. He had intended to go back to school, but he was not sure of his goals. He was waiting for his work comp claim to be completed.

The Respondent solicited and obtained a vocational rehabilitation consultation with Ms. Karen Kane-Thaler, who acknowledged that the Petitioner's primary occupation was that of a carpenter. The Respondent's vocational rehabilitation counselor testified on cross-examination that the Petitioner was precluded from returning to his usual and customary occupation as a carpenter. The Respondent's own vocational counselor acknowledged that there were various types of job placement assistance that she could have provided to Petitioner that would have increased the likelihood of returning to a different line of employment.

The Respondent raised great criticism of the Petitioner regarding the quality of his job searches. The Petitioner submitted various job search documentation in his own exhibits, but further acknowledged that there was a vast amount of additional job searches in the form of online job applications, in-person job applications, the self-writing of two separate resumes, none of which the Respondent's vocational counselor was aware of as she admitted on cross-examination. The Arbitrator notes that the Respondent's vocational counselor was not aware that the Petitioner had requested and, in fact, placed on file with the Illinois Workers' Compensation Commission a demand for vocational rehabilitation, which, at all times, was denied by the Respondent in its entirety. Respondent instead chose to let Petitioner flounder in his attempts to obtain employment and only retained a vocational consultant in the eleventh hour to be used as a witness at trial.

This Arbitrator finds the Petitioner's attempts to return to work insomuch as his attempt to look into additional education, online searches, in-person searches, and creation of two separate resumes focusing on different fields of employment as well as the Petitioner's demeanor to be credible and reasonable. Petitioner did not submit a request for vocational rehabilitation for this Arbitrator to consider, but instead simply requested a loss of trade award.

For all of the above reasons, the Arbitrator orders the Respondent to pay to the Petitioner maintenance benefits from September 8, 2016 through May 30, 2018.

Respondent shall pay Petitioner maintenance benefits of $310.28/week for 90 3/7 weeks, commencing 9/8/16 through 5/30/18, as provided in Section 8(a) of the Act.

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

The Arbitrator notes that Petitioner requested a PPD award rather than being considered for a wage differential award.

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

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that Dr. Rhode prepared an AMA impairment rating under the AMA Guides 6th Edition. During this exam, he noted that Petitioner had no loss of range of motion and no atrophy. He found Petitioner to have a final impairment of extremity of 3% to the right wrist, 3% to the right elbow, with a calculated total whole person impairment of 4%. However, this rating pursuant to the AMA Guides does not consider the permanent work restrictions and inability of the employer to accommodate those restrictions or the Petitioner's displacement from his usual and customary occupation. Further, impairment does not equal disability. The impairment rating is part of the determination for permanent partial disability benefits, but is not the sole or main factor. The Arbitrator therefore gives *little* weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes Petitioner was employed as a carpenter for most of his adult life. Petitioner now has permanent restrictions of light work, maximum 20 lbs. or less lift/carry; frequent at 10 lbs.; limited pushing/pulling, limited repetitive grasp, and no vibratory tools. As a result of these restrictions Petitioner has suffered a loss of occupation or trade insomuch as he is not able to engage in carpentry duties or activities, and is unable to use ordinary hand tools that would in any way involve exposure to vibration. The Arbitrator therefore gives *greater* weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 33 years old at the time of his injuries. Petitioner will have to live with the sequalae of his injuries for a longer period than would an older worker.. The Arbitrator therefore gives *some* weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes it is clear from the record that Petitioner cannot return to his prior occupation as a carpenter. According to Respondent's vocational expert Petitioner may be able to earn between $10.00 to $14.00 at the low end and up to $30.00 at the high end of the compensation range. The Arbitrator finds it more probable than not that the $10.00 to $14.00 per hour range is accurate. The Arbitrator therefore gives *greater* weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes the Petitioner was a credible witness. Petitioner's complaints and symptoms are consistent throughout the medical records. Petitioner suffered a right wrist dislocation as well as median, ulnar, and radial nerve entrapments which required surgical decompression. He underwent postoperative management and ultimately plateaued. Dr. Rhode noted that Petitioner was placed on modified position of light work. Dr. Rhode believed Petitioner's condition was permanent and placed Petitioner at MMI. A work status slip dated September 7, 2016, noted that Petitioner was released to modified duty of light work (maximum 20 lbs. or less lift/carry; frequent at 10 lbs.; limited pushing/pulling, limited repetitive grasp, and no vibratory tools). Because the medical records and evidence taken as a whole corroborate the Petitioner's complaints of pain, weakness and loss of function in her hands, the Arbitrator therefore gives *greater* weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 25% loss of use of the person as a whole pursuant to §8(d)2 of the Act. The Arbitrator notes that Petitioner is married with one dependent child therefore the minimum PPD rate applicable in this case is $286.00.

Issue (M) **Should penalties or fees be imposed upon Respondent?**

The Arbitrator finds that the Petitioner has filed for and was seeking penalties as part of Petitioner's Exhibit No. 16. However, the Arbitrator has also reviewed Respondent's IME report and deposition of Dr. Brown and finds that there was a good faith basis for denial of benefits based upon Dr. Brown's opinion.

Therefore, in consideration of the above, the Arbitrator declines to award penalties pursuant to Sections 19(k) and 19(l) or attorney fees pursuant to Section 16 to Petitioner.

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MANDI BRYANT,

Petitioner,

vs. NO: 18 WC 06370

20 IWCC0402

AISIN MANUFACTURING,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causal relationship, temporary total disability benefits, medical expenses, prospective medical care, and choice of medical providers, 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 remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill. 2d 327, 399 N.E.2d 1322 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 21, 2019 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay the reasonable and necessary medical expenses contained in Petitioner's group exhibit 1, as provided in Section 8(a) and subject to Section 8.2 of the Act, with the exception of the expenses incurred from physicians that fall outside of Petitioner's choice of physicians, namely Family Medical Center and Pickneyville Community Hospital. Respondent shall have credit for medical expenses previously paid and shall indemnify and hold Petitioner harmless from claims made by any health providers arising from the expenses for which it claims credit.

20IWCC0402

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $382.10 per week for a period of 72 5/7 weeks, representing January 29, 2018 through June 21, 2019, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b), this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any. Respondent shall have a credit of $28,656.75 for TTD benefits already paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall provide and pay for treatment recommended by Dr. Gornet as provided in §8(a) of the Act.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $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: JUL 17 2020

LEC/cak

O: 05/19/20

43

Stephen Mathis

D. Douglas McCarthy

SPECIAL CONCURRENCE/DISSENT

I concur with all aspects of the Majority's decision save its finding of causal relationship with respect to the cervical spine. I would reverse and find Petitioner failed to prove the requisite causal relationship. I respectfully dissent.

At trial, Petitioner testified on January 15, 2018, she slipped on ice falling onto her hands and knee. T. 10. On January 17, 2018, Petitioner sought treatment at Southern Illinois Healthcare

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complaining of left knee pain. PX3. During her initial visit, there is no mention of either back or neck pain. On January 29, 2018, Petitioner sought treatment from Dr. Zimmerman complaining of low back pain radiating into her buttocks. PX5. Petitioner made no mention of neck pain. Petitioner continued to treat with Dr. Zimmerman throughout January and February of 2018. On February 13, 2018, for the first time since her injury, Petitioner complains of neck pain. *Id.*

On March 2, 2018, on the referral of Dr. Zimmerman, Dr. Gornet evaluated Petitioner who complains of primarily lower back pain along with neck pain and headaches. Petitioner advised of a prior history of severe migraine headaches occurring approximately four times annually. Petitioner, thereafter, embarks on a year-long treatment regime primarily for her lower back culminating with surgery performed on November 13, 2018. PX8. In the interim, Petitioner undergoes two cervical epidural steroid injections on May 22, 2018 and June 12, 2018 which provides improvement to her pain. PX11 & PX8. Despite this improvement, Dr. Gornet recommends a two-level cervical disc replacement surgery. PX8.

On February 18, 2019, Dr. Gornet provided his testimony via evidence deposition. PX15. Dr. Gornet was questioned regarding a causal relationship between Petitioner's accident and her cervical spine condition. Dr. Gornet testified he "believed it is directly related to her fall of 1/15/18." PX15, p. 19-20. This is the extent of his testimony as to a causal relationship. He provides no basis – no foundation- in support of his opinion. "An expert opinion is only as valid as the reasons for the opinion." *Gross v. Illinois Workers' Compensation Commission*, 2011 IL App (4th) 100615WC.

In contrast, on March 19, 2019, Dr. deGrange provided his testimony via evidence deposition wherein he provided his opinion as to causal relationship and explained the basis of the same. RX1. Dr. deGrange testified Petitioner sustained a cervical strain as the result of her injury. RX2, p. 12. Dr. deGrange testified "given the mechanism and the absence of any radiculopathy involving the right upper extremity or upper extremities – and by 'radiculopathy,' I mean radiating pain, tingling, numbness, and weakness – that she had a cervical strain." *Id.* Moreover, Dr. deGrange explained Petitioner presented with a normal physical examination and no complaints of upper extremity radiculopathy.

As such, I would afford greater weight to the opinions of Dr. deGrange over those of Dr. Gornet. I would find Petitioner reached maximum medical improvement as of May 24, 2018 as it relates to her cervical spine and is not entitled to the prospective medical care recommended by Dr. Gornet. Therefore, I would find temporary total disability benefits are owed from January 29, 2018 through February 25, 2019, the date Petitioner reached maximum medical improvement as it relates to her lumbar spine. I would vacate the temporary total disability benefits awarded after this date. For the above stated reasons, I dissent.

L Elizabeth Coppoletti

L. Elizabeth Coppoletti

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

BRYANT, MANDI
Employee/Petitioner

Case# **18WC006370**

AISIN MANUFACTURING
Employer/Respondent

20IWCC0402

On 8/21/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.84% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0969 RICH RICH & COOKSEY PC
THOMAS C RICH
6 EXECUTIVE DR SUITE 3
FAIRVIEW HTS, IL 62208

0299 KEEFE & DePAULI PC
PAT KEEFE
#2 EXECUTIVE DR
FAIRVIEW HTS, IL 62208

20 IWCC0402

STATE OF ILLINOIS)
)SS.
COUNTY OF MADISON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

MANDI BRYANT
Employee/Petitioner

v.

AISIN MANUFACTURING
Employer/Respondent

Case # 18 WC 06370

Consolidated cases:

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Collinsville,** on **June 21, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **January 15, 2018**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$29,803.80**; the average weekly wage was **$573.15**.

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

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

Respondent shall be given a credit of **$28,656.75** for TTD, $- for TPD, $- for maintenance, and **$2,000.00** for other benefits, for a total credit of **$28,656.75**.

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

ORDER

Respondent shall pay the reasonable and necessary medical services outlined in Petitioner's group exhibit, as provided in § 8(a) and § 8.2 of the Act, the medical fee schedule, with the exception of the physicians that fall outside of Petitioner's choice of physician, namely Family Medical Center and Pinckneyville Community Hospital. Respondent shall have credit for any amounts previously paid and shall indemnify and hold Petitioner harmless from claims made by any health providers arising from the expenses for which it claims credit.

Respondent shall authorize and pay for the treatment recommended by Dr. Gornet.

Respondent shall pay Petitioner temporary total disability benefits of **$382.10**/week for **72 4/7** weeks, as provided in Section 8(b) of the Act, less its credit for the $28,656.75 in TTD benefits already paid.

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

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

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

Signature of Arbitrator

8/17/19
Date

ICArbDec19(b)

AUG 21 2019

FINDINGS OF FACT

On January 15, 2018, Petitioner was a quality control employee for Respondent, Aisin Manufacturing. (T.9) Her job was to inspect auto parts before they were shipped to Toyota. (T.9) The parties stipulated that on January 15, 2018, Petitioner sustained accidental injuries that arose out of and in the course and scope of her employment when, while walking into work, she slipped and fell in the parking lot when a car stopped suddenly in front of her, which in turn caused her to fall onto her left and right hands and strike her left knee. (T.10) Following the accident, Petitioner completed a form at Respondent's on-site Early Intervention Office, on which she indicated she suffered left knee pain with symptoms of burning and tenderness since the accident. (RX2) It was also noted that Petitioner experienced no other injuries in the past. *Id.* Petitioner was seen by Kacey Chamness, a therapist, on the day after the accident at Respondent's facility. *Id.* Petitioner indicated that she was in worse pain with a complaint of swelling into her calf. *Id.* Orthopedic signs were negative; however, Petitioner was noted to have bruising over the tibial tuberosity of her left knee. *Id.* She was advised to continue icing and avoid heat. *Id.*

The next day, Petitioner went to her family physician at Logan Primary Care. (PX3) There, she was seen by PA Micah Oakley and noted to have left knee pain after slipping on the ice and landing directly on her left knee. *Id.* Examination again showed tenderness over the tibial tuberosity with some bruising. *Id.* PA Oakley ordered x-rays of the knee, which were negative for fracture or dislocation. *Id.* Petitioner was instructed to use rest, ice, compression, and elevation to relieve her symptoms. *Id.*

In the next few days, Petitioner began noticing neck and back pain, but she continued to work. (T.11-12) During this time, she used ibuprofen and ice packs, which she testified did not help. (T.12) When her symptoms did not abate, Petitioner saw a local chiropractor, Dr. Zimmerman, on January 29, 2018. (PX5) She had seen Dr. Zimmerman prior to this accident in 2012 for low back pain when she and her ex-husband were attempting to build their own house. (T.12-13) In 2012, Petitioner received conservative treatment, and her symptoms improved. (T.13) She did not require diagnostic testing or referral to a specialist. (T.13) Dr. Zimmerman's initial intake sheet from this accident noted that the last time Petitioner was seen was August 1, 2012, five-and-a-half years ago. (PX5, 1/29/18) Petitioner also testified that following her

episode of trying to build her own dwelling, she went back to work full duty with no restrictions and participated in all activities with no new injuries until January 15, 2018. (T.13-14)

On January 29th, Dr. Zimmerman took the following history:

> Context – Mechanism of injury: Patient states on 01-22-2018 she fell on the ice in the parking lot. She states she was slightly achy then by the weekend she was in severe pain. She states walking increases her pain. She states standing long period of times [sic] she has radiating pain from the low back down the right leg to the knee. She states laying [sic] flat her pain radiates down to her right leg to the knee. She states she's to the point she constantly hurts and can't move without pain. She states she is miserable. (PX5, 1/29/18)

Petitioner reported pain in her thoracic spine, lumbar spine, sacrum, and pelvis. *Id.* Examination showed a 5'6" female weighing 120 pounds with a BMI of 19.4. *Id.* Ranges of motion in her thoracic and lumbar spine were significantly limited by pain. *Id.* Multiple orthopedic tests were positive for low back and sacroiliac pain, and there was tenderness to palpation of the thoracic spine, lumbar spine, and sacrum. *Id.* There was also increased or changed tone in the associated muscles and fascia identified in the thoracic spine, lumbar spine, and sacrum. *Id.* Muscle strength testing and sensation were normal, along with normal reflexes. *Id.* Dr. Zimmerman's diagnoses were strain of the muscle and tendon of back wall of thorax; strain of muscle, fascia and tendon of lower back; and radiculopathy, lumbar region. *Id.* Dr. Zimmerman began treatment by using chiropractic adjustments, electrical stimulation, and use of ice. *Id.* He recommended treatment 1 to 3 times per week for 4 weeks, and took Petitioner off work. *Id.*

On February 13, 2018, Petitioner presented to Dr. Zimmerman and gave a history as follows:

- The patient presents with Back pain. Patient states she hasn't done anything but take it easy. She states she still hurts all the time and[,] if she does anything it increases her back pain. She states she has been taking pain pills and muscle relaxers. She states she alternates ice and heat. Severity – the patient indicates that the pain is an estimated level of 6 on a scale of one to ten, ten being the most severe. Goal: Decrease pain to be a "3" on a scale of (0 to 10).

  Patient presents with pain in the left knee. Patient states her left knee has hurt since the fall and hurts all the time. Patient states her left knee pain is a 7 on a scale of (0 to 10) with ten being the most severe. Goal: Decrease pain to a "4" on a scale of (0 to 10).

- The patient presents with neck pain. Patient states her neck has hurt since the fall, but didn't say anything about it because she was just worried about her back. Patient states her neck pain is a 4 on a scale of (0 to 10) with ten being the most severe. Goal: Decrease pain to a "1" on a scale of (0 to 10). (PX5, 2/13/18)

Dr. Zimmerman's examination was again markedly positive with limited range of motion and objective findings of muscle spasm. *Id.* He continued Petitioner off work. *Id.*

After seeing Dr. Zimmerman, Petitioner also sought treatment at her family medical center for her low back pain, primarily for medication. (PX6) It was noted that pain medication was giving some relief to Petitioner; however, the relief was temporary, and she was still experiencing significant pain with range of motion. X-rays of the lumbar spine taken on February 5, 2018, at Pinckneyville Community Hospital showed minimal degenerative disc disease at L3-4 and L4-5. Dr. Zimmerman continued to treat Petitioner's cervical, thoracic, and lumbar spine and continued to document positive objective findings. Petitioner, however, received only temporary relief.

On March 2, 2018, Petitioner sought treatment with Dr. Matthew Gornet on referral from Dr. Zimmerman. (PX8, 3/2/18) The history taken was as follows:

> This is the first visit and spinal examination for Mandi Bryant. The Patient is a 36-year-old referred by Dr. Zimmerman. Her main complaint is low back pain to both sides, both buttocks, both hips, right greater than left, down the right leg to her foot and left leg to her knee. She also has neck pain with frequent headaches to both traps, upper back and right scapula.
>
> She states her current problem began on or about 1/15/18. She was walking into work at Aisin Manufacturing. She was in the parking lot and slipped on some ice and fell forward, landing on her left knee and right hand. It was reported that day. She went to Logan Primary, where initially x-rays were performed on her knee. She stated her neck and back pain [sic] were sore initially, but not significant[.] However, over the next period of days, it became severe. On 1/22/18, she saw her chiropractor, Dr. Zimmerman who has treated her for six to eight weeks. This has not provided any significant relief.
>
> She stated in the past, she had worked for a chiropractor and had some routine care. She thinks this may have been four to five years ago, but has had no other major issues. She also has a history of migraines that she would get fairly severe four times a year. She was diagnosed as having what may be a pituitary tumor and she thinks there may have been MRIs of her head or potentially her neck for this. She does not recall any treatment at all for her neck or back since she has been working for Aisin. *Id.*

Dr. Gornet's examination of the cervical spine noted pain into her neck, bilateral trapezii, and shoulders with paresthesias in her arms. *Id.* Flexion and extension exacerbated Petitioner's pain. *Id.* Deep tendon reflexes and sensation were normal. *Id.* Petitioner reported bilateral low back pain, particularly in her right side, right buttock, right hip, and down her right leg. *Id.* Motor examination showed mild change on the right at 4/5. *Id.* Cervical spine x-rays showed well-preserved disc height at all levels with no evidence of degeneration. *Id.* Lumbar spine films also showed no evidence of degeneration. *Id.* Dr. Gornet recommended medication, MRIs of Petitioner's cervical and lumbar spine, and light duty restrictions with no repetitive bending or lifting, no overhead work; and he gave instructions to alternate between sitting and standing as need. *Id.* He noted that since Petitioner had already failed chiropractic care, it should be discontinued. *Id.* He also concluded that Petitioner's neck and back symptoms were causally connected to the January 15th work accident. *Id.*

Petitioner returned on April 19, 2018, with a primary complaint of bilateral low back pain as well as neck pain and headaches. (PX8, 4/19/18) MRIs of Petitioner's cervical and lumbar spine taken prior to her appointment showed small central protrusions at C4-5, C5-6, and C6-7, with a small right foraminal component at C4-5 and a left foraminal component at C5-6 without cord compression or canal compromise; and showed an L4-5 central disc herniation created mild central stenosis and extension to the foramina, particularly on the left side. (PX9, 4/19/18) On this date, Petitioner brought in some old films from December 10, 2002. (PX8, 4/19/18) Dr. Gornet believed these showed some subtle disc pathology present at C5-6 and C6-7. *Id.* However, since the earlier study was not complete, it was difficult for Dr. Gornet to make a comparison. *Id.* Petitioner also brought a report of an MRI from August 20, 2010, that mentioned disc pathology at C4-5 and C5-6. *Id.* Petitioner tried to get an MRI of her lumbar spine but was only given x-rays. *Id.* Dr. Gornet believed that Petitioner was a candidate for injections at L4-5, C5-6, and C6-7, and referred her to Dr. Blake for same. *Id.*

Petitioner underwent the injections by Dr. Blake, respectively at L4-5 on May 8, 2018, at C6-7 on May 22, 2018, and at C5-6 on June 12, 2018. (PX10; PX11) The injections improved Petitioner's neck pain, but it was still present. (PX8, 6/21/18) Petitioner's low back pain remained her biggest issue, although she acknowledged receiving some temporary benefit from

the injections. *Id.* Dr. Gornet recommended a CT discogram at L4-5 and L5-S1, as well as MRI spectroscopy at L5-S1. *Id.*

In the interim, Respondent had Petitioner examined by Dr. Donald deGrange, who noted the history of the injury on January 15, 2018. (RX1, Exh. 2) He noted that Petitioner had been worked up with MRIs and epidural steroid injections in the cervical and lumbar spine with no lasting improvement. *Id.* Petitioner told Dr. deGrange she had constant low back pain with radiation into both legs, right greater than left, and that her symptoms decreased with rest and frequently changing position. *Id.* She also complained of neck pain, which she rated at a 5 out of 10, on a daily basis, and she stated that it was increased with activities of daily living. *Id.* Dr. deGrange's examination noted diffuse tenderness from the occiput through the sacrum with no spasm. *Id.* Range of motion of the cervical spine was noted to be limited in all planes, as was range of motion in the lumbar spine. *Id.* Dr. deGrange noted mild weakness in Petitioner low back motor examination, while deep tendon reflexes and sensory examination were intact. *Id.*

Dr. deGrange also reviewed the MRI films taken April 19, 2018, and believed they showed C4-5, C5-6, and C6-7 broad-based disc bulges without spinal stenosis. *Id.* With regard to Petitioner's lumbar spine, Dr. deGrange believed that there was a central herniated nucleus pulposus at L4-5 with mild-to-moderate canal encroachment. *Id.* Dr. deGrange's diagnosis was 1) cervical strain; 2) L4-5 HNP. *Id.* Dr. deGrange's report contained several paragraphs labeled "discussion" where he reviewed all medical records and opined that Petitioner's work accident appeared to have aggravated pre-existing problems in the lumbar spine for which, if epidural steroid injections, passage of time, and therapy did not provide satisfactory relief, a decompressive laminectomy and discectomy at L4-5 would be appropriate. *Id.* He did not see any indication for fusion or disc arthroplasty. *Id.*

With regard to Petitioner's cervical complaints, Dr. deGrange stated that Petitioner suffered a cervical strain from which she had reached maximum medical improvement. He based his opinion solely his belief that Petitioner's symptoms did not surface until she was evaluated by Dr. Gornet in March. *Id.* He believed that Petitioner had not reached maximum medical improvement with respect to her lumbar spine, which he considered an aggravation of a preexisting condition. *Id.* He believed, however, that should Petitioner opt for surgery, he would expect maximum medical improvement within 6 to 8 weeks. *Id.*

Petitioner continued her treatment with Dr. Gornet and underwent a discogram on her lumbar spine on July 27, 2018. (PX12, 7/27/18) This showed a non-provocative disc at L5-S1 with a provocative disc at L4-5 with concordant back pain. *Id.* It was noted that Petitioner was extremely stoic throughout the procedure and showed no functional overlay. *Id.* Petitioner saw Dr. Gornet on August 23, 2018, and brought with her Dr. deGrange's report. (PX8, 8/12/18) Since Petitioner's low back symptoms consisted of pain into both buttocks and hips, and her leg symptoms were bilateral rather than radiculopathy to one side, Dr. Gornet believed Petitioner's low back problem was structural in nature. *Id.* He stated that this type of patient inherently does poorly with decompression surgery, since removing part of the disc weakens the existing disc structure even further, which makes structural pain even worse. *Id.* He believed that Petitioner closely fit the criteria for disc replacement, and stated that Dr. deGrange's opinion was merely a statement unsupported by medical literature. *Id.* Because Petitioner's main issue was her low back, Dr. Gornet placed treatment of her cervical spine on hold. *Id.* He allowed Petitioner to continue working light duty. *Id.*

Dr. Gornet performed Petitioner's disc replacement on November 13, 2018, and his objective intraoperative findings included an obvious central large annular tear/defect coming from the superior endplate that extended so far down into the dura that he could visualize the dura itself. (PX13) When Petitioner returned on November 26, 2018, she reported that her right leg pain was gone, and Dr. Gornet's examination showed 5/5 strength in all groups. (PX8, 11/26/18) Follow-up visits showed that Petitioner continued to do well with her low back; however, she continued to have neck pain with headaches and pain into her trapezii, upper back, and scapulae. (PX8, 1/3/19) Since it had been almost a year since her previous MRI, Dr. Gornet ordered new studies. *Id.* If Petitioner continued to do well with regard to her low back, he would begin treating her neck. *Id.*

When Petitioner returned on February 25, 2019, she continued to report neck pain. (PX8, 2/25/19) Dr. Gornet noted that Petitioner had failed steroid injections, and that her next option was cervical disc replacement. *Id.* The cervical spine MRI completed on the same day showed bilateral foraminal protrusions at C5-6 and C6-7 resulting in mild to moderate bilateral foraminal stenosis at both levels but no central canal stenosis, and right foraminal protrusion at C4-5 resulting in mild right foraminal stenosis but no central canal or left foraminal stenosis. (PX9,

2/25/19) Dr. Gornet requested approval for disc replacement at C5-6, and C6-7. (PX8, 2/25/19) He noted that Petitioner had done well with regard to her back, and that she wished to move forward with cervical surgery. *Id.*

Petitioner testified at Arbitration that ever since the accident, her neck pain had been slowly increasing while she was still having low back pain. (T.15) She reported significant improvement from her low back surgery, but testified that medication and injections have had no success in relieving her neck pain. (T.17-19) She testified to severe migraine headaches, which occurred on a daily basis. (T.19) She takes pain medication and muscle relaxers, which she stated takes some of the edge off. (T.19) She testified to no prior neck symptoms and stated that she wished to have her surgery, get well, and go back to work. (T.20)

On cross-examination, Petitioner testified that she slipped and fell in a parking lot that was only for employees, and because it was 5:15/5:30 in the morning, it was dark. (T.23) She also testified that Dr. Zimmerman referred her to Dr. Gornet, because she and he had spoken about it. (T.26) She testified she learned about Dr. Gornet from her best friend, Jennifer Lively, who had surgery with him. (T.26) She candidly acknowledged that she had migraine headaches since she was 14, because she was a misdiagnosed Type 1 diabetic. (T.28-29)

Both Dr. Gornet and Dr. deGrange testified by way of deposition. (RX1; PX15)

On direct examination, Dr. deGrange testified consistent with his May 24, 2018, report, and testified to an addendum report he had written on June 14, 2018, which indicated that in June Petitioner could have returned to work with a 25 pound lifting limit. (RX1, p.9-12, 14; Exh. 2) He was also of the opinion that Petitioner would be able to return to work full duty should she pursue the additional treatment he outlined in his May report. *Id.* at 15. As of the time of the hearing, Dr. deGrange had not seen Petitioner for almost 1 year. He authored another report on December 4, 2018, and reviewed additional studies, specifically the discogram and post discogram CT. (RX1, Exh. 2) He stated that Petitioner had an obvious disc herniation at L4-5 and believed that the CT discogram was redundant and provided no useful information beyond that which was revealed on Petitioner's MRI. *Id.* He repeated that an L4-5 disc replacement was not indicated as a primary intervention for a herniated disc and that Petitioner should undergo a lumbar microdiscectomy. *Id.* With regard to Petitioner's cervical spine, Dr. deGrange authored a

report less than 3 weeks before his deposition and reiterated that Petitioner had not mentioned neck pain until she saw Dr. Gornet, and it was against backdrop that he believed that the cervical epidural steroid injections were not causally related to the neck injury. *Id.*

On cross-examination, Dr. deGrange testified that he performs 90% of his examinations and records reviews at the request of employers and gives approximately 30 to 35 depositions per year. (RX1, p.19) Dr. deGrange does not perform disc replacement in either the cervical or lumbar spine and has not performed any since his residency in 1997 or 1998. *Id.* at 21-22. He has not published any articles or been involved in research of publications since 1992. *Id.* at 23. He stated he reviewed no medical records in the 6 year period from 2012 to 2018 documenting any neck or back symptoms. *Id.* at 26. He acknowledged when Petitioner presented to him, she was having both neck and radiating low back pain. *Id.* at 26. These continued over 4 months post injury. *Id.* at 26-27. He acknowledged that Petitioner's cervical examination demonstrated limited range of motion in her neck in all planes, as well as limited range of motion in her lumbar spine. *Id.* at 27. He agreed that the radiologist reported disc protrusions at C5-6 and C6-7, and that disc protrusions in the cervical spine can cause pain in the patient's neck. *Id.* at 29-30.

In his initial report, Dr. deGrange stated that Dr. Gornet's note was the first mention that Petitioner made of any neck pain. *Id.* at 36. He stated that he had reviewed the records of Dr. Zimmerman; however, his format of Dr. Zimmerman's notes was out of order. *Id.* at 36-37. The following exchange took place:

Q. Okay. So the reason I wanted to ask you about this record is this does document the fact that Ms. Bryant was having neck pain and that her neck had hurt since the fall, but she didn't say anything about it because she was worried about her back.

A. That's exactly what he says. Patient states the neck pain – well, word for word what you just said.

Q. Okay. So your statement in your report that the first time she made neck complaints was to Dr. Gornet on March 2nd is obviously not correct?

A. Obviously.

Q. Okay.

A. And I apologize for any confusion on my part. I'm going to beat up my office staff as soon as we finish here.

Q. Well, no, don't do that.

A. I'll say you drove me to it.

Q. Okay. All right. So you agree that Ms. Bryant sustained injuries to her cervical and lumbar spine as a result of this work injury in January of 2018; is that a fair statement?

A. Yes, ma'am. I can't go back on my initial mechanism of injury. It's certainly reasonable that a fall that hard on ice, yes, she could definitely have strained her cervical spine or – I'm sorry – sustained a cervical strain. (RX1, p.39-40)

Dr. deGrange acknowledged that Petitioner's neck pain was reported much sooner than he stated in his original report. *Id.*

Despite the aforementioned admission, Dr. deGrange continued to maintain that Petitioner had a sprain/strain that should have resolved in 6 to 8 weeks, even though Petitioner was still reporting neck pain rated 5 out of 10 with limited range of motion in all planes of movement on his physical examination. *Id.* at 40-41. He agreed that Dr. Gornet had a "very impressive C.V., one of the most impressive outside of university settings that I've seen." *Id.* at 43. Dr. deGrange's report authored on February 8, 2019, however, took issue with Dr. Gornet's statement that part of the disc structurally weakened the disc; which Dr. deGrange felt implied that all disc herniations required disc replacement or fusion. *Id.* at 45; Exh. 2.

Dr. Gornet also testified by way of deposition. (PX15) He testified to the history of accident and his review of Dr. Zimmerman's chiropractic notes and the reports of Dr. deGrange. *Id.* at 11. When asked to respond to Dr. deGrange's comments that a discogram was not indicated, Dr. Gornet stated:

> Well, first, this is a patient that, again, for the most part, at the time of her testing had failed conservative measures. Discography – we know that MRIs are notorious for having no indication of where your pain is coming from. And so while she has disc pathology present, we need to associate that disc pathology with her current symptoms. So discography is immensely helpful in doing that. That is why in the clinical trials that I have been involved with[,] with the FDA, including the current FDA clinical trial on stem cells discography, is an assessment tool that the FDA has allowed for us to do that, to assess patients better. All of those were reasons why we moved forward with further testing. *Id.* at 12-13.

He also produced an article titled, "Defining the Ideal Lumbar Total Disc Replacement and Patient Standard of Care." *Id.* at 13. This was an article published in the Journal of Spine, one of the most prestigious spine journals, authored by himself and several others. *Id.* at 13-14.

Dr. Gornet testified to the excellent outcome obtained from Petitioner's low back surgery. *Id.* at 15-17. With regard to her cervical spine, he belied that Petitioner had structural disc pathology at C5-6 and C6-7. *Id.* at 17-18. He testified that he tried to manage her conservatively; but if her neck pain and headaches continued, he would operate on those structural problems. *Id.* at 18-19. He stated that the indications for cervical disc replacements were Petitioner's persistent axial neck pain, headaches, and pain into both trapezii, her upper back, and right scapula. *Id.* at 19. He believed that if allowed to perform surgery on Petitioner's cervical spine, she would be released to return to work full duty with regard to her back and her neck. *Id.* at 20.

Dr. Gornet testified that both the lumbar surgery and the cervical surgery being contemplated were related to Petitioner's work-related fall, and he testified that Petitioner likely sustained both a new injury and aggravation of her preexisting condition as a result thereof. *Id.* at 17, 19-20.

On cross-examination, Dr. Gornet was asked about his charges. *Id.* at 34. He explained that he was to charge and code an assistant's fee at a certain level; however, the fee schedule mandated payment at a significantly reduced rate, somewhere between 15% to 18%. *Id.* at 34-36, 39. He was also asked if he disliked Dr. deGrange. He replied:

> I absolutely disagree with that. I really like Dr. deGrange. I think he's a class act. I think he's an excellent surgeon. I asked Dr. deGrange to come over here and work with us for a period of time. I strongly disagree with that. *Id.* at 37-38.

Dr. Gornet made it clear that the fact that he criticized some of Dr. deGrange's opinions did not mean that he did not like him. *Id.* at 38.

CONCLUSIONS OF LAW

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

In addition to or aside from expert medical testimony, circumstantial evidence, especially when entirely in favor of the Petitioner, is sufficient to prove a causal nexus between an accident

and the resulting injury, such as a chain of events showing a claimant's ability to perform manual duties before accident but decreased ability to still perform immediately after accident. *Pulliam Masonry v. Indus. Comm'n*, 77 Ill. 2d 469, 397 N.E.2d 834 (1979); *Gano Electric Contracting v. Indus. Comm'n*, 631 N.E.2d 724 (1994); *International Harvester v. Indus. Comm'n*, 93 Ill.2d 59, 442 N.E.2d 908 (1982).

The law also holds that accidental injury need not be the sole causative factor, nor even the primary causative factor, as long as it is a causative factor in the resulting condition of ill-being. *Sisbro, Inc. v. Indus. Comm'n*, 797 N.E.2d 665, 672 (2003). [Emphasis added]. "Petitioner need only show that some act or phase of the employment was a causative factor of the resulting injury." *Fierke v. Industrial Commission*, 723 N.E.2d 846 (3d Dist. 2000). Employers are to take their employees as they find them. *A.C. & S. v. Industrial Comm'n*, 710 N.E.2d 837 (Ill. App. 1st Dist., 1999) citing *General Electric Co. v. Industrial Comm'n*, 433 N.E.2d 671, 672 (1982). If a preexisting condition is aggravated, exacerbated, or accelerated by an accidental injury, the employee is entitled to benefits. *Rock Road Constr. v. Indus. Comm'n*, 227 N.E.2d 65, 67-68 (Ill. 1967); see also *Illinois Valley Irrigation, Inc. v. Indus. Comm'n*, 362 N.E.2d 339 (Ill. 1977).

Dr. Gornet and Dr. deGrange agree that Petitioner suffered a lumbar spine injury causally connected to her work accident. The primary dispute centers on whether any substantial injury occurred to Petitioner's cervical spine. Although Petitioner clearly had preexisting issues in her spine, the record supports Petitioner's testimony that she was asymptomatic for years prior to the injury. Shortly following her accidental injury, however, Petitioner developed persistent neck and back pain in addition to her knee and bilateral upper extremity complaints. Consequently, the circumstantial evidence supports a finding of causal connection.

The Arbitrator is not persuaded by the opinion of Dr. deGrange, who believed that Petitioner suffered a mere strain, because of the amount of time he erroneously thought lapsed before she manifested symptoms. Dr. deGrange admitted in his deposition that he erred in believing that Petitioner's neck complaints first surfaced when she sought treatment with Dr. Gornet in March. On the contrary, Petitioner complained to Dr. Zimmerman in February of neck pain that began right after the accident, but she neglected same on account of her more severe complaints. (PX5, 2/13/18) Dr. deGrange does acknowledged that Petitioner suffered a neck injury of some sort, but did not believe it to be severe. However, Petitioner's symptoms persist

far beyond the medically accepted timeframe for a strain or a sprain to resolve. Additionally, it does not seem logical, assuming for the sake of argument that Dr. deGrange's supposition of the timeline of Petitioner's neck symptoms was correct, that a strain would manifest well beyond the period of time after which it should have already resolved. Moreover, Petitioner's structural disc injuries at C4 through C7 and her complaints have been correlated by objective diagnostic studies. Thus, the Arbitrator finds the opinion of Dr. Gornet to be more persuasive and finds that Petitioner's current condition of ill-being remains causally connected to her injury.

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

Issue (K): Is Petitioner entitled to any prospective medical care?

Upon establishing causal connection and the reasonableness and the necessity of recommended medical treatment, employers are responsible for necessary prospective medical care required by their employees. *Plantation Mfg. Co. v. Indus. Comm'n*, 294 Ill.App.3d 705, 691 N.E.2d. 13, 229 Ill.Dec. 77 (Ill. 2000). This includes treatment required to diagnose, relieve, or cure the effects of claimant's injury. *F & B Mfg. Co. v. Indus. Comm'n*, 758 N.E.2d 18 (1st Dist. 2001).

Based upon the above findings as to causal connection, the Arbitrator finds Petitioner is entitled to recovery for past and prospective medical benefits. The Arbitrator finds Dr. Gornet's testimony regarding the efficacy of his surgical recommendations persuasive given his extensive experience in his field. Although Dr. deGrange disagreed with the type of surgery Dr. Gornet recommended, the Arbitrator finds the objective findings during Petitioner's surgery, which show that Petitioner's disc was rent through to the dura, more than justified Dr. Gornet's recommendation for Petitioner's lumbar spine. With regard to Petitioner's cervical spine, the Arbitrator notes that Dr. deGrange lacks the expertise Dr. Gornet possesses with regard to disc replacements and the indications therefore. The Arbitrator also takes note of the positive outcome following Petitioner's lumbar spine surgery, and therefore finds Dr. Gornet's surgery appropriate.

The record also clearly shows that Petitioner remains markedly symptomatic with respect to her cervical spine despite exhausting conservative care. She has therefore not reached

maximum medical improvement and is entitled to the additional treatment recommended by Dr. Gornet, which he believes will return Petitioner to work full duty. Respondent shall therefore pay the medical expenses contained in Petitioner's group exhibit, provided that it indemnifies and holds Petitioner harmless from any claims arising from any expenses for which it claims credit of payment. Respondent shall also authorize and pay for the treatment recommended by Dr. Gornet for Petitioner's cervical spine.

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

The law in Illinois holds that "[a]n employee is temporarily totally incapacitated from the time an injury incapacitates him for work 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, 561 N.E.2d 623 (Ill. 1990). The ability to do light or restricted work does not preclude a finding of temporary total disability. *Archer Daniels Midland Co. v. Indus. Comm'n*, 138 Ill.2d 107, 561 N.E.2d 623 (Ill., 1990) citing *Ford Motor Co. v. Industrial Comm'n*, 126 Ill.App.3d 739, 743, 467 N.E.2d 1018, 81 Ill.Dec. 896 (1984).

As noted in the above findings, Petitioner has not reached maximum medical improvement and remains temporarily and totally incapacitated, as indicated by Dr. Gornet's treatment noted of May 16, 2019. (PX8, 5/16/19) Respondent shall therefore pay Petitioner temporary total disability benefits for an additional period of 16 4/7 weeks, for Petitioner's continued disability beyond February 25, 2019, through the date of hearing on June 21, 2019.

Issue (O): Did Petitioner exceed her choices of physician?

The Act entitles Petitioner to recovery for reasonable and necessary medical services for emergency care, services from any first choice of physician and referrals therefrom, and services from any second choice of physician and referrals therefrom. 820 ILCS 305/8(a). After careful consideration of the record, the Arbitrator finds that Petitioner did exceed her choice of physician. Petitioner's first choice of physician was Logan Primary care, and was referred from there to Herrin Hospital. Petitioner's second choice of physician was Zimmerman Chiropractic, from where she was referred to Dr. Gornet; and through the second chain of treatment from Dr. Gornet, Petitioner was referred to the MRI Partners of Chesterfield, Pain and Rehabilitation Specialists, Orthopedic Ambulatory Surgery Center, CT Partners, Center for Surgical

Excellence, and Mason Point. Petitioner's third choice of physician was thus Family Medical Center, and through the Family Medical Center, Pinckneyville Community Hospital. Respondent is not liable for the care and treatment given by the Family Medical Center and Pinckneyville Community Hospital.

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

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

WILLIAM A. LONG,

Petitioner,

vs. NO: 16 WC 002282

EUCLID BEVERAGE, LTD.,

Respondent.

20IWCC0403

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, notice, temporary total disability, causal connection, medical expenses, permanent disability and Section 8(j) credit, 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.

Medical expenses and Section 8(j) Credit

The Commission affirms and adopts the Arbitrator's Decision with the exception of the issue of medical bills and Respondent's Section 8(j) credit amount. The Commission notes that Petitioner's Exhibit four, page five and Petitioner's Exhibit 4A, page three, identify the Blue Cross/Blue Shield subscriber with the insured's identification number, indicating that the Petitioner's medical bills were not paid by Respondent's group health insurance carrier, but instead by his spouse's carrier. This identification number is referenced on a majority of the Petitioner's medical bills. Therefore, the Commission finds that the Respondent is not entitled to the Section 8(j) credit for medical bills paid. Therefore, in the Arbitrator's Conclusions of Law, the Commission strikes the last sentence of the Section, "In support of the Arbitrator's decision with respect to (J) Medical and (N) Credit."

The Commission further strikes the phrase "$76,126.24 for medical benefits that have been

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paid and" in the fourth paragraph in the Order of the Arbitrator's Decision so the sentence reads, "Respondent shall be given a credit of $77,552.22 (plus any additional benefits paid since October 10. 2018) for short-term disability and long-term disability benefits that have been paid. Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in section 8(j) of the Act."

The Commission finds that Respondent shall be liable for the medical bills paid by Blue Cross/Blue Shield, the group insurance carrier, pursuant to Sections 8(a) and 8.2 of the Act, in the amount of $76,126.24, or for the amount of the fee schedule, whichever is less. *Perez v. Ill. Workers' Comp. Comm'n,* 2018 IL App (2d) 170086WC, P12, 96 N.E.3d 524, 526, 2018 Ill. App. LEXIS 10, *4-5, 420 Ill. Dec. 439, 441.

All else is affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's Decision filed on December 12, 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 $773.65 per week for a period of 54-3/7 weeks, commencing November 28, 2014 through December 3, 2015, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner permanent and total disability benefits of $773.65/week for life, commencing December 4, 2015, as provided in Section 8(f) of the Act. Respondent shall pay Petitioner the benefits that have accrued through October 10, 2018, and shall pay the remainder of the award, if any, in weekly payments.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner's out-of-pocket expenses of $1,228.49.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall be liable for the reasonable and necessary medical expenses causally related to the work accident and shall hold Petitioner harmless for the medical expenses paid by Blue Cross/Blue Shield, pursuant to §8(a) and §8.2 of the Act, up to the sum of $76,126.24.

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 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.

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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: JUL 17 2020
KAD/bsd
O05/19/20
42

Maria E. Portela

Thomas J. Tyrrell

DISSENT

I respectfully dissent from the majority and would reverse the Arbitrator's Decision on the issues of accident and causal connection and deny benefits including medical, temporary total disability and permanent disability, based upon the facts set forth below.

Accident/Notice

Petitioner is right-hand dominant and had a history of bilateral shoulder surgeries predating the subject incident. Petitioner testified that he had two prior Workers' Compensation claims for previous shoulder surgeries. In both cases Petitioner reported that he hurt himself at work and he was able to negotiate both shoulder settlements *pro se*. Petitioner testified that he was familiar with the workers' compensation process. (T, pp. 73-75) Petitioner testified that he worked Monday, November 17, 2014. (T, p. 78) Petitioner testified that that there are Monday morning meetings and Respondent had reporting policies in place as to whom and how you report when you get hurt at work. (T, pp. 76-77)

Petitioner further testified that he believed that he told his supervisor, "Don," [Muezelaar] that he needed the day off on November 18, 2014, for a doctor's appointment. Petitioner testified that he scheduled the appointment more than one week prior. (T, pp. 46-47) Petitioner testified that he reported to his supervisor that his left shoulder complaint was not work-related. Petitioner testified, "I told Don I was going to the doctors. He asked me then if this was going to be a workman's comp claim, and I told him "no," and to my best recollection, he just told me, "Get it fixed and come back when you're ready to go back to work." (T, p. 48) There was no evidence in the medical records specifying the day Petitioner made the doctor's appointment or to corroborate Petitioner's testimony regarding the day the appointment was made.

On November 20, 2014, Petitioner went to Muezelaar's office for an in-person meeting. Petitioner reported having shoulder difficulties and needed to be off work. Both Petitioner and

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Muezelaar testified that they had daily contact when Petitioner was working. Both men agreed that Petitioner did not report a work incident or work-related problem with the left shoulder. (T, pp. 11-112, 115-116) Therefore Muezelaar did not complete work injury reports that would be associated with the report of a work injury. (T, pp. 112-113) Petitioner was coded as being off-work for a non-work-related disability. Petitioner was terminated in November 2015 per the terms of the Collective Bargaining Agreement. (T, p. 60, 119-122; PX7)

Since he was off work for a non-work related injury, the Petitioner applied for short-term and long-term disability benefits with Guardian, the plan administrator. He received those benefits in 2015 through the date of trial, in October 2018. Petitioner agreed that as part of the application process for short-term disability there was a telephone interview. (T, p. 83) Respondent's Exhibit 10 is a transcript of the phone interview between the Petitioner and the representative from Guardian stamped December 8, 2014. The document was identified by Petitioner and he confirmed all biographical information was correct. The document reflects that Petitioner reported that the accident occurred on November 15, 2014 at home lifting a door and that it was not work-related. The first date of treatment was listed as November 18, 2014. (RX10) On cross-examination Petitioner testified that he believed that there was a misunderstanding, either his or the interviewer's, where it was documented that he replied that he had injured his left shoulder at home on November 15, 2014 lifting a door. (T, p. 85)

However, Petitioner never reported a work-related accident until he filed an Application for Adjustment of Claim on January 25, 2016, one year and 2 months after the alleged accident date.

Finally, Arbitrator's Exhibit 1, the Request for Hearing and trial stipulation form, at number three, requires Petitioner to identify the date and to whom Notice was given and the job title of the person to whom Notice was provided. None of that information was completed by Petitioner. Petitioner did not identify the date or person or job title to whom he provided Notice.

Petitioner saw Dr. Saleem at Castle Orthopaedics on November 18, 2014, and offered a history of shoulder pain bilaterally. No history of symptom development was offered except he had, "been having problems going on for quite some time now." (PX1) He reported an increase in progressive pain with overhead activity and difficulty with lifting, pushing, or pulling. He reported that he delivered beer for a living, and that has been aggravating it quite a bit. Dr. Saleem assessed bilateral shoulder pain, left more problematic than right. Petitioner underwent a left-shoulder MRI on November 20, 2014. When he returned to see Dr. Saleem, he offered no further history of work-related pain or aggravation. (PX1)

Petitioner now alleges that the single report of his left shoulder being aggravated by work with Respondent supersedes his denial of a work accident to his supervisor and a report of a specific injury on November 15, 2014 at home to the Guardian representative. In light of the fact that the Petitioner was very familiar with work-injury reporting requirements, and his unequivocal denial of a work injury, the Petitioner's testimony that he or the Guardian adjuster misunderstood is not sufficient to rebut Respondent's Exhibit 10, the Guardian transcript of the phone interview. This interview comports with Petitioner's own denial of a work-related accident, his admission that he told his supervisor it was not work-related and his supervisor's testimony that Petitioner

denied the injury happened at work. Based on this, I would find that Petitioner did not sustain his burden of proving accident.

With regard to Notice, the Majority ignores the prejudice to the Respondent by Petitioner's failure to timely report the alleged work accident; not only did he fail to report it, but Petitioner denied it was work-related. By failing to give Notice prior to the Respondent receiving the Application for Adjustment of Claim after it was filed on January 25, 2016, Respondent was prevented from contemporaneously investigating the alleged accident or obtaining a Section 12 evaluation prior to Petitioner having undergone surgery.

Causal Connection

Dr. Saleem testified that he did not have knowledge of Petitioner lifting a door at home.

Dr. Saleem testified that he, "did not think that there was one particular injury that caused the tear, but that his work was an aggravating factor." (PX11, p. 29)

Dr. Saleem testified on cross-examination that he would talk about Petitioner's re-current tear prior to his trying to re-repair it. At that point, he described that there was a recurrent rotator cuff tear involving the supraspinatus tendon and a partial tear of the subscapularis tendon. (PX11, p. 34) Dr. Saleem was asked by Petitioner's attorney to provide narrative reports and was compensated for doing so. (PX11, p. 35) Dr. Saleem did not agree with Respondent's characterization of his opinion "That it's the repetitive heavy lifting from his job that caused this particular injury." Correcting counsel, Dr. Saleem replied, "I think I more specifically stated that it was likely something that aggravated it. I think I even more specifically stated that it's not necessarily that that job caused this rotator cuff tear." (PX11, p.36) The most specific he could be about causation is that it was an aggravation because "[t]he scope of his tear is hard to say whether –we know it's a relatively chronic tear. We know that there's some chronicity to his tear. Whether it happened, you know, 8, 10 months prior or it's a tear that he had previously had fixed and it never healed even from that first surgery, and then it--or it healed and then it re-tore, that's impossible to determine that." (PX11, pp. 36-37)

On cross-examination, Dr. Saleem testified that his opinion is dependent on the accuracy of the history Petitioner gave him and the veracity and completeness of the history. Dr. Saleem conceded if the history that Petitioner gave is not accurate or truthful or complete, that could change his opinion regarding what caused this injury. (PX11, p. 37)

Petitioner never mentioned a particular incident to Dr. Saleem. Dr. Saleem testified "Again, based on his MRI, his findings are relatively more of what I would call an acute-on-chronic type problem, so that I don't think his problem is all brand-new. Whether or not it was one injury, I think his tendon was never really fully normal. So he has some chronic injury to his shoulder, and then he's like I mentioned earlier, some people are able to function with a deficit in their rotator cuff. But then if they encounter increased activity or do something to aggravate it, it could make that problem worse." Respondent's attorney asked, "So if there was one specific incident that he would identify to cause pain, that could change your opinion?" Dr. Saleem replied, "It could, but it would make me think of maybe he has more of what, again, is acute-on-chronic just

given the scope of his injury, that it would be a combination-type problem." (PX11, pp. 38, 39)

Dr. Saleem's testimony is equivocal at best and does not prove, by a preponderance of the evidence, that Petitioner's condition of ill-being was caused or aggravated by his job, especially in light of the history Petitioner gave to the Guardian adjuster and the unequivocal denial of a work-related injury to his supervisor.

Vocational Rehabilitation/Permanent Disability

Petitioner was 61 years old at the time of his left shoulder injury. Vocamotive's Evaluation Report dated March 13, 2018, authored by Joe Belmonte, confirms that Belmonte personally interviewed Petitioner and reviewed medical records. (PX9) The report noted Petitioner is right-hand dominant and otherwise in good health. He uses only over-the-counter Tylenol or Ibuprofen on an as-needed basis. He does not use this daily. He reported no use of any other medication. (PX9, p. 2) Petitioner testified he was not taking any medications except over-the-counter aspirin or Tylenol. (T, p 90)

Belmonte's report noted permanent restrictions as outlined by Dr. Saleem that included no reaching above shoulder level and occasional reaching to waist and chest height. Dr. Saleem recommended no weight lifting greater than 25 pounds and only occasional lifting between 11 and 25 pounds, infrequent lifting between 6 to 10 pounds and zero to 5 pounds he could lift continuously. He did not recommend overhead lifting or over shoulder level. He was allowed to drive a light truck but not heavy equipment. (PX9, p. 7) Petitioner testified he still had a valid Commercial Driver's License (CDL). (T, p. 15) He reported to Belmonte he had a CDL, class A with an endorsement for air brakes. Per Dr. Saleem, Petitioner was able to drive an automobile, but not a manual transmission, as well as light, but not heavy trucks. He reported no difficulty sitting in his vehicle as a driver, and could effectively utilize mirrors and look over his shoulder to drive in reverse if necessary. He reported he is able to sit, stand and walk within normal limits, all aspects of his right-hand dominant upper extremity function are generally within normal limits and he demonstrated some left upper extremity function. His vision was corrected and his hearing was fine. (PX9, pp. 2-3) It is obvious that there are many driving jobs including food and prescription delivery, cab driving or ride share, or local truck delivery routes that do not require lifting, but none of those are enumerated in the Vocamotive report. Mr. Belmonte concedes after one interview and opines that "[t]his consultant cannot identify availability of any stable labor market offering gainful employment for Mr. Long." (PX9, p. 10)

Further, Petitioner reported that he attended Kaneland Public High School in Maple Park, IL, completing the standard four (4) year curriculum with graduation in 1971. Petitioner reported no difficulties with reading or spelling, but his math skills were not very good. He reported he never participated in any remedial or advanced classes. He completed one year of studies at Waubonsee Junior College in 1972, enrolling in general studies. (PX9, p. 8)

He reported he learned to drive trucks on a farm and he learned to drive other kinds of equipment, including a forklift as well as graders, loaders and snowplows with no certifications. His most recent and extensive experience was as a sales route driver and he worked as a farmer and highway maintenance worker. (PX9, p. 8)

Petitioner reported that he is retiring to Minnesota. He still owns 72 acres of farmland in Elburn, the majority of which is up for sale as he is no longer farming. He stated his wife is retired. He does not have any other financial dependents. He reported he owns a functional automobile. He reported he has been awarded Social Security Disability Income. He does not have any Long Term or Credit Disability policies in force. He stated he has not been completing any job search activity.

In *Marathon Oil Co. v. Industrial Comm'n* (1990), 203 Ill. App. 3d 809, 815, 56N.E.2d 141, 148 Ill. Dec. 835, the court observed:

> "an employee is totally and permanently disabled under workers' compensation law where he is unable to make some contribution to industry sufficient to justify payment of wages to him. [Citation.] He must show that he is, for practical purposes, unemployable. [Citation.] A person need not be reduced to a state of total physical helplessness, but is totally disabled when he cannot perform services except those that are so limited in quantity, dependability or quality that there is no reasonably stable market for them."
> Conversely, "if an employee is qualified for and capable of obtaining gainful employment without seriously endangering his health or life, such employee is not totally and permanently disabled." *E.R. Moore Co. v. Industrial Comm'n* (1978), 71 Ill. 2d 353, 361-62, 376 N.E.2d 206, 17 Ill. Dec. 207.
> The claimant has the burden of proving the extent and permanence of his injury by a preponderance of evidence. *(Esposito v. Industrial Comm'n* (1989), 186 Ill. App. 3d 728, 737, 542 N.E.2d 843, 134 Ill. Dec. 497.)
> "If the claimant's disability is limited in nature so that he is not obviously unemployable, or if there is no medical evidence to support a claim of total disability, the burden is upon the claimant to establish the unavailability of employment to a person in his circumstances. However, once the employee has initially established that he falls in what has been termed the 'odd-lot' category (one who, though not altogether incapacitated for work, is so handicapped that he will not be employed regularly in any well-known branch of the labor market [citation]), then the burden shifts to the employer to show that some kind of suitable work is regularly and continuously available to the claimant." *Valley Mould & Iron Co.* (1981), 84 Ill. 2d 538, 546-47, 419 N.E.2d 1159, 50 Ill. Dec. 710.

Schoon v. Industrial Comm'n, 259 Ill. App. 3d 587, 590-591, 630 N.E.2d 1341, 1343-1344, 1994 Ill. App. LEXIS 394, *6-8, 197 Ill. Dec. 217, 219-220.

Without a medical opinion that he is permanently and totally disabled, Petitioner's burden of proof is to establish that no suitable employment exists; the burden only shifts to Respondent if the Petitioner meets that burden. Further, it is patently obvious that Petitioner merely took himself out of the job market, made his plan to retire, without doing any job search. I do not find the Vocamotive report dispositive. Petitioner did not meet his burden of proving he is "so handicapped that he will not be employed regularly in any well-known branch of the labor market." Relying on the Vocamotive report and Belmonte's opinion that Petitioner is unemployable, is nonsensical given Petitioner's physical capabilities, and transferrable skills set, admission that he is moving to retire to Minnesota and sell his land in Illinois, and, most notably, without any evidence of any job

search whatsoever.

The *Schoon* court reviewed the requirements under *National Tea*, and held further,

> In *National Tea Company v. Industrial Comm'n* (1983), 97 Ill.2d 424, 432-33, 454 N.E.2d 672, 73 Ill. Dec. 575 (where the employer failed to assume its responsibility to rehabilitate the injured employee who could no longer perform the assigned job), the court recognized a number of factors to consider in determining whether rehabilitation is appropriate. Factors favoring rehabilitation include: (1) the employee has sustained an injury which caused a reduction in earning power and there is evidence rehabilitation will increase his earning capacity; (2) the employee is likely to lose job security due to his injury; and (3) the employee is likely to obtain employment upon completion of rehabilitation training. Factors mitigating against rehabilitation include: (1) the employee has unsuccessfully undergone similar treatment in the past; (2) the employee has received training under a prior rehabilitation program which would enable him to resume employment; (3) the employee is not "trainable" due to age, education, training and occupation; and (4) the employee has sufficient skills to obtain employment without further training or education. Other factors the court considered relevant were the relative costs and benefits to be derived from the program; the employee's work-life expectancy; his ability and motivation to undertake the program; and his prospects for recovering work capacity through medical rehabilitation or other means. *National Tea Company v. Industrial Comm'n* (1983), 97 Ill.2d at 432-33.
>
> Upon reviewing the *National Tea Company* case, it is apparent that rehabilitation is not a condition precedent to employment in all cases. Specifically, one factor mitigating against rehabilitation includes considering whether the claimant has sufficient skills to obtain employment without further training or education.

Schoon v. Industrial Comm'n, 259 Ill. App. 3d 587, 593-594, 630 N.E.2d 1341, 1345-1346, 1994 Ill. App. LEXIS 394, *13-15, 197 Ill. Dec. 217, 221-222.

It is obvious that the Petitioner " has sufficient skills to obtain employment without further training or education." It is also obvious that Petitioner voluntarily took himself out of the job market when he applied for and received SSDI and moved to Minnesota with his wife who had already retired. Petitioner has not shown that he is so handicapped that he would not be employed regularly in any well-known branch of the labor market. For these reasons, he did not meet his burden that he is permanently and totally disabled under the odd-lot theory.

For the above stated reasons, I respectfully dissent.

Kathryn A. Doerries

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LONG, WILLIAM
Employee/Petitioner

Case# **16WC002282**

EUCLUD BEVERAGE LTD
Employer/Respondent

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On 12/12/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.48% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0657 TUCKER & SACKETT LLC
MARGIE KOMES PUTZLER
107 W EXCHANGE ST
SYCAMORE, IL 60178

5001 GAIDO & FINTZEN
ROBERT SMITH
30 N LASALLE ST SUITE 3010
CHICAGO, IL 60602

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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

William Long
Employee/Petitioner

v.

Euclid Beverage Ltd.
Employer/Respondent

Case # **16** WC **2282**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Stephen J. Friedman**, Arbitrator of the Commission, in the city of **Geneva**, on **October 10, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

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FINDINGS

On **November 18, 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 $**60,344.44**; the average weekly wage was $**1,160.47**.

On the date of accident, Petitioner was **61** years of age, ***married*** with **0** dependent children.

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

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

Respondent shall be given a credit of $**0.00** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**77,552.22** for other benefits, for a total credit of $**77,552.22**.

Respondent is entitled to a credit of $**76,126.24** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $773.65/week for 54 3/7 weeks, commencing November 18, 2014 through December 3, 2015, as provided in Section 8(b) of the Act.

Respondent shall pay to Petitioner reasonable and necessary out-of-pocket medical services of $1,228.49, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner permanent and total disability benefits of $773.65/week for life, commencing December 4, 2015, as provided in Section 8(f) of the Act. Respondent shall pay Petitioner the benefits that have accrued through October 10, 2018, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall be given a credit of $76,126.24 for medical benefits that have been paid and $77,552.22 (plus any additional benefits paid since October 10, 2018) for STD and LTD benefits that have been paid. 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.

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

December 11, 2018
Date

DEC 12 2018

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Statement of Facts

Petitioner William Long testified that he has been employed full time by Respondent Euclid Beverage since 1999. He graduated from high school and has one year of junior college. He has a valid CDL license. Prior to working for Respondent, he worked at Elburn Packing Company. He also farmed and worked as an assistant township supervisor. He testified he initially worked part time evenings for Respondent for 5 years. From 1999 through 2014, he was employed as a driver helper. This is a Teamster Union position. Petitioner testified he usually worked Tuesday through Friday. His normal day was 8 hours. During a holiday season, he could work up to 12 to 14 hours a day. The job duties are detailed in Article 14 of the Union Manual admitted as PX 7. In addition to driving the route truck or transport, his job was to deliver beer to customers, rotate beer, build displays and stock shelves. He testified that route trucks go to gas stations, liquor stores, bars and restaurants and transports go to big box stores. He would generally take the transport. Petitioner testified he has routes that he would follow for each working day.

Petitioner did not load his truck. The truck was loaded with six packs and flats of beer cans or bottles and half barrels. a fully loaded transport had 22 pallets, each containing 98 cans of beer or 56 cases of bottles. Route trucks had bays. The bays had a roll top door which was opened and closed with a strap. He would have to reach overhead to open and close the bay doors. The route truck bays were 2 to 3 feet off the ground and product could be stacked 7 foot high. PX 8 is a photo depicting a loaded bay. Transports had either a roll top or two cargo doors on the rear. They had a dock stop which was level to the dock.

Petitioner testified the truck was not loaded in the order of delivery. He would have to move product around to find each order. He would deliver barrels weighing 150 to 175 pounds. These would be stacked in the back bays. He would unload these from the truck by hand and deliver them using a hand cart. Some customers would require him to deliver the load up or down stairs. He would deliver cases of beer bottles weighing about 35 pounds and cases of cans weighting 18 pounds. These would be unloaded by hand. Petitioner testified he would reach overhead and out in front of him to do this. They would be taken to the customer on a hand cart carrying 10 cases of cans or 6 cases of bottles.

Petitioner testified that he would stock the customers' shelves and coolers and rotate the stock. The shelves could be high or low. Some were over his head. He would build displays a couple of times per month. These could be 15 to 20 cases high at the back. Petitioner testified he is reaching overhead and above shoulder height all the time in performing his job duties.

Petitioner testified he had prior surgeries on his right and left shoulder. With respect to his left shoulder, he pulled open a transport door and felt something in his shoulder. He had rotator cuff surgery. He received settlement of 20% loss of use of the right arm in 05 WC 16828 and 25% loss of use of the left arm in 08 WC 5407. He did not have a lawyer in those matters. He made a report in each of those cases that he was hurt at work. Petitioner testified that the Teamster's manual (PX 7) required immediate reporting of any accident. Respondent also had such a policy. Petitioner testified he has no medical treatment between his release from care for his prior left shoulder condition and November 18, 2014. Petitioner worked his regular job, which had not changed since 2005.

Donald Muezelaar testified that he is the route manager for Respondent. Petitioner would report to him. He testified that the job of driver and helper had essentially the same duties. Respondent has an accident reporting policy. There were regular meetings with employees to refresh them on the policy. If an accident is

reported to him, he would draft the first report of injury and transport the employee to Tyler Medical for a drug screen and a physical. Prior to November 2014, Petitioner never complained of any left shoulder problem. He did not miss any time or have any difficulties completing his job duties.

Petitioner saw Dr. Saleem for his left shoulder on November 18, 2014. He testified that he set up the appointment over a week before. He testified that he did not have a specific incident. His pain got gradually worse. He felt it over several months. The last month, he had to call. Petitioner worked Monday, November 17, 2014 because it was the holiday week before Thanksgiving. In the early morning on November 18, 2018, he called Mr. Muezelaar to tell him he was to be off for the doctor. He also called off work on November 19, 2014. Petitioner testified he spoke with Don in person on November 20, 2014 and told him he was going to the doctor. He told him this was not a Workers' Comp claim because he could not pinpoint any one incident that he was injured. It was an ongoing thing. He had the earlier surgery in 2005 or 2006 and received compensation for it and signed off on it. He assumed that he could not claim it again. Mr. Muezelaar testified that Petitioner called him on November 18, 2014 between 6:00 and 6:30 AM to tell him he was not going to be able to work because he had an illness and needed to see the doctor. He called again on November 19, 2014 saying he was sick and needed to see the doctor and have some tests. Mr. Muezelaar spoke with Petitioner in person on November 20, 2014 in his office. Petitioner told him he was having shoulder problems and needed an MRI. He asked Petitioner if he did this on the job and was told no, he did not do it at Respondent.

Mr. Muezelaar testified he did not fill out work injury paperwork. He notified the HR department. The email is Ex. 1 to RX 12. He identified RX 12 as an affidavit he prepared in this matter. The exhibit states that Petitioner told him on November 20, 2014 that he had hurt his shoulder and was waiting for the MRI results. Petitioner stated he did not injury his shoulder while working for Respondent and offered nothing affirmative as to the cause of his problems. Mr. Muezelaar identified RX 15 as Time & Attendance records. They show Petitioner worked from 5:43 AM to 10:37 AM on Monday, November 17, 2014. He was marked as sick on November 18-21, 2014. As of November 24, 2014, he was listed as NWRD (non-work-related disability) until his termination in November 2015 per Union agreement. He testified that if an employee reported he has a doctor's appointment, that would be coded as "sick."

Respondent introduced RX 10 (certified as a business record in RX 11) which documents a Guardian intake telephone conference with Petitioner. Petitioner recalls having the conversation. The form notes that Petitioner reported a shoulder injury on 11/15/14 at home lifting a door. Petitioner denies that this is correct. He testified there may have been confusion with his earlier accident at work when he lifted a door.

Petitioner saw Dr. Saleem on November 18, 2014 with complaints in the shoulders, left worse that the right. (PX 1). The history given was that he has been having problems going on for quite some time now. He actually had surgery 8 to 9 years ago with Dr. Marciniak. He said he has been doing well up until last year. He states he now has some increase in progressive pain with any overhead activity. He has difficulty with any lifting, pushing, or pulling. He does deliver beer for a living, and that has been aggravating it quite a bit. Dr. Saleem diagnosed a possible rotator cuff tear and ordered an MRI of the left shoulder (PX 1, p 34-35). The November 20, 2014 MRI noted a supraspinatus insertional tear, a partial tear of the subscapularis and AC joint arthrosis (PX 1, p 37). On November 28, 2014, Dr. Saleem diagnosed a recurrent left rotator cuff tear and recommended a revision rotator cuff repair (PX 1, p 38-39).

Petitioner had left shoulder surgery at Rush Copley Medical Center on January 12, 2015. The operative report notes that the procedure was an arthroscopic revision rotator cuff repair with injection of platelet rich plasma,

arthroscopic subacromial decompression, arthroscopic distal clavicle resection, arthroscopic capsular debridement and release rotator interval, and open biceps tenodesis. The post-operative diagnosis was recurrent rotator cuff tear, subacromial impingement, acromioclavicular joint arthritis, biceps tendinopathy, and capsulitis (PX 2, p 22-24).

Petitioner had post-operative care at Castle Orthopedics. Dr. Saleem ordered physical therapy beginning January 15, 2015. On February 14, 2015, Petitioner was reprimanded for not wearing his immobilizer but was allowed to travel by car to Minnesota as long as he did not drive (PX 1, p 46-47). Petitioner saw Dr. Saleem on March 26, 2015 reporting quite a bit of discomfort. He had some loss of motion. He was continued in therapy (PX 1, p 49-50). On May 7, 2015, Petitioner still reported discomfort and demonstrated loss of motion. Dr. Saleem noted that it will take 6 to 9 months for recovery. He stated that Petitioner may not have a normal shoulder (PX 1, p 52-53). On June 18, 2015, Dr. Saleem notes a fair amount of weakness and discomfort. There was limited range of motion. Dr. Saleem recommended aggressive therapy (PX 1, p 55-56).

The records reflect Petitioner attended physical therapy through August 11, 2015 (PX 1, p 78-87). Petitioner was scheduled for a repeat MRI at his visit on August 13, 2015 due to persistent discomfort and limitations (PX 1, p 59). On August 28, 2015, Dr. Saleem interpreted the August 24, 2015 MRI as showing some persistent or recurrent rotator cuff tear but better that his preoperative MRI. He did not recommend further repair surgery. He recommended an additional 3 months of range of motion exercises. He noted that the only surgical solution would be a reverse shoulder replacement, but that Petitioner was not a candidate at that point (PX 1, p 63-64). Dr. Saleem provided Guardian with restrictions of no use of the left arm, no crawling, climbing ladders, reaching out or above shoulder and no driving (PX 10, p 22).

Petitioner received Short Term Disability beginning November 25, 2014, He applied for and was granted Long Term Disability on May 17, 2015 (RX 5, RX 6). Benefit payment are documented in RX 3 and RX 7. Petitioner testified he was terminated by Respondent in November 2015 pursuant to the terms of the Teamster agreement that provided for termination if he was off work for a year. He was notified by letter dated November 20, 2015 from Kyle Webb advising the had been off work for 12 consecutive months for a non-occupational illness or injury (RX 8, RX 9). Petitioner served Respondent with his Application for Adjustment of Claim on January 14, 2016. Respondent advised Petitioner's counsel that they had no record of any reported work injury (RX 14).

Petitioner saw Dr. Saleem on December 3, 2015 for persistent left shoulder pain. Dr. Saleem noted he was status post repair of a fairly large rotator cuff tear. He noted the post-operative MRI showed a persistent/recurrent tear. Physical examination noted lost of range of motion with pain and weakness. Dr. Saleem stated that he recommended no further treatment at that time. If Petitioner's symptoms get worse, he could consider a reverse shoulder replacement, but he should wait as long as possible (PX 1, p 65). Dr. Saleem provided permanent restrictions of occasional reaching waist to chest height, no reaching above shoulder level, occasional ladder climbing, occasional lifting 11 to 25 pounds, no lifting over 25 pounds (PX 10, p 29). Dr. Saleem saw Petitioner on September 15, 2016 with continued pain, weakness and loss of motion. He continued his same recommendations and restrictions (PX 1, p 68-69).

Dr. Saleem prepared a narrative report on January 20, 2017 (PX 5). He reviewed and summarized his treatment records through September 15, 2016. He opined that Petitioner was at maximum medical improvement. He did not feel Petitioner had gotten substantial improvement in his range of motion or strength. He opined that Petitioner had permanent restrictions due to his injury, noting he had provided a disability form

on December 7, 2016 with restrictions of no lifting over 25 pounds, occasional lifting of 11-25 pounds, frequent lifting of 6 to 10 pounds, no overhead or over shoulder lifting, driving an automatic but not manual transmission vehicle, and driving light trucks but no heavy equipment. He stated the condition was permanent and Petitioner will require a reverse shoulder replacement when he can no longer tolerate the symptoms. He opined that the Petitioner's work requirement of heavy lifting contributed to and aggravated the underlying condition (PX 5). On October 19, 2017, Dr. Saleem prepared a supplemental narrative report after a review of the Teamsters Manual and a detailed summary of job duties (PX 6). He noted the details of the job including the photo of a loaded truck bay and the physical requirements to unload the product from the truck requiring a fair amount of overhead lifting and holding items at chest level. He concluded that Petitioner's job was a very heavy, physically demanding job requiring overhead lifting in a repetitive manner. He opined that this type of occupation is certainly a high-risk occupation for rotator cuff tears. He opined that the Petitioner at least aggravated his underlying rotator cuff tear and was definitely at increased risk for developing rotator cuff tear based upon his occupation (PX 6).

Dr. Saleem testified by evidence deposition taken July 12, 2018 (PX 11). Dr. Saleem testified to his qualifications and his treatment records. He noted that Petitioner, because of the prior rotator cuff tear and repair, was more susceptible to a rotator cuff tear. Dr. Saleem testified to his narrative reports including his opinion on maximum medical improvement and permanent restrictions. He opined that based upon the history and summary of the job that the Petitioner's problem was aggravated or made worse by heavy lifting required in his occupation. There was not one particular injury that caused the tear, but that his work was an aggravating factor. Dr. Saleem summarized the additional information concerning the lifting and physical nature of Petitioner's job as described to him in the documents reviewed in preparing PX 6. He opined that this work at least aggravated the underlying rotator cuff tear and that Petitioner's occupation placed him at an increased risk of developing a rotator cuff tear (PX 11).

Dr. Saleem testified that Petitioner did not report any specific incident. The job did not necessarily cause this rotator cuff tear. It was likely something that aggravated it. The tear was relatively chronic. Whether it is a tear that occurred months before, or if it was the tear that was previously fixed and never healed or healed and re-tore is impossible to determine. He would call it an acute-on-chronic condition. Petitioner's tendon was never completely normal, so he had some chronic injury to the shoulder. When such a person encounters increased activity or does something to aggravate it, it could make that problem worse. Dr. Saleem testified that his opinions were based on the history he received. If Petitioner was not truthful, his opinions could change. He was not told that Petitioner injured himself on November 15, 2014 at home lifting a door (PX 11).

Petitioner had a vocational evaluation by Joseph Belmonte, who prepared a report dated March 13, 2018 (PX 9). Mr. Belmonte detailed Petitioner's medical status and physical restrictions. He notes that, other that the left shoulder, Petitioner is in good health. He has no restrictions for his right arm. He is taking no medications. He uses no assistive devices. he has a valid driver's license. He can sit, stand and walk within normal limits. He can crouch, stoop and squat, He has normal vision and hearing. He notes Petitioner's education as a high school graduate with one year of junior college. He notes no trade skills or computer literacy. He records Petitioner's work history at Respondent, as a farmer and working in the slaughterhouse. Following his review and interview with the Petitioner, Mr. Belmonte opines that Petitioner is an older worker. He would be limited to the Light Physical Demand Level. He is further restricted within this classification because of his restriction on reaching. He notes that Petitioner has not looked for work in 20 years and does not have skills to look for work online. He notes no alternate available occupations. Mr. Belmonte concludes that Petitioner cannot perform his customary occupation or jobs he has previously held. He opines that there is no stable job market offering

gainful employment to Petitioner. He opines that Petitioner is not a candidate for vocational rehabilitation consistent with the guidelines of *National Tea* (PX 9).

Petitioner testified that he has not looked for work since he was terminated by Respondent in November 2015. He continues to receive Long Term Disability. He applied for and is receiving Social Security disability. He notices difficulty and pain in his left shoulder performing many tasks such as reaching to a top shelf. He has pain and his arm only goes so far. He has some problems sleeping. Petitioner testified he is not taking medications except aspirin and Tylenol. He has not seen Dr. Saleem since September 2016. Petitioner confirmed he is right handed. He has no restrictions on his legs or neck. He can drive his personal car. He has not taken any steps to enhance his typing or computer skills. Petitioner considers himself disabled.

Conclusions of Law

In support of the Arbitrator's decision with respect to (C) Accident and (D) Date of Accident, and (F) Causal Connection, the Arbitrator finds as follows:

To obtain compensation under the Act, a claimant must show, by a preponderance of the evidence, that he suffered a disabling injury that arose out of and in the course of the claimant's employment. Petitioner in the present case is alleging that he developed symptom related to an aggravation of a left shoulder rotator cuff tear as a result of the repetitive lifting and carrying he was performing for Respondent. An employee who suffers a repetitive trauma injury still may apply for benefits under the Act but must meet the same standard of proof as an employee who suffers a sudden injury. *Durand v. Industrial Comm'n, 224 Ill. 2d 53, 64, 862 N.E.2d 918, 924, 308 Ill. Dec. 715 (2006).* In a repetitive trauma case, issues of accident and causation are intertwined. Therefore, a review of the evidence allows both issues to be resolved together. *Boettcher v. Spectrum Property Group and First Merit Venture Realty Group,* 97 W.C. 44539, 99 I.I.C. 0961.

An employee who alleges injury based on repetitive trauma must show that the injury is work related and not the result of a normal degenerative aging process. *Peoria County Belwood Nursing Home v. Industrial Comm'n, 115 Ill. 2d 524, 530, 505 N.E.2d 1026, 106 Ill. Dec. 235 (1987); Edward Hines Precision Components v. Industrial Comm'n, 356 Ill. App. 3d 186, 194, 825 N.E.2d 773, 292 Ill. Dec. 185 (2005).* In cases relying on the repetitive-trauma concept, the claimant generally relies on medical testimony establishing a causal connection between the work performed and claimant's disability. *Williams v. Industrial Comm'n, 244 Ill. App. 3d 204, 209, 614 N.E.2d 177, 180, 185 Ill. Dec. 43 (1993).*

Petitioner testified in great detail as to the physical requirements of his job. This testimony was unrebutted. Respondent's route manager was present and testified in this matter but offered no evidence to contradict Petitioner's description of his work duties. Petitioner was required to lift and carry cases of beer weighing from 18 to 35 pounds. In unloading these cases from his truck, he was required to reach over shoulder and overhead repeatedly to locate each delivery and move the product to a hand cart for delivery to the customer. He testified that a truck could have up to 1000 items per day. He described the physical requirement of moving, lifting and delivery of the cases and barrels using a hand cart. He also described the stocking and rotating of product at the customer location. Based upon this credible and unrebutted testimony the Arbitrator agrees with Dr. Saleem that Petitioner's job was a very heavy, physically demanding job requiring overhead lifting in a repetitive manner. These are not activities of daily living. The Arbitrator agrees with Dr. Saleem that the job placed Petitioner at an

increased risk of injury. In the ordinary course of performing his job, Petitioner's duties exposed him to a unique risk of the employment.

The Commission may find a causal relationship based on a medical expert's opinion that the injury "could have" or "might have" been caused by an accident. *Mason & Dixon Lines, Inc. v. Industrial Comm'n, 99 Ill. 2d 174, 182, 457 N.E.2d 1222, 1226, 75 Ill. Dec. 663 (1983).* However, expert medical evidence is not essential to support the Commission's conclusion that a causal relationship exists between a claimant's work duties and his condition of ill-being. *International Harvester v. Industrial Comm'n, 93 Ill. 2d 59, 63, 442 N.E.2d 908, 911, 66 Ill. Dec. 347 (1982).* A chain of events suggesting a causal connection may suffice to prove causation. *Consolidation Coal Co. v. Industrial Comm'n, 265 Ill. App. 3d 830, 839, 639 N.E.2d 886, 892, 203 Ill. Dec. 327 (1994).* It is well established that prior good health followed by a change immediately following an accident allows an inference that a subsequent condition of ill-being is the result of the accident. *Navistar International Transportation Co. v. Industrial Comm'n, 315 Ill. App. 3d 1197, 1205 (2000).*

In the present case, the evidence establishes that Petitioner had a prior injury and treatment to the left shoulder. He received a settlement for this prior claim from Respondent in 2008. The rationale justifying the use of the "chain of events" analysis to demonstrate the existence of an injury would also support its use to demonstrate an aggravation of a preexisting injury. *Par Electric v. Illinois Workers' Comp. Comm'n, 2018 Ill. App. 3d 170656WC, 2018 Ill. App. LEXIS 775.* Petitioner has established that his condition of ill-being in the left shoulder is causally related to his employment under a chain of events theory. After Petitioner's prior left shoulder surgery, he returned to his full duty as a driver helper for over 6 years doing heavy physical labor before developing new complaints in the left shoulder. Thereafter, he sought medical treatment. An MRI noted a recurrent rotator cuff tear. He proceeded with a surgical repair and follow up care. Based upon the chain of events theory, his condition is causally related to the repetitive heavy work activity.

Petitioner also offered the unrebutted medical opinions of Dr. Saleem. Repetitive trauma claims involving the alleged aggravation of a preexisting condition cannot succeed unless the claimant presents medical evidence suggesting that (1) the claimant had a preexisting condition that was or could have been aggravated by his repetitive work activities, and (2) his current condition of ill-being was or could have been caused (at least in part) by this work-related trauma and is not simply the result of a normal, degenerative aging process. The relevant inquiry in preexisting-condition cases is whether the employee's condition is attributable solely to a degenerative process of the preexisting condition or to the aggravation or acceleration of the preexisting condition resulting from a work-related accident. *Sisbro, Inc. v. Industrial Comm'n, 207 Ill. 2d 193 at 204-05; 797 N.E.2d 665; 2003 Ill. LEXIS 776; 278 Ill. Dec. 70.*

To meet this burden, Petitioner offered the medical opinions of Dr. Saleem that the work activity aggravated the condition of Petitioner's shoulder. Respondent offered no contrary medical opinions on causation. Expert testimony shall be weighed like other evidence with its weight determined by the character, capacity, skill and opportunities for observation, as well as the state of mind of the expert and the nature of the case and its facts. *Madison Mining Company v. Industrial Commission, 309 Ill. 91, 138 N.E. 211 (1923).* Dr. Saleem's opinion was based upon his history, which included knowledge of the prior surgery, Petitioner's statements that he now has some increase in progressive pain with any overhead activity, he has difficulty with any lifting, pushing, or pulling, and that he does deliver beer for a living, and that has been aggravating it quite a bit. He considered his

medical treatment, the MRI studies, and a description of Petitioner's job duties taken from the Union manual and the description of the duties which are identical to Petitioner's unrebutted testimony.

Respondent has challenged the accuracy of the history provided to Dr. Saleem based upon the statement recorded by the Guardian adjuster on December 8, 2014 that states Petitioner injured his shoulder at home lifting a door on November 15, 2014. The Arbitrator finds Petitioner's testimony credible that this is a miscommunication by the adjuster. The Arbitrator notes Petitioner's credible testimony that he scheduled his November 18, 2014 appointment a week before the appointment, before any event could have occurred on November 15. The alleged home event does not appear anywhere in the medical records. The Arbitrator also accepts that the description of lifting a door does not make any sense as a home accident since this activity is clearly related to the delivery trucks. The Arbitrator gives no weight to this document.

Dr. Saleem's opinion was based upon complete and accurate information concerning the prior condition, the onset of symptoms, the physical activity increasing the symptoms and the physical nature of the Petitioner's job duties. The Arbitrator finds the opinions of Dr. Saleem credible and persuasive.

Respondent has also questioned the Petitioner's claimed date of manifestation of November 18, 2014. The standard for determining the manifestation date in a repetitive trauma case is flexible and fact-specific and is guided by considerations of fairness. *Durand v. Industrial Comm'n, 224 Ill. 2d 53, 862 N.E.2d 918 (2006),* "The facts must be closely examined in repetitive-injury cases to ensure a fair result for both the faithful employee and the employer's insurance carrier."; see also *Oscar Mayer & Co. v. Industrial Comm'n, 176 Ill. App. 3d 607, 612, 531 N.E.2d 174, 126 Ill. Dec. 41 (1988); Three "D" Discount Store v. Industrial Comm'n, 198 Ill. App. 3d 43, 49, 556 N.E.2d 261, 144 Ill. Dec. 794 (1989).* The date on which the employee notices a repetitive trauma injury is not necessarily the manifestation date. *Oscar Mayer & Co., 176 Ill. App. 3d at 611*; see also *Durand, 224 Ill. 2d at 68.* Instead, the date on which the employee became unable to work, due to physical collapse or medical treatment, helps determine the manifestation date. *Oscar Mayer & Co., 176 Ill. App. 3d at 611*; see also *Durand, 224 Ill. 2d at 68-69.* Courts considering various factors have typically set the manifestation date on either the date on which the employee requires medical treatment or the date on which the employee can no longer perform work activities. *Durand, 224 Ill. 2d at 72.* In the present case, November 18, 2014 is both the date Petitioner's first sought medical treatment and the date he was no longer able to work. The Arbitrator finds that November 18, 2014 is the appropriate date of manifestation in this matter.

Based upon the record as a whole, the Arbitrator finds that Petitioner has proven by a preponderance of the evidence that he suffered a repetitive trauma accidental injury arising out of and in the course of his employment with Respondent with a date of manifestation on November 18, 2014 and that further finds that his condition of ill-being in the left shoulder is causally connected to the accidental injury sustained.

In support of the Arbitrator's decision with respect to (E) Notice, the Arbitrator finds as follows:

Respondent disputes that Petitioner provided timely notice pursuant to the provisions of the Act. The evidence establishes two separate instances of alleged notice to Respondent. The first is the reporting to Mr. Muezelaar in November 2014 where Petitioner reported a shoulder injury but told Mr. Muezelaar that he did not injure it on the job working for Respondent. The second reporting is the January 2016 receipt by Respondent of the Application for Adjustment of Claim. Based upon the law and evidence, the Arbitrator finds that these are both sufficient and timely notice under the Act.

Section 6(c) of the Act states that notice of the accident shall be given to the employer as soon as practicable, but not later than 45 days after the accident. However, Petitioner received both medical benefits and non-occupational disability benefits for which credit has been allowed under Section 8(j) of the Act. Section 8(j)1 of the Act states that, "In such event, the period of time for giving notice of accidental injury and filing application for adjustment of claim does not commence to run until the termination of such payments." The evidence establishes that the benefits covered medical treatment through December 2015. The long term disability continued through the date of trial. Therefore,Petitioner's period for giving notice had not expired as of the receipt by Respondent of the Application for Adjustment of Claim in January 2016 and therefore timely notice was provided within the provisions of the Act. See *Crow's Hybrid Corn Co. V, Industrial Commission, 72 Ill. 2d 168, 380 NE 2d 777, 20 Ill. Dec. 568, 1978 Ill. LEXIS 299 (1978).*

Further, the Arbitrator finds that the initial reporting by Petitioner of his shoulder condition in November 2014 would be defective notice pursuant to the Act. Section 6(c) (2) states that "[n]o defect or inaccuracy of such notice shall be a bar to the maintenance of proceedings on arbitration or otherwise by the employee unless the employer proves that he is unduly prejudiced in such proceedings by such defect or inaccuracy." 820 /LCS 305/6(c). The purpose of the notice provisions is to enable the employer to investigate promptly and to ascertain the facts of the alleged accident. *City of Rockford v. Industrial Commission, 214 N.E. 2d 763 (1966).* The giving of notice under the Act is jurisdictional and a prerequisite of the right to maintain a proceeding under the Act. However, the legislature has mandated a liberal construction on the issue of notice. *S&H Floor Covering v. The Workers Compensation Commission, 870 N.E.2d 821 (2007).* The purpose of the notice requirement is "both to protect the employer against fraudulent claims by giving him an opportunity to investigate promptly and ascertain the facts of the alleged accident and to allow him to minimize his liability by affording the injured employee immediate medical treatment." *United States Steel Corp. v. Industrial Comm'n, 32 Ill. 2d 68, 75, 203 N.E.2d 569, 573 (1964).* The notice is jurisdictional, and the failure of the claimant to give notice will bar his claim. Thrall Car Manufacturing Co. v. Industrial Comm'n, 64 Ill. 2d 459, 465, 356 N.E.2d 516, 519 (1976). However, a claim is only barred if no notice whatsoever has been given. *Silica Sand Transport, Inc. v. Industrial Comm'n, 197 Ill. App. 3d 640, 651, 554 N.E.2d 734, 742 (1990).* "If some notice has been given, but the notice is defective or inaccurate, then the employer must show that he has been unduly prejudiced." *Id.*

Petitioner provided the nature of his injury, namely an injury to his left shoulder and advised Respondent that he was unable to work. His unrebutted testimony was that he told Respondent that this was not a Workers' Comp claim because he could not pinpoint any one incident that he was injured. He had the earlier surgery in 2005 or 2006 and received compensation for it and signed off on it. He assumed that he could not claim it again. His subsequent use of his group health insurance and non-occupational disability is consistent with this understanding. Case law has found that such reporting would be defective notice, not no notice. See: *Tolbert v. Ill. Workers' Compensation Comm'n. 2014 Ill. App. (4th) 130523WC citing Raymond v. Industrial Commission, 354 Ill. 586, 188 NE 861 (1933); Burris v. State of Illinois, Dept. of Human Services, 13 IWCC 567; Koonce v. Cerro Copper, 01 IIC 363* ("Petitioner completed a group health insurance claim form showing he was disabled as of August 9, 1997. However, he did not complete portions of the form describing the accident or giving the date of the accident. Respondent knew of the fact of Petitioner's injury but not that he was claiming it was work related. This is sufficient to satisfy the notice requirement of the Act.")

Respondent presented no evidence of any prejudice as a result of any defect in the notice. In fact, since the claim arises from the repetitive nature of the job duties of a driver which have not changed since at least 2005,

Respondent had ample opportunity to contest the nature of the physical requirements of the job. But despite having the route supervisor present, Respondent did not offer any testimony or other evidence to dispute Petitioner's detailed explanation of his duties. They offered no other evidence to show any prejudice by any delay in the reporting of the claim of a work-related repetitive injury.

Based upon the record as a whole, the Arbitrator finds that Petitioner provided Respondent with notice of the accident within the time limits stated in the Act.

In support of the Arbitrator's decision with respect to (J) Medical and (N) Credit, the Arbitrator finds as follows:

Under section 8(a) of the Act, a claimant is entitled to recover reasonable medical expenses that are causally related to the accident and that are necessary to diagnose, relieve, or cure the effects of his injury. *Absolute Cleaning/SVMBL v. Illinois Workers' Compensation Comm'n, 409 Ill. App. 3d 463, 470, 949 N.E.2d 1158, 1165, 351 Ill. Dec. 63 (2011).* Based upon the Arbitrator's findings with respect to Accident and Causal Connection, reasonable and necessary treatment for Petitioner's left shoulder would be causally connected to the accident. Petitioner submitted the medical bills and a summary of the payments made as PX 4 and PX 4a. The services for these charges are substantiated by the medical records offered as PX 1, PX 2 and PX 3. Having reviewed the medical records and bills, the Arbitrator finds the charges reflected in PX 4 and PX 4a are reasonable, necessary and causally related to the accident.

The bills reflect that there are no outstanding balances. The bills were paid and adjusted by Blue Cross/ Blue Shield. Petitioner was a union employee of Respondent. Respondent claimed an 8(j) credit for payments made, the amount to be determined. Per the bills submitted, Blue Cross/Blue Shield payments made were $76,126.24. Petitioner made payments for deductibles and copays of $1,228.49 for which he is entitled to reimbursement.

Based upon the record as a whole and the Arbitrator's findings with respect to Accident and Causal Connection, the Arbitrator finds that Petitioner is entitled to payment for out-of-pocket payments of $1,228.49. Respondent shall be given a credit of $76,126.24 for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

In support of the Arbitrator's decision with respect to (K) Temporary Compensation, the Arbitrator finds as follows:

Temporary compensation is provided for in Section 8(b) of the Workers' Compensation Act, which provides, weekly compensation shall be paid as long as the total temporary incapacity lasts, which has interpreted to mean that an employee is temporarily totally incapacitated from the time an injury incapacitates him for work until such time as he is as far recovered or restored as the permanent character of his injury will permit. It is a well-settled principle that when a claimant seeks TTD benefits, the dispositive inquiry is whether the claimant's condition has stabilized, i.e., whether the claimant has reached maximum medical improvement. *Westin Hotel v. Industrial Comm'n, 372 Ill. App. 3d 527, 542, 865 N.E.2d 342, 310 Ill. Dec. 18 (2007); Land & Lakes Co. v. Industrial Comm'n, 359 Ill. App. 3d 582, 594, 834 N.E.2d 583, 296 Ill. Dec. 26 (2005); F&B Manufacturing Co. v. Industrial Comm'n, 325 Ill. App. 3d 527, 531, 758 N.E.2d 18, 259 Ill. Dec. 173 (2001).* See also *Archer Daniels Midland Co. v. Industrial Comm'n, 138 Ill. 2d 107, 118, 561 N.E.2d 623, 149 Ill. Dec. 253 (1990).*

Petitioner was disabled as of November 18, 2014 when he first sought treatment with Dr. Saleem. He underwent surgery for his left shoulder on January 12, 2015 and continued physical therapy through August 11, 2015. Petitioner was scheduled for a repeat MRI at his visit on August 13, 2015 due to persistent discomfort and limitations. On August 28, 2015, Dr. Saleem did not recommend further repair surgery. He recommended an additional 3 months of range of motion exercises. He noted that the only surgical solution would be a reverse shoulder replacement, but that Petitioner was not a candidate at that point. Dr. Saleem provided Guardian with restrictions of no use of the left arm, no crawling, climbing ladders, reaching out or above shoulder and no driving. On December 3, 2015, Dr. Saleem recommended no further treatment at that time. Dr. Saleem provided permanent restrictions of occasional reaching waist to chest height, no reaching above shoulder level, occasional ladder climbing, occasional lifting 11 to 25 pounds, no lifting over 25 pounds. In his subsequent narrative reports and during his deposition testimony, Dr. Saleem opined that Petitioner is at maximum medical improvement and requires restrictions consistent with those provided following the December 3, 2015 visit. No additional treatment was provided after that date. The Arbitrator therefore finds that Petitioner's condition of ill-being in the left shoulder reached maximum medical improvement as of December 3, 2015 and Petitioner's entitlement to temporary total disability ended as of that date.

After December 3, 2015, Petitioner is seeking maintenance. Section 8(a) provides for both physical rehabilitation and vocational rehabilitation and mandates that the employer pay all maintenance costs and expenses "incidental" to a program of "rehabilitation." See also *Nascote Industries v. Industrial Comm'n, 353 Ill. App. 3d 1067, 1075, 820 N.E.2d 570, 289 Ill. Dec. 794 (2004)*. However, by its plain terms, Section 8(a) requires the employer to pay only those maintenance costs and expenses that are incidental to rehabilitation. That means that an employer is obligated to pay maintenance benefits only "while a claimant is engaged in a prescribed vocational-rehabilitation program." *W.B. Olson, Inc., 2012 IL App (1st) 113129WC at ¶ 39; see also Nascote Industries, 353 Ill. App. 3d at 1075.* Thus, if the claimant is not engaging in some type of "rehabilitation" (whether it be physical rehabilitation, formal job training, or a self-directed job search), the employer's obligation to provide maintenance is not triggered. Petitioner testified that he has not made any effort to find employment. His vocational assessment by Robert Belmonte found that he is not a candidate for rehabilitation. Petitioner has failed to prove that he is entitled to maintenance benefits for the period after reaching maximum medical improvement on December 3, 2015.

Based upon the record as a whole and the Arbitrator's findings with respect to Accident and Causal Connection, the Arbitrator finds that Petitioner has proven by a preponderance of the evidence that he is entitled to temporary total disability benefits commencing November 18, 2014 through December 3, 2015, a period of 54 3/7 weeks.

In support of the Arbitrator's decision with respect to (L) Nature & Extent, the Arbitrator finds as follows:

Petitioner is seeking compensation for permanent total disability. An employee is totally and permanently disabled when he is unable to make some contribution to industry sufficient to justify the payment of wages. *A.M.T.C. of Illinois, Inc., Aero Mayflower Transit Co. v. Industrial Comm'n, 77 Ill. 2d 482, 487 (1979)*. An employee need not be reduced to complete physical incapacity to be entitled to PTD benefits. *Ceco Corp. v. Industrial Comm'n, 95 Ill. 2d 278, 286, 447 N.E.2d 842, 845, 69 Ill. Dec. 407 (1983)*. Instead, a PTD award is proper when the employee can make no contribution to industry sufficient to earn a wage. *Westin Hotel v. Industrial Comm'n, 372 Ill. App. 3d 527, 544, 865 N.E.2d 342,*

357, 310 Ill. Dec. 18 (2007). "The focus of the Commission's analysis must be upon the degree to which the claimant's medical disability impairs his employability." *Alano v. Industrial Comm'n, 282 Ill. App. 3d 531, 534, 668N.E.2d 21, 24, 217 Ill. Dec. 836 (1996).* A person is not entitled to PTD benefits if he is qualified for and capable of obtaining gainful employment without seriously endangering his health or life. *Interlake, Inc. v. Industrial Comm'n, 86 Ill. 2d 168, 176, 427 N.E.2d 103, 107, 56 Ill. Dec. 23 (1981).*

Petitioner has been released to return to work with restrictions. Dr. Saleem has placed him permanent restrictions of occasional reaching waist to chest height, no reaching above shoulder level, occasional ladder climbing, occasional lifting 11 to 25 pounds, no lifting over 25 pounds. There is no dispute that Petitioner could not return to his prior employment with these restrictions. If, as in this case, a claimant's disability is of such a nature that he is not obviously unemployable, or there is no medical evidence to support a claim of total disability, the burden is upon the claimant to prove by a preponderance of the evidence that he fits into an "odd lot" category; that being an individual who, although not altogether incapacitated, is so handicapped that he is not regularly employable in any well-known branch of the labor market. *Valley Mould & Iron Co. v. Industrial Comm'n, 84 Ill. 2d 538, 546-47 (1981).* A claimant ordinarily satisfies his burden in one of two ways: (1) by showing diligent but unsuccessful attempts to find work, or (2) by showing that, because of his age, skills, training, and work history, he will not be regularly employed in a well-known branch of the labor market. *Westin Hotel v. Industrial Comm'n, 372 Ill. App. 3d 527, 544 (2007).* Once a claimant establishes that he falls within an "odd lot" category, the burden shifts to the employer to prove that the claimant is employable in a stable labor market and that such a market exists. *Id.*

Petitioner did not attempt any type of job search. Instead, Petitioner underwent a vocational assessment with Robert Belmonte. Mr. Belmonte concludes that Petitioner cannot perform his customary occupation or jobs he has previously held. He opines that there is no stable job market offering gainful employment to Petitioner. He opines that Petitioner is not a candidate for vocational rehabilitation consistent with the guidelines of *National Tea.* Expert testimony shall be weighed like other evidence with its weight determined by the character, capacity, skill and opportunities for observation, as well as the state of mind of the expert and the nature of the case and its facts. *Madison Mining Company v. Industrial Commission, 309 Ill. 91, 138 N.E. 211 (1923).* Mr. Belmonte detailed Petitioner's medical status and physical restrictions. He notes that, other that the left shoulder, Petitioner is in good health. He has no restrictions for his right arm. He is taking no medications. He uses no assistive devices. he has a valid driver's license. He can sit, stand and walk within normal limits. He can crouch, stoop and squat, He has normal vision and hearing. He notes Petitioner's education as a high school graduate with one year of junior college. He notes no trade skills or computer literacy. He records Petitioner's work history at Respondent, as a farmer and working in the slaughterhouse. Following his review and interview with the Petitioner, Mr. Belmonte opines that Petitioner is an older worker. He would be limited to the Light Physical Demand Level. He is further restricted within this classification because of his restriction on reaching. He notes that Petitioner has not looked for work in 20 years and does not have skills to look for work online. The Arbitrator finds the opinions of Mr. Belmonte are based on a complete and accurate understanding of Petitioner's situation and meet Petitioner's burden of establishing that he is an odd-lot permanent total disability.

Respondent presented no expert to dispute Mr. Belmonte's conclusions. While Respondent noted the Petitioner's lack of disability to the right arm, neck or legs and his ability to drive a car, all of these capabilities were included in Mr. Belmonte's analysis which concluded that there was no stable labor market for Petitioner. Petitioner's lack of a job search, lack of effort to enhance his computer skills and his assessment that he is a

disabled person are consistent with Mr. Belmonte's opinion that he is not a candidate for rehabilitation and therefore such efforts would not result in gainful employment. No evidence was submitted that the physical restrictions placed by Dr. Saleem were overly restrictive or that Petitioner was performing any activities inconsistent with the restrictions imposed. Respondent made no job offer to Petitioner within his permanent restrictions. Based upon the evidence submitted, the Arbitrator finds the opinions of Mr. Belmonte persuasive and unrefuted by any evidence presented by Respondent.

Based upon the record as a whole and the Arbitrator's findings with respect to Accident and Causal Connection, the Arbitrator finds that Petitioner has proven by a preponderance of the evidence that, as of December 4, 2015, the date of maximum medical improvement, he is entitled to permanent and total disability benefits, as provided in Section 8(f) of the Act.

In support of the Arbitrator's decision with respect to (N) Credit, the Arbitrator finds as follows:

The Arbitrator has already addressed Respondent's credit pursuant to Section 8(j) for payment of medical bills above in the finding with respect to Medical. In addition, Respondent made payments for short term disability (STD) and long term disability (LTD). Payment records were submitted as RX 3 and RX 7. The parties stipulated that Respondent's credit for the non-occupational lost time payments through the date of trial were $77,552.22. Petitioner testified that he is continuing to receive LTD payments. The Arbitrator finds that Respondent may have made additional payments since the date of trial for which credit would be allowed.

Based upon the record as a whole, and the Arbitrator's findings with respect to Medical, Temporary Compensation and Nature & Extent, the Arbitrator finds that Respondent shall be given a credit of $76,126.24 for medical benefits that have been paid and $77,552.22 (plus any additional benefits paid since October 10, 2018) for STD and LTD benefits that have been paid. Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Tommy Johnson,
Petitioner,
vs.

NO: 18 WC 18869

Ameren,
Respondent.

20IWCC0404

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 2, 2020, is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $59,400.00. 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.

JUL 17 2020

DATED:
o70920
BNF/mw
045

Barbara N. Flores

Marc Parker

Kathryn A. Doerries

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

JOHNSON, TOMMY Case# **18WC018869**

Employee/Petitioner

AMEREN

Employer/Respondent

20IWCC0404

On 1/2/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.56% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0969 RICH RICH & COOKSEY CHAPPELL
THOMAS C RICH
6 EXECUTIVE DR SUITE 3
FAIRVIEW HTS, IL 62208

1241 LEMP & MURPHY
WILLIAM LEMP
8045 BIG BEND BLVD SUITE 202
WEBSTER GROVES, MO 63119

STATE OF ILLINOIS)
)SS.
COUNTY OF MADISON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

Tommy Johnson
Employee/Petitioner

v.

Ameren
Employer/Respondent

Case # 18 WC 18869

Consolidated cases: n/a

20IWCC0404

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Collinsville, on November 14, 2019. By stipulation, the parties agree:

On the date of accident, May 24, 2018, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $78,816.40; the average weekly wage was $1,515.70.

At the time of injury, Petitioner was 56 years of age, married, with 0 dependent child(ren).

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

Respondent shall be given a credit of $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. The parties stipulated TTD benefits were paid in full.

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $790.64 per week for 75 weeks because the injury sustained caused the 15% loss of use of the person as a whole, as provided in Section 8(d)2 of the Act.

Respondent shall pay Petitioner compensation that has accrued from November 11, 2019, through November 14, 2019, and shall pay the remainder of the award, if any, in weekly payments.

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

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

William R. Gallagher, Arbitrator

December 29, 2019
Date

JAN 2 - 2020

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged he sustained an accidental injury arising out of and in the course of his employment by Respondent on May 24, 2018. According to the Application, Petitioner "Fell" and sustained an injury to his "Neck, back, right arm/elbow, body as a whole" (Arbitrator's Exhibit 2). The only disputed issue in this case was the nature and extent of disability (Arbitrator's Exhibit 1).

Petitioner worked for Respondent as a gas journeyman. Petitioner's job duties included adjusting/replacing meters, repairing gas lines, carrying tools to/from his truck, etc. On May 24, 2018, Petitioner was in the process of changing a gas meter when he was attacked by a German Shepherd. Petitioner was able to get away by jumping over a fence, but when he did so, he sustained an injury to his neck/head.

Following the accident, Petitioner went to the ER of Belleville Memorial Hospital. At that time, Petitioner complained of back and neck pain. A CT scan of Petitioner's cervical spine was obtained which revealed a prior fusion at C3-C4 and disc replacements at C3-C4, C4-C5 and C5-C6 (Petitioner's Exhibit 3).

Petitioner subsequently sought treatment from Dr. Matthew Gornet, an orthopedic surgeon, who saw him on June 9, 2018. Petitioner testified he was previously treated by Dr. Gornet for a low back injury. Dr. Gornet's records noted he had previously performed decompression/fusion surgery at L5-S1 on December 16, 2014 (Petitioner's Exhibit 4).

Petitioner also underwent cervical spine surgeries prior to the accident of May 24, 2018. On May 24, 2007, Dr. Robert Schultz, a neurosurgeon, performed a discectomy and fusion with metal hardware at C4-C5 and C5-C6 (Respondent's Exhibit 1).

Dr. Schultz subsequently treated Petitioner for a herniated disc at C3-C4 and performed a fusion at that level in 2009. The operative report of that surgery was not tendered into evidence at trial. However, a functional capacity evaluation (FCE) performed on April 13, 2012, was received into evidence. At that time, Petitioner had complaints of cervical pain and numbness in both elbows/hands (Respondent's Exhibit 2).

All of the prior spine surgeries were because of injuries Petitioner had sustained in work-related accidents. In regard to the cervical spine injuries, Petitioner received settlements of 27 1/2% permanent partial disability to the person as a whole and 28% permanent partial disability to the person as a whole. In regard to the low back injury, Petitioner received an award of 15% permanent partial disability to the person as a whole (Respondent's Exhibits 3 and 4).

When Dr. Gornet saw Petitioner on June 9, 2018, he noted he previously diagnosed Petitioner with a pseudoarthrosis at C3-C4. On examination, he noted a decreased sensation in the C7 dermatome on the left side. He opined Petitioner's current symptoms were related to the accident of May 24, 2018, and ordered an MRI scan (Petitioner's Exhibit 4).

The MRI was performed on June 9, 2018. According to the radiologist, there were post op findings at C3-C4, C4-C5 and C5-C6 and a bilateral disc protrusion at C6-C7 (Petitioner's Exhibit 5).

Dr. Gornet subsequently referred Petitioner to Dr. Kaylea Boutwell. Dr. Boutwell saw Petitioner on September 13, 2018, and administered an epidural steroid injection on the right at C6-C7. The injection only provided some temporary relief. When Dr. Gornet saw Petitioner on October 18, 2018, he recommended Petitioner undergo disc replacement surgery at C6-C7 (Petitioner's Exhibits 4 and 9).

Dr. Gornet performed disc replacement surgery on November 14, 2018. Dr. Gornet noted the procedure was unusual because of the prior fusions from C3 to C6 and the failed fusion at C3-C4. However, he was able to successfully perform the disc replacement procedure at C6-C7 (Petitioner's Exhibit 13).

At the direction of Respondent, Petitioner was examined by Dr. Michael Chabot, an orthopedic surgeon, on January 2, 2019. In connection with his examination of Petitioner, Dr. Chabot reviewed medical records (including his prior report of January 20, 2016) and diagnostic studies provided to him by Respondent. Dr. Chabot opined the treatment provided to Petitioner, including the disc replacement surgery, was attributable to the accident of May 24, 2018, and was reasonable (Respondent's Exhibit 6).

Dr. Gornet saw Petitioner following surgery and released Petitioner to return to work without restrictions effective March 5, 2019. When he last saw Petitioner on November 11, 2019, he noted Petitioner was working full duty and was pleased with the result. Dr. Gornet opined Petitioner was at MMI at that time (Petitioner's Exhibit 4).

Again at the request of Respondent, Petitioner was examined by Dr. Chabot on August 5, 2019. Dr. Chabot reviewed both medical records and "Court Records" regarding Petitioner's prior settlements and award. Dr. Chabot noted the prior PPD "awards" of 15%, 27.5% and 28% body as a whole, or a total of 70.5% PPD to the body as a whole. Dr. Chabot opined Petitioner had a PPD of 8% to the body as a whole related to his cervical spine injury of May 24, 2018. This was not an AMA impairment rating (Respondent's Exhibit 7).

At trial, Petitioner testified he was able to return to work to his regular job, but he still experiences some stiffness in his neck and exercises a greater degree of caution while at work. Petitioner stated he works at a slower pace than what he did previously.

Conclusion of Law

The Arbitrator concludes Petitioner had sustained permanent partial disability to the extent of 15% loss of use of the person as a whole.

In support of this conclusion the Arbitrator notes the following:

Dr. Chabot opined Petitioner had an 8% permanent partial disability (PPD) to the man as a whole because of the cervical spine injury. As noted herein, this was not an AMA impairment rating. Further, Dr. Chabot's rating seems to be based, in part, on the settlements/award previously obtained by Petitioner. The Arbitrator gives this factor no weight.

At the time of the accident, Petitioner worked as a gas journeyman. Petitioner's job duties included adjusting/repairing meters, repairing gas lines, carrying tools, etc. Petitioner was able to return to work, but now performs his work duties with greater caution. The Arbitrator gives this factor moderate weight.

Petitioner was 56 years old at the time of the accident and 57 years old at the time of trial. Petitioner has approximately 10 years before he will reach normal retirement age and will have to live with the effects of the injury for the remainder of his natural and working life. The Arbitrator gives this factor moderate weight.

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

Petitioner sustained an injury to his cervical spine which ultimately required disc replacement surgery at C6-C7. While Petitioner was able to return to work to his regular job, he continues to have complaints of stiffness in his neck consistent with the injury he sustained. The Arbitrator gives this factor significant weight.

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Maria Rojas,

Petitioner,

20IWCC0405

vs.

No. 13 WC 15852

Northwest Community Hospital,

Respondent.

DECISION AND OPINION ON REVIEW

Petition for Review having been filed by Petitioner herein and notice given to all parties, the Commission, after reviewing the entire record in this matter, and being advised of the facts and law, finds that the Commission has jurisdiction to consider Petitioner's Petition for Review. The Commission further finds that no mutual mistake of fact exists and declines to vacate the Arbitrator's approval of the settlement contract in this matter.

The facts before us stem from a settlement contract submitted to, and approved by, an Arbitrator as well as a parallel premises liability lawsuit filed in the circuit court. Maria Rojas ("Petitioner") filed her Application for Adjustment of Claim on May 15, 2013. Therein, she alleged that she suffered a work-related injury to her right hand, wrist and arm, and whole person that occurred on March 20, 2013 while employed by Northwest Community Hospital ("Respondent"). Approximately two years later, on March 19, 2015, Petitioner filed a civil suit against The Wellness Center, a corporation, and Northwest Community Hospital d/b/a The Wellness Center, a corporation ("Defendants") in the Circuit Court of Cook County alleging an injury on March 20, 2013 while exercising on an elliptical machine on the hospital's premises.

Respondent prepared a settlement contract relating to Petitioner's workers' compensation claim. The contract was signed by Petitioner. It was also signed by Petitioner's counsel on June 20, 2017 and previously by Respondent's counsel on November 20, 2016. The contract reflected Petitioner's allegation that she had sustained a right ulnar and radial fracture resulting in surgery

while employed by Respondent. No medical bills or temporary total disability benefits had been paid by Respondent, and the compensability of Petitioner's alleged occupational injury was disputed. In its final clause, the contract states that "[t]he settlement represents: A full and final settlement of any and all issues and disputes." Petitioner waived her rights under the Illinois Workers' Compensation Act ("Act"). Respondent retained its lien rights pursuant to Section 5 of the Act. The settlement amount totaled $300.00, and the contract was approved by an Arbitrator on June 20, 2017.

Six days later, on June 26, 2017, Defendants filed a motion to dismiss the civil suit in the Circuit Court based upon the exclusivity provision of Section 5 of the Illinois Workers' Compensation Act ("Act"). Shortly thereafter, on July 19, 2017, Petitioner filed a Petition for Review before the Commission seeking rescission of the settlement contract based upon a mutual mistake of fact and ambiguity in the contract. The Circuit Court then dismissed the civil suit on August 8, 2017. Respondent returned to the Commission and filed a Motion to Dismiss Petitioner's Petition for Review on September 28, 2017 alleging, inter alia, that the Commission was without jurisdiction to consider Petitioner's Petition for Review. A hearing was held on January 23, 2018 before the then-Commissioner Luskin wherein it was agreed that the matter would be briefed and argued to the Commission. Both parties submitted briefs in support of their motions for the Commission to consider and ultimately presented before the undersigned panel of Commissioners for oral arguments on May 21, 2020.

The threshold issue is whether the Commission has jurisdiction to consider whether the Arbitrator's approval of the settlement should be vacated. The Commission is an administrative agency with powers limited to those explicitly granted by the legislature. *Alvarado v. Indus. Comm'n*, 216 Ill. 2d 547, 553 (2005). Section 19(b) of the Act 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. 820 ILCS 305/19(b) (West 2014).

The question in this case is whether an Arbitrator's approval of a settlement contract is a decision by the Arbitrator or a decision by the Commission. Surprisingly, no precedent exists directly addressing the facts of this case where a settlement contract was approved and then a Petition for Review of that contract was filed within 30 days seeking to rescind or vacate the Arbitrator's approval. The cases cited by Respondent, including *Michelson v. Industrial Comm'n*, 375 Ill. 462 (1941), address contracts approved by the Commission or issues not raised by an interested party within 30 days of the Arbitrator's approval of the contract.

Absent any specific precedent, the Commission finds that 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 therefore finds that it retains jurisdiction to review the contract approved by the Arbitrator given the timely filed Petition for Review. To find otherwise would effectively render approved settlement contracts (not otherwise recalled for clerical error within 15 days) the final decision of the Commission contrary to powers explicitly granted by the legislature in Section 19(b). See *Alvarado*, 216 Ill. 2d at 553. As Petitioner, here, filed her Petition for Review within 30 days of contract approval by the Arbitrator, the Commission finds that it has jurisdiction to review the contract.

20IWCC0405

Having found subject matter jurisdiction exists in this matter, we now address Petitioner's contention that the settlement contract contains a mutual mistake of fact and/or that it is ambiguous. Petitioner contends that the Arbitrator would not have approved the contract had she known that Respondent would use that contract to seek dismissal of Petitioner's civil action. However, the Commission declines to consider what is not contained within the contract before it.

The Commission has reviewed the entire contract carefully. The agreement resolves a highly disputed claim utilizing broad language similar to that found in many contracts presented to Arbitrators and the Commission. However, the terms of the contract are clear in that the very compensability of the claim filed by Petitioner was in dispute and she waived rights in exchange for receiving a certain sum of money. The use of the approved contract as a tool by the Defendants in the civil action to close out her rights there is beyond the Commission's authority to assess.

Thus, upon review of the settlement contract as submitted and after considering the parties' arguments and briefs, and being advised of the facts and the law, the Commission finds no basis to vacate the Arbitrator's approval of the contract. Therefore, the Arbitrator's approval of the settlement is affirmed.

Finally, the Commission provides the following response to Petitioner's request for Special Findings on Review, pursuant to Commission Rule 9040.40:

1. Does the payment of $300 under the settlement contract represent payments of compensation under the Workers Compensation Act?

RESPONSE: The Commission finds that the settlement payment represents a full and final settlement of any and all issues and disputes under the Act as agreed by the parties.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's approval of the Settlement Contract Lump Sum Petition and Order in this matter is hereby affirmed as stated herein.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $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: JUL 17 2020

Marc Parker

Barbara N. Flores

Deborah L. Simpson

o-5/21/20
mp-dak
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STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

LAVELL ROBINSON,

Petitioner,

20IWCC0406

vs.

NO: 15 WC 17540

PARAMOUNT STAFFING,

Respondent.

DECISION AND OPINION ON REVIEW

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

Following a careful review of the entire record, the Commission affirms and adopts the Arbitrator's findings of fact and conclusions of law as to all issues except for the award of medical expenses. Specifically, the Commission affirms the Arbitrator's finding that Petitioner sustained a compensable accident that arose out of and in the course of his employment on May 12, 2015, and that his current condition is causally related to said accident. The Commission further affirms the Arbitrator's award of permanent partial disability of 12.5% MAW as well as temporary total disability benefits from May 22, 2015 to January 21, 2016.

However, as it relates to the award of medical expenses, the Commission finds that the Arbitrator's award encompasses several charges for medical treatment unrelated to Petitioner's low back condition. Specifically, the bill for Chicago Family Health Center in Petitioner's Exhibit 4 contains charges that relate to Petitioner's non-work-related medical issues, including charges for various blood glucose and urinalysis tests. While Petitioner treated at Chicago Family Health Center for his back, his primary care physician also addressed his numerous other conditions, including his Type 2 diabetes, hyperlipidemia, hypertension, chronic pancreatitis, atherosclerosis of the abdominal aorta, and atypical chest pain. As the blood tests and urinalysis

20IWCC0406

tests in Petitioner's Exhibit 4 relate to these unrelated conditions, their associated charges must be deducted from the award of medical expenses.

For that reason, the Commission finds that Respondent is not responsible for the following unrelated medical charges from Chicago Family Health Center: the $23.00 charge for the reagent strip and blood glucose test on May 28, 2015; the $35.00 charge for the glycosylated hemoglobin test on May 28, 2015; the $26.00 charge for the urinalysis test on May 28, 2015; the $23.00 charge for the reagent strip and blood glucose test on June 15, 2015; the $26.00 charge for the urinalysis test on June 15, 2015; the $94.00 charge for the intraoral complete series on June 22, 2015; the $50.00 charge for the oral evaluation on June 22, 2015; the $23.00 charge for the reagent strip and blood glucose test on June 26, 2015; the $23.00 charge for the reagent strip and blood glucose test on September 21, 2015; and the $35.00 charge for the glycosylated hemoglobin test on September 21, 2015.

Additionally, the Commission finds that Respondent is not liable for the multiple charges of $275.00 in the APM Surgical Group bills for "unusual travel." Petitioner's Exhibit 15 shows that APM Surgical Group charged Petitioner $275.00 for unusual travel on October 19, 2015, November 9, 2015, and November 23, 2015. There was no testimony at the hearing nor information in the treatment records to explain or justify those charges. The Commission therefore has no understanding as to what the medical provider meant by "unusual travel" and why such charges were assessed.

The Commission thus modifies the Decision of the Arbitrator to find that Respondent is not liable for the above-named medical expenses from Chicago Family Health Center and APM Surgical Group, as contained in Petitioner's Exhibit 4 and Petitioner's Exhibit 15 respectively.

In all other respects, the Commission otherwise affirms and adopts the Decision of the Arbitrator, including the award of all other reasonable, necessary, and related medical expenses pursuant to §8(a) and §8.2 of the Illinois Workers' Compensation Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator dated July 19, 2019 is modified as stated herein. The Commission otherwise affirms and adopts the Decision of the Arbitrator.

IT IS FURTHER ORDERED that Respondent is not liable for the following unrelated medical charges from Chicago Family Health Center: the $23.00 charge for the reagent strip and blood glucose test on May 28, 2015; the $35.00 charge for the glycosylated hemoglobin test on May 28, 2015; the $26.00 charge for the urinalysis test on May 28, 2015; the $23.00 charge for the reagent strip and blood glucose test on June 15, 2015; the $26.00 charge for the urinalysis test on June 15, 2015; the $94.00 charge for the intraoral complete series on June 22, 2015; the $50.00 charge for the oral evaluation on June 22, 2015; the $23.00 charge for the reagent strip and blood glucose test on June 26, 2015; the $23.00 charge for the reagent strip and blood glucose test on September 21, 2015; and the $35.00 charge for the glycosylated hemoglobin test on September 21, 2015. Respondent is also not liable for the charges of $275.00 from APM Surgical Group for "unusual travel" on October 19, 2015, November 9, 2015, and November 23, 2015. Respondent is otherwise liable for all reasonable and necessary medical expenses related

20IWCC0406

to Petitioner's low back condition pursuant to §8(a) and §8.2 of the Act.

IT IS FURTHER ORDERED that Respondent shall pay Petitioner temporary total disability benefits of $253.00 per week from May 22, 2015 through January 21, 2016, which represents a period of 35 weeks, in accordance with §8(b) of the Act.

IT IS FURTHER ORDERED that Respondent pay to Petitioner the sum of $253.00 per week for a period of 62.5 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused a 12.5% loss of use of the person as a whole.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in the Circuit Court.

DATED: JUL 17 2020

Barbara N. Flores

Marc Parker

DLS/met
O: 5/21/20
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DISSENT

I respectfully dissent from the Decision of the majority. I would have found that Petitioner lacked credibility due to the numerous inconsistencies within and amongst Petitioner's testimony, Lucy Serrano's testimony, and the accident histories in the treatment records.

There is no mention in Petitioner's early treatment records of any work accident. Petitioner testified that he told the medical providers at the hospital and Chicago Family Health Center that he had gotten hurt at work. However, there is no discussion of a work accident in the treatment notes from when Petitioner presented to the hospital on May 22, 2015 or Chicago Family Health Center on May 28, 2015. The first mention of any work accident came on June 4, 2015, when Petitioner told Dr. Goldvekht that he was working on May 12, 2015 and started feeling severe low back pain. However, this report of a work accident is vague, as Petitioner did not describe lifting any boxes at the time of his injury. Petitioner testified at the hearing that he was loading boxes on top of a skid six feet high when he felt stabbing back pain. The treatment records show that

20IWCC0406

Petitioner did not tell any doctor this specific version of the accident, which is that he was loading boxes at the time of his injury, until he saw Dr. Jain on July 20, 2015.

Although Petitioner then told Dr. Jain that he was lifting boxes, there remains inconsistencies regarding the weight of those boxes. Petitioner told Dr. Jain that the boxes he was loading were probably 15 to 25 pounds. However, in a corresponding intake form, Petitioner wrote that his job involved lifting boxes and twisting with 50 to 75 pounds of packing and loading skids. Petitioner also testified at the hearing that the boxes varied in weight with the heaviest being 60 pounds, but he did not dispute if Dr. Jain's records said he was lifting 15 to 25 pounds given that the boxes were of different weights that might be 25 or 60 pounds. However, Petitioner's on-site supervisor, Lucy Serrano, testified that no box in Petitioner's department weighed 60 pounds and the employees in other departments were not allowed to lift over 50 pounds.

Regardless of the discrepancies concerning how much Petitioner was generally required to lift, there was no clear testimony as to how much the specific box he was lifting at the time of the accident weighed. Petitioner testified that he was holding a box above his head when he first felt the back pain, but he did not recall how much that box weighed. Petitioner also told Dr. Ghanayem on February 16, 2017 that he did not recall the size of the box he was lifting.

There are additional inconsistencies in the record regarding Petitioner's release to full duty work. Petitioner initially testified on both direct and cross examination that he was never released to full duty by his doctors. However, the treatment records show that on January 21, 2016, Dr. Goldvekht placed Petitioner at maximum medical improvement and returned him to full duty with no restrictions. When asked if he was aware that Dr. Goldvekht had returned him to work at that time, Petitioner then testified that Dr. Goldvekht had released him, but he could not go back to work. Petitioner testified that he then went to a Social Security doctor who said he could not work. However, the last treatment note in the record is the January 21, 2016 note from Dr. Goldvekht.

There are further inconsistencies regarding if Petitioner worked after the accident, if he asked for light duty accommodations, and if he was fired. Petitioner first testified on direct examination that he was not working in any capacity from the accident date to the day he went to the emergency room on May 22, 2015. However, on cross examination, Petitioner testified that he had continued working after May 12, 2015. He also testified on direct examination that after the accident, he tried to continue working, in part because he did not want to complain to Respondent out of fear of being fired. However, Petitioner testified that Respondent fired him anyway, so he went to the emergency room on May 22, 2015 when the pain got bad. This testimony makes it sound as though Petitioner went to the emergency room after being fired; however, Petitioner also testified that after his doctor gave him light duty restrictions on May 28, he called to discuss accommodations with Respondent and Respondent was unable to accommodate them.

Petitioner also testified on cross examination that he did not recall the last day he worked. However, when he was then asked about going to the hospital on May 22, 2015, he testified that it was also the last day he worked, because he had called off that day.

Petitioner further testified that as of May 28, 2015, he was no longer employed by

Respondent and had contact with Respondent about being terminated. He testified that Respondent had told him that he could not come back to work under restrictions. Petitioner testified that he then asked if they were terminating him, to which Respondent said that they do not have people working for them with restrictions. This testimony is not clear as to whether Respondent actually fired Petitioner, or whether Respondent told him that they could not accommodate his light duty restrictions and Petitioner considered that a termination.

Additionally, on June 26, 2015, Petitioner presented to Chicago Family Health Center and reported that his employer was not allowing him to return to work without restrictions. This treatment record is dated after when Petitioner testified that he had already been fired.

Petitioner further testified that he had spoken with someone on the phone at Respondent's office about returning to work in some capacity, but he was not sure if it was Ms. Serrano or another woman. Petitioner testified that he also advised a woman at Respondent's office, who he thought was Ms. Serrano, that he had gotten hurt at work when he called off to say he was going to the emergency room.

However, Ms. Serrano testified that she did not have any discussions with Petitioner or anyone at Dart Container about him returning to light duty. Ms. Serrano also testified that she would have been notified of any work accident, but she did not find out that Petitioner was claiming a work injury until she received notice from their risk manager on June 8, 2015. In the reports Ms. Serrano then filled out on June 8, 2015, she wrote "Unknown" when asked for the date, time, and description of the incident and the nature or cause of the injury. She also wrote "N/A" when asked when and to who the accident was reported.

Ms. Serrano further testified that she did not have any discussions with Petitioner about an injury on May 12, 2015. She testified that as the on-site supervisor, she would have learned of any accident that occurred, as it would have been reported to her by either the employee or one of the leads. However, Ms. Serrano did not recall ever hearing about or having anyone tell her about an injury involving Petitioner.

Given that Ms. Serrano testified that she would have been informed of any accident, her testimony suggests that Petitioner's accident may not have occurred as described. Petitioner testified that immediately after his accident, his supervisor saw him bent over in pain and a woman who worked for Solo Cup brought him Ibuprofen. He also testified that he informed Solo Cup about his accident. However, Ms. Serrano indicated that she was in close communication with the supervisors and leads at Solo Cup, and no one knew or informed her of this accident. She also testified that the last day Petitioner worked was May 19, 2015, which further contradicts Petitioner's testimony regarding his last day worked.

In considering all the above facts, there are inconsistencies regarding: Petitioner's accident histories, the general weight of the boxes he was required to lift, the specific weight of the box he was lifting at the time of the alleged accident, if and when Petitioner worked after the accident date, if and when Petitioner was fired, if and when Petitioner spoke to Respondent about light duty accommodations, and if and when Respondent or Solo Cup was informed by Petitioner about any accident.

When considered together, these inconsistencies greatly diminish Petitioner's credibility. For that reason, I respectfully dissent from the Decision of the majority and would have found that Petitioner failed to meet his burden of proving through credible evidence that he sustained an accident that arose out of and the course of his employment on May 12, 2015.

DLS/met
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Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

20IWCC0406

ROBINSON, LAVELL
Employee/Petitioner

Case# **15WC017540**

PARAMOUNT STAFFING
Employer/Respondent

On 7/19/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

5094 SKLARE LAW GROUP LTD
MICHAEL TRYBALSKI
20 N CLARK ST SUITE 1450
CHICAGO, IL 60602

2389 GILDEA COGHLAN & REGAN LTD
JEREMY MAZZA
901W BURLINGTON AVE #500
WESTERN SPRINGS, IL 60558

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

20IWCC0406

- [ ] 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

Lavell Robinson
Employee/Petitioner

v.

Paramount Staffing
Employer/Respondent

Case # **15** WC **17540**

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 **Brian T. Cronin**, Arbitrator of the Commission, in the city of **Chicago**, on **4-24-19**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **5-12-15**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**18,700.00**; the average weekly wage was $**360.00**.

On the date of accident, Petitioner was **57** years of age, ***single*** with **1** dependent child.

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

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

Respondent shall be given a credit of $**0.00** 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

Medical benefits

Respondent shall pay Petitioner ***$121,317.34***, which is an amount equal to a total of the unpaid medical bills, for the reasonable, necessary and related medical services rendered to Petitioner, pursuant to Section 8(a) and subject to Section 8.2 of the Act.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of ***$253.00***/week from ***5-22-15*** through ***1/21/16***, which represents a period of ***35*** weeks, since he was temporarily totally disabled during this time, in accordance with Section 8(b) of the Act.

Permanent Partial Disability

Respondent shall pay Petitioner ***$253.00***/week for ***62.5*** weeks, since, as a result of the accident of 5-12-15, Petitioner has sustained a loss of use of his person as a whole to the extent of ***12.5%***, pursuant to Section 8(d)2 of the Act.

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

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

20IWCC0406

Signature of Arbitrator

7-18-19
Date

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Lavell Robinson
Employee/Petitioner

v. Case No. 15 WC 17540

Paramount Staffing
Employer/Respondent

Findings of Fact:

Petitioner Lavell Robinson testified that he was an employee of Paramount Staffing on May 12, 2015. On that date, he was working at Solo Cup Company. Petitioner testified that he believed he began working for Solo Cup in February 2015. (Tr. 8-9). He described his job duties as "assembly line work." This consisted of loading plates into boxes, taking boxes off the assembly line, and placing them on skids. Petitioner could not specify the number of boxes he moved per day as this was "different" every day. He stated that the boxes involved were different weights and testified that the heaviest could be "about 60 pounds." (Tr. 9-10).

Petitioner testified that on May 12, 2015 he was loading boxes onto skids, and recalled stacking boxes "like six high," roughly "two to three feet above the floor." When placing a box at the top, he "felt like a stabbing in [his] back." Petitioner stated that he spoke with a supervisor from Solo Cup about "his back hurting real bad." Petitioner testified that the supervisor recommended Petitioner "go into the break room and rest." (Tr. 11-12).

When asked to provide further specifics regarding the incident, Petitioner stated that he could not recall how much the box he was lifting weighed. After the incident, Petitioner went into the break room to "wait until it was time for me to go home." He testified that he was laying on the bench in the break room, trying to stop his back from hurting. A lady came into the break room and gave him two (2) Ibuprofens. (Tr. 13-14).

Petitioner stated that he did not want to complain because he didn't want to be fired. He did decide to go to the ER on May 22, 2015. Petitioner initially testified that he was not working his normal duties between May 12, 2015 and May 22, 2015, and then stated that he was not working at all, in any capacity, during that time. (Tr. 14-15). On cross-examination, Petitioner states that he was still working for Paramount Staffing after the injury date. When pressed, he was unable to recall the last date that he worked but believed that it was May 22, 2015. (Tr. 26-27).

Petitioner initially sought treatment at the Emergency Department of Advocate Trinity Hospital at 1:52 a.m. on May 22, 2015. Nurse Patterson noted that the reason for the visit was "Chest pain; Back pain; pt sts back pain." Petitioner reported to Dr. Plamoottil: "back pain for a

few days. no tryuama. (sic) no work up dome (sic) in past. midl (sic) heavy lifting." Dr. Plamoottil then recorded the following **History of Present Illness**:

> "The patient presents with back pain and lumbar pain. The onset was 1 weeks (sic) ago. The course/duration of symptoms is constant. Type of injury: lifting and turning. Radiating pain: none. The character of symptoms is sharp. The degree at onset was moderate. The exacerbating factor is movement. Prior episodes: none. Therapy today: none. Associated symptoms: none. Additional history: none." (PX 1, pp. 15-16)

Upon examining Petitioner, Dr. Plamoottil found decreased range of motion of the back. Lumbar: diffuse, vertebral point tenderness, Sacral: Diffuse. With regard to the musculoskeletal system, the doctor found a normal range of motion and normal strength. He also found no focal neurological deficit observed. (PX 1, p. 17)

An ECG was done. Dr. Vyas interpreted it as showing "Sinus rhythm with premature atrial complexes." (PX 1, pp. 9-10)

A CT of the lumbar spine without contrast showed degenerative spondylosis at L5-S1 and suggestion of broad-based central disc protrusion with no evidence of significant concentric stenoses. There was also mild degenerative spondylosis at L3-4 and L4-5. (PX 1, p. 51)

Dr. Plamoottil diagnosed Petitioner with complaint of back pain, and degenerative joint disease of the lumbar spine. He prescribed Tylenol #3 with codeine, agave him materials on back injury prevention, and instructed him to follow up in 1-2 days with Access Brandon Family Health Center. (PX 1, p. 18) An off-work slip dated May 22, 2015 was completed. (PX 1, p. 58B)

Petitioner testified that when he went to the ER, he had an MRI of the back and was told that he had a "bulge spleen" and that his "spleen had almost like came loose." He recalled receiving Tramadol and was told to follow up with his Primary Care Physician. Petitioner testified that he was told not to go back to work until after he saw the primary doctor. (Tr. 15-16). (PX 1)

Petitioner also testified that he called his employer on the date of his ER visit to state that he could not work because he was at the hospital. He also testified that he told the medical providers at Advocate Trinity Hospital that he had hurt himself while working. (Tr. 27).

On May 28, 2015, Petitioner presented to Chicago Family Health Center for "back pain and chronic conditions." In the History of Present Illness, it states, in pertinent part, the following:

"The symptoms began 1 week ago and generally lasts varies (sic). The symptoms are reported as being moderate. The symptoms occur constantly. The location is lower back (bilaterally). Aggravating factors include bending, twisting. Relieving factors include Tylenol with codeine.

Spondylosis from L3-L4 and L5-S1, chronic pancreatitis, atherosclerosis of abdominal aorta and iliac vessels, degenerative change right S1 joint noted on CT of lumbar spine w/o contrast. Pt. reports taking meds (Tylenol w/codeine ordered by ER MD."

The chart note also states that his chronic conditions included hyperlipidemia, hypertension, chronic pancreatitis, and uncontrolled diabetes. The assessment was bulging lumbar disc. Petitioner was directed to avoid lifting greater than 10 pounds and was advised to use a back-support brace. He might be a candidate for a muscle relaxant following check of Petitioner's renal function. The notes also indicated that Petitioner might require a follow-up appointment with a cardiologist for atypical chest pain. (PX 3).

A work-status note from Chicago Family Health Center on May 28, 2015 indicated that Petitioner should be excused for two days and return to work on June 1, 2015 with no lifting greater than 10 pounds. (Id).

Petitioner testified that his primary care doctor told him he could try to return to work, but not to lift more than 15 pounds. (Tr. 17). He also testified that he had informed the providers at Chicago Family Health Center that he had been injured at work. (Tr. 28).

Petitioner testified that he had discussions with his employer about light-duty work but was told that the employer could not accommodate the restrictions. (Tr. 17). On cross-examination, Petitioner testified that he did not know with whom he spoke at the employer about returning to work. He testified that he had advised someone at Paramount Staffing that he had gotten hurt at work. Again, Petitioner could not identify the individual he spoke with, and only stated that it was "the lady I talked to on the phone." (Tr. 35).

Petitioner testified that he was aware of the fact that he was terminated from his employment as of May 28, 2015. (Tr. 31).

Petitioner testified that he signed an Application for Adjustment of Claim on June 3, 2015. He agreed that he had met with his attorney prior to that date. (Tr. 29-30).

On June 4, 2015, Petitioner was seen by Dr. Goldvekht of Advanced Physical Medicine. Petitioner advised the M.D. that he was working on an assembly line on May 12, 2015 when he felt severe pain in the lower back. Petitioner stated that bending, lifting, carrying, pushing, and pulling aggravated his pain. He was unable to sit for long periods of time due to discomfort. The exam revealed moderately decreased ROM with bilateral flexion and extension. Petitioner exhibited severe spasms at the end range. Dr. Goldvekht also noted tender trigger points at the lower paraspinal muscles and in the gluteus maximus. SLR testing was negative. Assessment was lumbar facet syndrome. Petitioner received Mobic and Flexeril, and a prescription for physical therapy. (PX 5).

Petitioner commenced physical therapy with Advanced Physical Medicine Centers on June 9, 2015. He presented with traumatic soft tissue injuries, with loss of function, ROM, strength, and muscle tone, and associated poor endurance. Petitioner was directed to begin therapy 2-3 times per week. (Id).

Petitioner returned to Chicago Family Health Center on June 15, 2015. He noted ongoing pain in the bilateral lower back. Exam revealed tenderness, muscle spasms, and moderate pain with ROM testing. Petitioner received a script for a muscle relaxant, and a referral to the Pain Clinic for ongoing pain management. Other issues included elevated sugar levels (diabetes), and a urinary tract infection. Petitioner was also directed to undergo a cardiac stress test. (PX 3).

Petitioner followed up with Chicago Family Health Center on June 26, 2015. He reported mild-to-moderate symptoms in the lower back that is aggravated by bending and lifting. His symptoms had improved somewhat from the last visit. Petitioner testified that his employer was not allowing him to return to work without restrictions at this time. He was considering quitting and filing a lawsuit against his employer. Petitioner was advised to continue medications, physical therapy, and use of a back brace. His work restrictions included no lifting greater than 10-15 pounds. (Id).

On July 2, 2015, Petitioner returned to Dr. Goldvekht and reported severe pain in the lower back. Dr. Goldvekht recommended continuing the medication and physical therapy. He also ordered an MRI of the lower back to rule out disc pathology. (PX 5).

Petitioner underwent an MRI of the lumbar spine on July 13, 2015 at Archer Open MRI. The scan showed lumbar spondylosis with disc bulging contributing to neural foraminal narrowing at multiple levels. There was also grade I retrolisthesis of L5 on S1. (PX 10).

On July 16, 2015, Petitioner followed up with Dr. Goldvekht. Following review of the MRI, Dr. Goldvekht recommended continued therapy and a referral to interventional pain management. (PX 5).

Petitioner commenced treatment with Dr. Jain of Pinnacle Pain Management on July 20, 2015. He reported an injury on May 12, 2015 when working on an assembly line packing and loading boxes onto a skid. Petitioner believed the boxes were "quite heavy," but then stated they were "probably between 15 and 25 pounds." Petitioner felt therapy had been somewhat beneficial, but he continued to have a substantial amount of lower back pain. The symptoms were worse with prolonged sitting, walking, or bending. However, his pain was somewhat alleviated with lifting. Exam revealed lumbar axial pain, with pain to palpation along the paraspinal muscles. There were no motor or sensory deficits. Petitioner exhibited a negative SLR test, with some hamstring tightness on the left. MRI showed a 2 mm neuroforaminal disc bulge at L3-4, with a 2 mm annular disc bulge at L4-5, and a 3 mm broad-based annular disc bulge at L5-S1. There was neuroforaminal narrowing at all levels. As Petitioner did not exhibit any substantial radicular symptoms, recommendations included bilateral L4-5 and L5-S1 facet joint injections. He was directed to continue with physical therapy and use Flexeril and Tramadol. Dr. Jain advised Petitioner to remain off work. (PX 12).

During his testimony, Petitioner stated that he did not recall telling Dr. Jain about the weight he was required to lift as part of his job. He noted that he had no reason to dispute that the records of Dr. Jain reflected lifting between 15 and 25 pounds. Petitioner then testified that the boxes he was required to lift could weigh between 50 and 60 pounds. (Tr. 31-32).

He next returned to Dr. Goldvekht on August 13, 2015 and reported that he was "waiting to undergo a procedure." Petitioner could continue with therapy and medications. He was advised to follow up with pain management. (PX 5).

Petitioner followed up with Dr. Jain on August 17, 2015. He reported low back pain with shooting symptoms down the backs of his legs, accompanied by tingling. These symptoms occurred when he did any walking or bending over. Dr. Jain continued to recommend medications and bilateral facet injections. Petitioner was advised to remain off work. (PX 12).

On September 28, 2015, Petitioner underwent bilateral L4-5 and L5-S1 facet joint injections. Post-operative diagnoses were lumbar facet syndrome, lumbar discogenic pain, and lumbosacral radiculopathy. (Id).

Petitioner returned to Dr. Jain on October 5, 2015 and reported excellent results from the injections. He felt 70% overall pain relief following the procedures. His medications significantly alleviated his pain with no side effects. Petitioner also reported benefit from physical therapy. SLR testing on this date was positive for bilateral hamstring tightness. Dr. Jain recommended repeat bilateral facet joint injections. Petitioner could continue with therapy and remain off work. (Id).

On October 19, 2015, Petitioner underwent bilateral L4-5 and L5-S1 facet joint injections to address lumbar discogenic pain, lumbar facet syndrome, and lumbosacral radiculopathy. (Id).

Petitioner next followed up with Dr. Jain on October 26, 2015. He reported 100% improvement with almost complete resolution of his symptoms for seven days. However, his symptoms had returned. The complaints included bilateral axial pain, increased with activities. Petitioner continued to participate in physical therapy, which he felt was helping. Petitioner was also using a lumbar support and a TENS unit. He stated that he did not feel that he would be able to resume activities based on his current symptoms with bending or lifting. Impression was facet-mediated pain which limited his ability to return to vocational activities. Dr. Jain recommended lumbar medial branch blocks and radiofrequency ablation. Petitioner could continue with physical therapy and medications and remain off work. (Id).

On November 9, 2015, Petitioner underwent bilateral L3-5 medial branch nerve blocks, and facet blocks from L3-S1. Post-operative diagnoses included lumbar discogenic pain, lumbar facet syndrome, and lumbosacral radiculopathy. (Id).

Petitioner received repeat medial branch nerve blocks and facet blocks on November 23, 2015 with Dr. Jain. (Id).

He followed up with Dr. Jain on November 30, 2015 and noted 100% pain relief from the blocks which had continued until the previous day. Petitioner reported that he had been unable to attend PT during the past month because it had been inconvenient for him. After examining Petitioner, Dr. Jain's impression was lumbar facet syndrome. Recommendations included radiofrequency ablation. Dr. Jain stated he would begin on the left side and proceed to the right side. Petitioner could continue with physical therapy and medications and remain off work. (Id).

Petitioner's last visit to Dr. Jain took place on January 11, 2016. He had not undergone the recommended ablation procedures due to lack of approval. Petitioner continued to report lower lumbar pain with numbness and tingling to the bilateral posterior thighs. He had persistent palpable tenderness on the paraspinal and paravertebral muscles of the lower lumbar region. SLR was negative bilaterally. There were no spasms during this exam. Dr. Jain continued to recommend ablation, PT, and medications. Petitioner was advised to remain off work. (Id).

Physical therapy notes from Advanced Physical Medicine indicate Petitioner regularly attended sessions from June 9, 2015 through January 19, 2016. (PX 5).

Petitioner saw Dr. Goldvekht on January 21, 2016. Petitioner felt physical therapy had helped tremendously and reported that he was no longer experiencing pain and/or discomfort in the lower back. Bending, lifting, carrying, pushing, and pulling no longer aggravated his pain. Petitioner's ROM was within full limits. He no longer experienced tender trigger points. Petitioner could use medication when experiencing flare-ups. He could discontinue therapy and had reached MMI. (Id).

Petitioner testified that he was not released to return to work full duty at any point. He stated that his doctors told him not to return to work after he completed treatment. Petitioner testified that he was currently on Social Security Disability. (Tr. 20-21). He noted that he continues to experience back pain that "comes and goes." His present symptoms were localized in the lower back and down the left leg. Petitioner's pain affected his daily activities - he had difficulty standing and cooking because he needed to sit down. He felt unable to "get comfortable." Petitioner testified that occasionally, his "feet just start flapping" when he walks. (Tr. 23-25).

On cross-examination, Petitioner reiterated that his doctors did not return him to full duty work. He agreed that Dr. Goldvekht had released him from care in January 2016, however Petitioner went to another provider who told him he could not work. Petitioner did not identify this provider and did not provide records after he was released on January 21, 2016. (Tr. 32-34).

Petitioner also testified that he pursued medical treatment from mid-May 2015 through mid-January 2016, which is a period of 35 weeks. He stated that he was unaware of the amount his providers charged for his treatment during this period. (Tr. 32-33).

Petitioner presented evidence showing that his various medical providers charged in excess of $121,000.00 for the treatment he received in connection with this claim. (*See* PX list).

On February 16, 2017, Petitioner underwent a Section 12 examination with Dr. Alexander Ghanayem at Loyola University Medical Center. Petitioner reported that he was lifting boxes on May 12, 2015 when he twisted and injured his back. He noted that there was not a specific event that caused the symptoms. Petitioner could not recall the size of the box he was lifting and had no details about the specifics of the lifting activities or the frequency of the twisting involved. He reported back pain at the lumbar base with referral to the top of his left thigh. Dr. Ghanayem noted that Petitioner's exam revealed tenderness throughout the base of the lumbar spine, and tenderness with light palpation. Petitioner also had low back pain with axial

compression of the head, truncal rotation through the knees, and distraction through the shoulders. The lower extremity neurologic exam revealed no focal motor or sensory deficits. Dr. Ghanayem reviewed Petitioner's lumbar MRI and interpreted age-appropriate degenerative changes. There were no traumatic or nerve compressive lesions. Dr. Ghanayem also stated that it appeared there was no mention of a work injury for three to four weeks after the occurrence. In the report, Dr. Ghanayem noted that Petitioner's reported back injury was vague and reiterated the significant delay in reporting. He diagnosed Petitioner with subjective complaints of muscular back pain. Dr. Ghanayem stated that if Petitioner had sustained an injury, it would be a back sprain. An appropriate course of treatment for a back sprain would be a 3-4 week course of physical therapy. Petitioner could return to work on a full-duty basis and had reached MMI. (RX 2).

The parties took the deposition testimony of Dr. Alexander Ghanayem on January 9, 2019. Dr. Ghanayem is the Chairman of the Department of Orthopedic Surgery at Loyola University Medical Center. He also serves as the director of the division of spine surgery, and is a professor in the School of Medicine, both in orthopedic surgery and neurosurgery. In addition to these duties, Dr. Ghanayem confirmed that he continues to treat spinal patients. Dr. Ghanayem testified that Petitioner had been unable to identify a specific event that caused Petitioner's lower back pain. Petitioner related a history of treatment, which included physical therapy, chiropractic care, and a number of injections. Dr. Ghanayem related the results of his physical examination, detailing the fact that the exam revealed multiple positive Waddell's signs, consistent with symptom magnification. The objective testing conducted was normal. Dr. Ghanayem's review of Petitioner's MRI films revealed no traumatic or compressive findings, and age-appropriate degenerative changes. He confirmed a diagnosis of subjective muscular back pain and stated that an appropriate treatment plan for this condition would be a 3-4 week course of therapy. Dr. Ghanayem testified that Petitioner could return to work on a full-duty basis and opined Petitioner had reached MMI as of the date of his Section 12 exam on February 16, 2017. (RX 1)

At trial, Respondent presented testimony from Ms. Lucy Serrano. Ms. Serrano identified her position as an on-site supervisor with Paramount Staffing. Her duties include supervising "leads" under her (3), training employees/hires, communicating with clients, and drafting termination forms/accident reports/write-ups. She stated that she works on-site at the client location, specifically at Dart Container, formerly called Solo Cup. (Tr. 37-38). In further discussion of her job responsibilities, Ms. Serrano testified that she follows up with employees on the production floor and communicates with leads of departments and their supervisors. She stated that she is in constant contact with all parties at the client location, including her own (Paramount) employees. (Tr. 39-40).

Ms. Serrano further testified that she had a vague recollection of Petitioner; he worked the third shift and Ms. Serrano worked in the morning. She did not have much direct interaction with Petitioner. Ms. Serrano noted that Petitioner began working for the Respondent on February 2, 2015. She testified that she did not have any discussions with Petitioner regarding an injury on May 12, 2015. (Tr. 40-41).

After hearing Petitioner's testimony regarding his job duties, Ms. Serrano stated that she takes issue with Petitioner's statements about the weights of boxes he manipulated/lifted. She stated that there was no box in the paper plates department that weighs as much as 60 pounds. Ms. Serrano indicated that she was aware of the weights of the boxes because she has weighed them. She also noted that in other departments at this client site, an employee is not allowed to - lift over 50 pounds by himself - - he must get help." (Tr. 41-42).

Ms. Serrano testified that as the on-site supervisor, if there was an injury, either one of the employees or one of her leads would have told her about it. She would have learned of any work accident suffered by any of her employees. She did not recall hearing or having anyone from Dart tell her about an injury to Petitioner. (Tr. 42-43).

Ms. Serrano testified that she has reviewed Petitioner's file and notes that his last day of work was on May 19, 2015. She testified that she did not speak with Petitioner about returning to work either on a light-duty or a full-duty basis. Ms. Serrano stated that either she, or one of her leads, would have been the contact person with regard to return-to-work options. She did not have any discussion with Petitioner, any of her leads, or anyone with Dart about Petitioner's return to work. (Tr. 43-44).

Ms. Serrano also provided testimony about the process involved in investigating a claim. She stated that typically the process will include asking an employee questions, having him or her to write a statement, and following up with the department to determine whether there were any witnesses to the incident. Once Respondent has all of the information, if the employee feels he or she needs immediate medical attention, they send him or her to their clinic and have him follow up with a doctor. Ms. Serrano stated that she first received notice of an alleged work injury on June 8, 2015. The notice came from Respondent's risk manager. After she received notice of an alleged accident, Ms. Serrano completed a First Report of Injury on June 8, 2015. (Tr. 45-46). Both Petitioner and Respondent presented a copy of the First Report of Injury as an exhibit. (*See* PX 19, RX 3).

In completing her investigation, Ms. Serrano testified that she spoke with Violeta, a third-shift lead, about Petitioner. Ms. Serrano testified that Violeta was not aware of a work injury and that Violeta had not received a report that Petitioner had been injured at work. Ms. Serrano also testified that she spoke with individuals at Dart and testified that they did not report anything about a work injury to Petitioner. (Tr. 46-48).

On cross-examination, Ms. Serrano testified that she worked mornings and Petitioner worked on the third shift. Ms. Serrano started work at 6:30 a.m., and the third shift finished work at 7:00 a.m. So, there was a ½ hour overlap. In 2015, she supervised roughly 80-100 employees at this location. (Tr. 49). She confirmed that in May 2015, Jim Muffitt was the third shift supervisor for Dart and that Violeta was the third shift supervisor for Paramount Staffing. Violeta did not provide Ms. Serrano with any written account of an injury or an alleged injury. Ms. Serrano confirmed that Petitioner had engaged in discussions with Violeta after May 19, 2015 about returning to work. Violeta had inquired when Petitioner planned to return to work, because he had missed time. Violeta did not complete any paperwork because Petitioner had not reported an injury. (Tr. 52-54).

On redirect examination, Ms. Serrano testified that hypothetically, if Violeta, or whoever was the lead on that shift, was told about a work accident, that person would complete the accident report and Ms. Serrano would follow up with a risk manager or the risk management team on-site. If the accident was reported to Jim Muffitt, it would come to Ms. Serrano and she would write the report. In the case of Petitioner, nothing happened because nothing was reported. (Tr. 54-55).

Conclusions of Law:

In support of his decision with regard to issue (C) "Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?", the Arbitrator finds as follows:

The Arbitrator finds, by a mere preponderance of the evidence, that Petitioner has met his burden of proof that on May 12, 2015, he sustained an accident that arose out of and in the course of his employment by Respondent.

The Arbitrator recognizes that there are some inconsistencies in Petitioner's accident histories.

Petitioner testified that he provided his Primary Care Physician at Chicago Family Health Center with a description of his accident at his May 28, 2015 visit. The Arbitrator notes that the records from this visit to Chicago Family Health Center do not include any reference to a work injury, or of any injury, for that matter. The May 28, 2015 records do refer to back pain and chronic conditions.

Petitioner testified that he was aware that his employment with Respondent was terminated on May 28, 2015.

Petitioner testified that he signed his Application for Adjustment of Claim on June 3, 2015. He agreed that he had met with his attorney prior to that date. (Tr. 29-30).

The day after signing his Application, Petitioner commenced treatment with Dr. Goldvekht of Advanced Physical Medicine. Dr. Goldvekht's initial treating record includes the first detailed description of Petitioner's May 12, 2015 injury, and the for the first time, mentions that it was work-related. In his Section 12 report, Dr. Ghanayem referred to the "significant delay" in the reporting of a low back injury and testified that the first mention of a work injury occurred several weeks after the alleged incident.

Ms. Lucy Serrano testified that Petitioner never spoke with her about a work injury, and that she never received any report from any of her leads, or from any of the employees of Solo Cup/Dart regarding a work injury. Her investigation was not triggered until June 8, 2015, following Petitioner's completion of the Application for Adjustment of Claim, and receipt by the risk manager of Paramount Staffing. Ms. Serrano confirmed that Violeta, a third shift lead, had

spoken with Petitioner about his work status, but stated that neither Violeta, nor anyone at Solo Cup/Dart, reported having discussions with Petitioner about a work injury.

Petitioner testified on several occasions that none of his medical providers had released him to return to work on a full-duty basis. However, the medical evidence presented by Petitioner clearly shows that Petitioner received a full-duty work release from Dr. Goldvehkt, effective January 22, 2016. Additionally, Petitioner initially testified that he had not returned to work for the Respondent between May 12, 2015 and May 22, 2015, which was his initial medical treatment at the ER.

During cross-examination, Petitioner testified he had continued working for the Respondent after May 12, 2015 and advised that his last day worked was May 22, 2015, which was the date of his initial medical treatment. Ms. Serrano testified that Petitioner's last day of work was actually May 19, 2015.

Additionally, the Arbitrator notes that Petitioner, on two occasions, testified that his job duties required him to lift boxes that weighed up to 60 pounds. Ms. Serrano testified that there were no boxes in the plates department that weighed 60 pounds and confirmed that she was aware of this information because she had weighed the boxes. The Arbitrator also notes that the medical records of Dr. Jain include a reference to Petitioner lifting weights significantly less than 50-60 pounds. But when pressed as to the accuracy of Dr. Jain's record, Petitioner again stated the requirement to lift 50-60 pound weights.

Notwithstanding evidence to the contrary, the Arbitrator finds for Petitioner on the issue of accident.

Respondent is not disputing the issue of notice.

At trial, Petitioner testified that he was loading boxes onto skids on May 12, 2015 when he felt a stabbing pain in his back. Petitioner testified that he spoke with a supervisor about his back pain and said that his back is "hurting real bad." Petitioner was directed to rest in the break room and proceeded to the break room. While in the break room, a female employee of Solo Cup/Dart brought him two tablets of Ibuprofen. Petitioner failed to identify this female employee by name.

Petitioner testified that he did not report any injury to Paramount Staffing for fear of being terminated. He then testified that he later advised an unnamed woman from Paramount Staffing by telephone on the day that he called off and told her that he needed to go to the Emergency Room.

Petitioner's employment was terminated on May 28, 2015.

At 1:52 a.m. on May 22, 2015, which was ten days after the alleged accident, Petitioner first sought treatment. Nurse Patterson of Advocate Trinity Hospital noted that the reason for the visit was "Chest pain; Back pain; pt sts back pain." Then, Dr. Plamoottil of Advocate Trinity

Hospital wrote: "back pain for a few days. no tryuama. (sic) no work up dome (sic) in past. midl (sic) heavy lifting." Dr. Plamoottil then recorded the following **History of Present Illness**:

> "The patient presents with back pain and lumbar pain. The onset was 1 weeks (sic) ago. The course/duration of symptoms is constant. Type of injury: lifting and turning. Radiating pain: none. The character of symptoms is sharp. The degree at onset was moderate. The exacerbating factor is movement. Prior episodes: none. Therapy today: none. Associated symptoms: none. Additional history: none." (PX 1, pp. 15-16)

The Arbitrator notes that Dr. Plamoottil was likely attempting to record "no trauma." However, the Arbitrator places great weight on the entry: "Type of injury: lifting and turning."

It is clear that in his capacity as an assembly line worker for Respondent, Petitioner was required to load plates into boxes, lift the boxes off the assembly line, and stack the boxes on pallets.

There is no evidence that Petitioner was engaged in lifting and turning activities outside of his work for Respondent for the date in question.

In support of his decision with regard to issue (F) "Is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds as follows:

The Arbitrator incorporates the above-referenced findings of fact and conclusions of laws as is fully restated herein.

The Arbitrator finds that Petitioner's current condition of ill-being is causally related to the accident of May 12, 2015. In holding so, the Arbitrator relies on the various medical records and testimony offered by Petitioner at trial.

Petitioner testified that he began having low back pain following the May 12, 2015 accident. Petitioner specifically denied having any condition of ill-being present in his low back prior to May 12, 2015. Petitioner further denied having sought medical treatment for his low back prior to May 12, 2015. This testimony is supported by the corresponding medical records

When Petitioner first presented for medical treatment at Advocate Trinity Hospital ED on May 22, 2015, it was noted that his symptoms had begun one week earlier and that as far as prior episodes were concerned there were "none." (PX 1, p. 16)

Additionally, Dr. Goldvehkt's records make no mention of prior complaints of, or treatment for, low back pain. (PX 5) Also, Dr. Jain's wrote: "the patient notes that prior to this injury, he has not had any substantial pain." (PX 12, p. 4)

Similarly, the report prepared by the Archer Open MRI staff on July 13, 2015 notes the non-availability of any prior lumbar spine imaging for use as a comparison. (PX 10, p. 4)

Respondent presented no medical records that indicate Petitioner had a history of low back pain or other symptoms prior to May 12, 2015. Similarly, no evidence was produced as to medical treatment rendered to Petitioner's low back before May 12, 2015. No evidence was produced that Petitioner has ever filed a workers' compensation or personal injury claim for his low back.

The record further establishes that Petitioner worked in this capacity for Respondent for approximately three months prior to the accident. Respondent offered no evidence that Petitioner was ever physically unable to perform the duties of that job prior to May 12, 2015.

Furthermore, Respondent's Section 12 physician, Dr. Alexander Ghanayem, testified "No, no, no, no, no, no" when asked whether he was suggesting that a back injury may have predated May 12, 2015. (RX 1, p. 14) Worth noting here is the fact that Dr. Ghanayem never definitively opined that Petitioner did not experience a low back injury on May 12, 2015. Rather, Dr. Ghanayem testified as to his uncertainty on the matter, stating "I'm not sure if he had a back injury or not." (RX 1, p. 14) Dr. Ghanayem also testified; "I don't recall seeing any back pain records that predated [the May 12th, 2015 incident]." (RX 1, p. 15)

Petitioner's treating physician, Dr. Neeraj Jain repeatedly recorded in his records the following: "It is my opinion that the patient's symptoms for which he is being seen today are directly related to the injury" and that this opinion was "based on the patient's history, physical exam, imaging studies, and medical records." (PX 12, pp. 5, 13, 22, 31, 43, 50)

In support of his decision with regard to issue (J) "Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?", the Arbitrator finds as follows:

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

The Arbitrator finds that all of the medical treatment, as laid out in Petitioner's Exhibits 1-17, was causally related, reasonable, and necessary in the successful treatment of the injuries that resulted from the May 12, 2015 accident. The Arbitrator further finds that Respondent is liable for, and has yet to satisfy, those charges incurred by Petitioner in the reasonable and necessary medical treatment of his injuries. As such, Respondent is responsible for payment of the outstanding bills that total $121,317.34, which are outlined in Petitioner's Exhibits 2, 4, 6, 7, 9, 11, 13, 15 & 17 and are summarized in Arbitrator's Exhibit 1, Section 7.

In so finding, the Arbitrator relies on the records of Petitioner's treating doctor – Dr. Neeraj Jain – who stated numerous times throughout his reports that "it is my opinion that the treatment rendered thus far has been reasonable and of necessary frequency and duration. These

opinions are stated to a reasonable medical probability. These opinions are based on patient's history, physical exam, imaging studies, and medical record ..." (PX 12, pp. 5, 13, 22, 31, 43 50)

Respondent's Section 12 physician, Dr. Alexander Ghanayem, opined that "A 3 to 4-week course of physical therapy would be medically reasonable for [a back sprain] and anything else would be unreasonable and unnecessary relative to an alleged work injury" (RX. 1, pp. 1-2).

The Arbitrator is not persuaded by the opinions of Dr. Alexander Ghanayem for a number of reasons, and as such, gives them less weight than he does to the opinions of the treating physicians.

The Arbitrator notes first the limited extent and duration of Dr. Ghanayem's examination and medical record review. During his deposition, Dr. Ghanayem was unable to recall how long he had spent face to face with Petitioner and explained: "This is a quick exam ... a couple of minutes." (RX 1, p. 12) Dr. Ghanayem exclaimed to both counsel at that deposition, "I can teach both of you how to do a spine exam. I can teach you how to do it in ten minutes" (Rx. 1, p. 12) Petitioner testified that Dr. Ghanayem spent maybe two minutes with him.

The Arbitrator notes that there is reason to question whether Dr. Ghanayem reviewed all of the relevant medical records prior to rendering his opinion on this case. Dr. Ghanayem's Section 12 report, dated February 16, 2017, did not contain an accounting of the medical records/materials he reviewed. Dr. Ghanayem did not have an accounting of such available to him at the deposition on January 9, 2019. Dr. Ghanayem was similarly unable to provide any independent recollection as to what records were provided by Respondent.

When asked, Dr. Ghanayem could not offer any details or testimony as to the earliest date of treatment for which he reviewed medical records. Lastly, the Arbitrator finds it noteworthy that Dr. Ghanayem's examination took place more than two years after the accident and more than one year after all medical treatment had concluded.

Based on the above, the Arbitrator finds that Petitioner has met his burden of proof with respect to this issue. Respondent shall satisfy the $121,317.34 in outstanding medical charges, pursuant to Section 8(a) and subject to Section 8.2 of the Act.

In support of his decision with regard to issue (K) "What temporary benefits are in dispute? TTD," the Arbitrator finds as follows:

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

On May 22, 2015, the Emergency Department physician at Advocate Trinity Hospital authored a prescription slip in which he took Petitioner off work. (PX 1)

On May 28, 2015, Sherie Marshall of Chicago Family Health Center authored a "To Whom It May Concern" letter in which, effective June 1, 2015, she released Petitioner to restricted work in which he is not to lift over 10 pounds. (PX 3)

Petitioner testified that he had discussions with Respondent about light-duty work but was told that they could not accommodate his restrictions. (Tr. 17).

Petitioner testified that his employment with Respondent was terminated on May 28, 2015.

Dr. Jain took Petitioner completely off work on July 20, 2015. (PX 12)

Effective January 22, 2016, Dr. Goldvehkt released Petitioner to return to full-duty work. (PX 5)

The Arbitrator finds that Petitioner is entitled to temporary total disability benefits of $253.00/week from May 22, 2015 through January 21, 2016, which represents a period of 35 weeks.

In support of his decision with regard to issue (L) "What is the nature and extent of the injury?", the Arbitrator finds as follows:

The Arbitrator incorporates the above-referenced findings of fact and conclusions of laws as is fully restated herein.

Pursuant to Section 8.1b of the Act, for accidental injuries that occur on or after September 1, 2011, the following criteria are to be used in the determination of permanent partial disability:

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

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

With regard to subsection (i) of §8.1b(b), the reported level of impairment pursuant to subsection (a), the Arbitrator notes that no permanent partial disability impairment report and/or opinion was submitted into evidence. The Arbitrator therefore shall not consider this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals Petitioner was employed as an assembly line worker for Respondent. As such, he would load disposable plates in boxes, take the boxes off the assembly line, and stack the boxes on skids. The Arbitrator therefore gives moderate weight to this factor and finds that it would result in an increase in permanency.

With regard to subsection (iii) of §8.1b(b), the age of the employee at the time of the injury, the Arbitrator notes that Petitioner was 57 years old at the time of the accident. Petitioner would be considered an older worker, and, *ceteris paribus*, would have a shorter work life expectancy than a younger worker. The Arbitrator therefore gives minor weight to this factor and finds that it would result in a slight decrease in permanency.

With regard to subsection (iv) of §8.1b(b), the employee's future earning capacity, the Arbitrator notes that no evidence was presented to indicate that Petitioner future earning capacity was affected by this accident. The Arbitrator therefore gives moderate weight to this factor and finds that it would result in a decrease in permanency.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes the following:

The Arbitrator notes that Petitioner was released from care by his treating physician, Dr. Aleksandr Goldvehkt, effective January 22, 2016. Prior to that, Petitioner had undergone four rounds of injection treatment, completed numerous weeks of physical therapy, received prescription medication, and used a back brace and TENS unit. Petitioner was found unable to return to full-duty work for 35 weeks post-accident.

Additionally, the Arbitrator notes that CT imaging of Petitioner's lumbar spine obtained on May 22, 2015 revealed mild disc bulges at L3-L4 and L4-L5, as well as the suggestion of broad-based central disc protrusion at L5-S1.

Furthermore, during his final examination of Petitioner on January 11, 2016, Dr. Neeraj Jain noted the presence of a radiating pain, which Petitioner rated as a 6/10 on the pain scale. Petitioner, during that final examination, also stated that he continued to take pain medication, experienced a lack of improvement from physical therapy, and used a lumbar support brace and a TENS unit.

The Arbitrator therefore gives major weight to this factor and finds that it would result in a decrease in permanency.

Determination of permanent partial disability ("PPD") is not simply a calculation but is an evaluation of the five factors. The Arbitrator has carefully considered all five factors. By applying §8.1b and by considering the relevance and weight of all five factors, the Arbitrator

finds that as a result of the May 12, 2015 accident, Petitioner has sustained a permanent loss of use of his person as a whole to the extent of 12.5%, pursuant to Section 8(d)2 of the Act.

Brian T. Cronin
Arbitrator

7-18-19
Date

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Dennis Clark,

Petitioner,

20IWCC0407

vs.

NO: 17 WC 13036

Eastern Township of Franklin County, Illinois,

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 24, 2019, is hereby affirmed and adopted.

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

20 IWCC0407

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

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

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

DATED: JUL 17 2020
O7/9/20
DLS/rm
046

Deborah L. Simpson

Barbara N. Flores

Marc Parker

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

20IWCC0407

CLARK, DENNIS
Employee/Petitioner

Case# **17WC013036**

EASTERN TOWNSHIP OF FRANKLIN CO ILLINOIS
Employer/Respondent

On 9/24/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.86% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0246 HANAGAN & McGOVERN PC
STEVEN F HANAGAN
123 S 10TH ST SUITE 601
MOUNT VERNON, IL 62864

3150 LAW OFFICE OF JAMES M KELLY
PAUL DYKSTRA
7817 N KBOXVILLE AVE
PEORIA, IL 61614

20IWCC0407

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)

Dennis Clark
Employee/Petitioner

Case # 17 WC 13036

v.

Consolidated cases: n/a

Eastern Township of Franklin Co. Illinois
Employer/Respondent

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

DISPUTED ISSUES

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

FINDINGS

20IWCC0407

On the date of accident, December 9, 2016, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $49,186.96; the average weekly wage was $943.98.

On the date of accident, Petitioner was 44 years of age, married with 4 dependent child(ren).

Respondent has not paid all reasonable and necessary charges for all reasonable and necessary medical services. The parties stipulated that all medical incurred to date had or would be paid.

Respondent shall be given a credit of $86,846.16 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $86,846.16. The parties stipulated TTD was owed through the date of trial.

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 19, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

Respondent shall authorize and pay for prospective medical treatment including, but not limited to, the two level cervical disc replacement surgery recommended by Dr. Matthew Gornet.

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)

September 16, 2019
Date

SEP 24 2019

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged he sustained an accidental injury arising out of and in the course of his employment by Respondent on December 9, 2016. According to the Application, Petitioner was "Struck by falling tree" and sustained "Multiple" injuries (Arbitrator's Exhibit 2). This case was tried in a 19(b) proceeding and Petitioner sought an order for payment of prospective medical treatment, specifically, a two level cervical disc surgery recommended by Dr. Matthew Gornet, an orthopedic surgeon. Petitioner and Respondent stipulated Petitioner sustained a work-related accident, all medical incurred to date had or would be paid and Petitioner was entitled to ongoing temporary total disability benefits. Respondent disputed liability for the prospective medical treatment sought by Petitioner on the basis of causal relationship and the reasonableness/necessity of the medical treatment being sought (Arbitrator's Exhibit 1).

Petitioner worked for two employers. Petitioner was employed as a tree trimmer by the Oil Field Electric Company. Petitioner was also employed by Respondent as the Road Commissioner. Petitioner's job duties for Respondent included cleaning right of ways, maintaining easements, tree trimming, etc. On December 9, 2016, Petitioner sustained an accident while he was in the process of trimming a large tree. Petitioner estimated the tree was three feet in diameter at its base. As Petitioner was in the process of cutting down the tree, it fell on him striking him in the right shoulder and causing him to fall to the ground.

Petitioner sustained very serious injuries as a result of the accident and was initially airlifted to Deaconess Hospital in Evansville, Indiana. At Deaconess Hospital, Petitioner was diagnosed as having sustained open, displaced and comminuted fractures of the right tibia and fibula, a fracture of the right clavicle, fractures of seven ribs on the right side, multiple fractures of thoracic spine transverse processes, a collapsed lung on the right and a laceration to the right kidney (Petitioner's Exhibit 1).

Petitioner has received extensive medical treatment, undergone multiple surgeries for his right clavicular fracture, right lower leg fracture and right shoulder injury. Petitioner also underwent a surgical removal of his right kidney. Respondent did not dispute its liability for any of the preceding medical treatment provided to Petitioner so the Arbitrator does not see the need to summarize/abstract the medical regarding those injuries and will focus solely on the cervical spine injury and the medical treatment recommended.

At the direction of Respondent's nurse case manager, Petitioner was seen and treated by Dr. George Paletta, an orthopedic surgeon, and Dr. Matthew Gornet, an orthopedic surgeon, for his right shoulder and neck injuries, respectively. As previously noted, Dr. Gornet has recommended Petitioner undergo a two level cervical disc replacement surgery and this is the primary disputed issue in this case at this time.

Dr. Gornet initially evaluated Petitioner on September 11, 2017. At that time, Petitioner advised Dr. Gornet of the accident of December 9, 2016, and the medical treatment he received thereafter. In regard to his neck, Petitioner complained of neck pain at the base with burning in both trapezius/shoulders as well as tingling/parasthesias down both arms. Petitioner also

complained of low back pain. Dr. Gornet reviewed an MRI scan that was previously performed and opined it was of moderate/poor quality, but revealed potential annular tears at C5-C6 and C6-C7. Dr. Gornet ordered another MRI scan (Petitioner's Exhibit 16).

The MRI ordered by Dr. Gornet was performed on September 11, 2017, and Dr. Gornet opined it revealed annular tears at C5-C6 and C6-C7, and possibly also at C4-C5. He also noted it was suggestive of foraminal herniations at C3-C4 on both the left and right sides. Dr. Gornet opined Petitioner had disc injuries at C5-C6 and C6-C7 and referred Petitioner to Dr. Helen Blake for injections at those levels (Petitioner's Exhibit 16).

Dr. Gornet again saw Petitioner on November 13, 2017, primarily for mid and low back pain. He reviewed MRI scans of the thoracic and lumbar spine. He opined the MRI of the thoracic spine revealed herniations at T6-T7 and T7-T8. He opined the MRI of the lumbar spine revealed an annular tear at L4-L5. He referred Petitioner to Dr. Blake for injections (Petitioner's Exhibit 16).

When Dr. Gornet saw Petitioner on February 1, 2018, he noted Dr. Paletta had treated him for shoulder condition. He also noted the cervical injections gave Petitioner some relief, but he recommended Petitioner undergo disc replacement surgery at C5-C6 and C6-C7 (Petitioner's Exhibit 16).

Dr. Gornet continued to follow Petitioner as Petitioner was being treated for his other injuries. When he saw Petitioner on April 2, 2018, he noted Petitioner had recently undergone surgical removal of his right kidney. Dr. Gornet renewed his recommendation Petitioner undergo cervical disc replacement surgery (Petitioner's Exhibit 16).

At the direction of Respondent, Petitioner was examined by Dr. R. Peter Mirkin, an orthopedic surgeon, on June 18, 2018. In connection with his examination of Petitioner, Dr. Mirkin reviewed medical records and diagnostic studies provided to him by Respondent. In regard to Petitioner's cervical spine, Dr. Mirkin opined the MRI of August 31, 2017, was completely normal and there was no indication for any cervical surgery. He opined the current MRI (the one ordered by Dr. Gornet) only revealed some mild degenerative disc bulging but nothing that would require surgery (Respondent's Exhibit 1; Deposition Exhibit 2).

Dr. Gornet saw Petitioner on July 16, 2018, and he reviewed Dr. Mirkin's report. Dr. Gornet again reviewed both cervical MRIs and noted Petitioner had disc injuries at C5-C6 and C6-C7 and, to a lesser extent, at C4-C5. Dr. Gornet agreed with Dr. Mirkin that Petitioner did not have significant nerve compression, but he noted Petitioner had significant neck/shoulder pain and parasthesias down both arms. Dr. Gornet again renewed his recommendation Petitioner undergo disc replacement surgery at C5-C6 and C6-C7 (Petitioner's Exhibit 17).

Dr. Gornet was deposed on February 28, 2019, 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, including his recommendation Petitioner undergo disc replacement surgery at C5-C6 and C6-C7 (Petitioner's Exhibit 18, pp 18-19).

Dr. Gornet testified the condition he diagnosed in Petitioner's cervical spine was related to the accident of December 9, 2016. He further stated that disc replacement surgery would provide significant relief of Petitioner's neck/shoulder pain and tingling into both arms (Petitioner's Exhibit 18; pp 19-20).

On cross-examination, Dr. Gornet agreed he did not know exactly when Petitioner first complained of neck pain; however, Dr. Gornet noted Petitioner sustained severe injuries and was on narcotic medication when hospitalized. He noted Petitioner had sustained a fracture of the clavicle which was just inches from the cervical spine. Dr. Gornet specifically noted that "...if you're on high dose narcotics and immobilized, you may not really have manifestation of those symptoms where it becomes a major issue for you for months until those issues resolve." (Petitioner's Exhibit 18; pp 38-41).

In regard to his reading of the MRIs, Dr. Gornet testified on cross-examination that the first MRI was of poor/moderate quality and did not include foraminal views. Dr. Gornet stated the MRI he ordered confirmed the presence of disc injuries at C5-C6 and C6-C7 (Petitioner's Exhibit 18; pp 44-47).

Dr. Mirkin was deposed on June 24, 2019, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Mirkin's testimony was consistent with his medical report and he reaffirmed the opinions contained therein. Specifically, Dr. Mirkin testified both MRIs of the cervical spine were normal and only revealed some mild degenerative bulging consistent with Petitioner's age. Dr. Mirkin stated Petitioner did not need any further treatment in regard to his neck (Respondent's Exhibit 1; pp 12-17).

On cross-examination, Dr. Mirkin agreed that severe injuries to one part of the body could cause a delay in a person having or recognizing symptoms from a less severe injury. Dr. Mirkin also agreed Petitioner had no history of any neck complaints prior to the accident (Respondent's Exhibit 1; p 23).

When questioned whether a disc injury could cause symptoms even if there was no compression of a nerve root, Dr. Mirkin stated he did not know and there were a large number of reasons why one might have axial back pain. In regard to Dr. Gornet's surgical recommendation, Dr. Mirkin stated "I think that Dr. Gornet's characterization of this needing surgery is unethical and beyond the scope of what a spinal surgeon should be practicing this time and age" (Respondent's Exhibit 1; pp 25, 28).

At trial, Petitioner testified he still has numerous complaints referable to his neck which consist of pain/burning in the neck which goes down the back of both arms. Petitioner also stated both of his hands will lockup, especially his ring and little fingers. He wants to proceed with the surgery as recommended by Dr. Gornet.

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

The Arbitrator concludes Petitioner's current condition of ill-being is causally related to the accident of December 9, 2016.

In support of this conclusion the Arbitrator notes the following:

There was no question Petitioner sustained serious injuries as a result of the accident of December 9, 2016, including multiple rib and thoracic transverse process fractures; open/comminuted fractures of the right tibia and fibula, a fracture of the right clavicle, a collapsed lung, an injury to his right shoulder and an injury to his right kidney which ultimately required surgical removal.

Given the preceding, the fact that there may have been a delay in Petitioner having cervical spine complaints or recognizing same is reasonable. Further, Petitioner had no cervical spine complaints prior to the accident.

Petitioner was referred to Dr. Gornet by Respondent's nurse case manager and he became Petitioner's primary treating physician for his cervical spine. Dr. Gornet testified there was a causal relationship between Petitioner's current cervical spine condition and the accident of December 9, 2016. When he was deposed, Dr. Gornet specifically noted Petitioner was on a high dose of narcotics and immobilized and this may have caused a delay in Petitioner having or recognizing cervical spine symptoms.

Dr. Gornet reviewed the MRI scans of Petitioner's cervical spine and opined that the one he ordered was of superior quality and revealed disc injuries at C5-C6 and C6-C7.

Respondent's Section 12 examiner, Dr. Mirkin, also reviewed both MRIs and opined they were normal and only revealed some degenerative bulging consistent with Petitioner's age. However, Dr. Mirkin acknowledged that there may be a delay when a person sustains a serious injury to one part of his body or in recognizing some symptoms of a less severe injury to another part of his body. He also agreed there was no evidence Petitioner had any prior cervical spine complaints.

Based upon the preceding, the Arbitrator finds the opinion of Dr. Gornet to be more persuasive than that of Dr. Mirkin in regard to causality.

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

Based upon the stipulation of Petitioner and Respondent, the Arbitrator concludes that all of the medical treatment provided to Petitioner to date was reasonable and necessary and 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 19, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

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 two level cervical disc replacement surgery recommended by Dr. Gornet.

In support of this conclusion the Arbitrator notes the following:

As noted herein, Dr. Gornet has been Petitioner's primary treating physician for his cervical spine injury and has recommended Petitioner undergo disc replacement surgery at C5-C6 and C6-C7

In disputed issue (F) the Arbitrator found Dr. Gornet to be more persuasive than Dr. Mirkin in regard to causality. Further, the Arbitrator notes that when he was deposed, Dr. Mirkin did not just testify that he had a difference of opinion with Dr. Gornet regarding Dr. Gornet's treatment recommendation, but he accused Dr. Gornet of being "unethical" in recommending surgery.

Based upon the preceding, the Arbitrator finds Dr. Gornet's opinion in regard to Petitioner's need for prospective medical treatment to be more persuasive than that of Dr. Mirkin.

William R. Gallagher, Arbitrator

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Shae R. Jamison,

Petitioner,

20IWCC0409

vs.

NO: 18 WC 36959

State of Illinois-Dept of Corrections,

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 9, 2019, is hereby affirmed and adopted.

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

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

20IWCC0409

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

Pursuant to §19(f)(1) of the Act, claims against the State of Illinois are not subject to judicial review. Therefore, no appeal bond is set in this case.

DATED: JUL 17 2020
o7/9/20
DLS/rm
046

Deborah L. Simpson

Barbara N. Flores

Marc Parker

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

20IWCC0409

JAMISON, SHAE R
Employee/Petitioner

Case# **18WC036959**

18WC036958

STATE OF ILLINOIS -DEPT OF CORRECTIONS
Employer/Respondent

On 12/9/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.56% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

DEC - 9 2019

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

20IWCC0409

20IWCC0409

STATE OF ILLINOIS)
)SS.
COUNTY OF WILLIAMSON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Shae R. Jamison
Employee/Petitioner

v.

State of Illinois-Dept. of Corrections
Employer/Respondent

Case # 18 WC 36959

Consolidated cases: 18 WC 36958

An *Application for Adjustment 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 October 16, 2019. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, November 2, 2018, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $60,273.02; the average weekly wage was $1,159.10.

On the date of accident, Petitioner was 28 years of age, single with 1 dependent child(ren).

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

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

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

ORDER

Based upon the Arbitrator's Conclusions of Law attached hereto, all benefits are awarded in case number 18 WC 36958.

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)

November 30, 2019
Date

DEC 9 - 2019

Findings of Fact

Petitioner filed two Applications for Adjustment of Claim which alleged he sustained accidental injuries arising out of and in the course of his employment by Respondent. In case 18 WC 36958, the Application alleged that on May 14, 2018, Petitioner sustained an injury "In course of employment" to his "Right knee." At trial, Petitioner's counsel made an oral motion to amend the date of accident to May 15, 2018, which was granted by the Arbitrator (Arbitrator's Exhibit 2). In case 18 WC 36959, the Application alleged that on November 2, 2018, Petitioner sustained an injury "In course of employment" to his "Right knee" (Arbitrator's Exhibit 3). The cases were consolidated and heard in a 19(b) proceeding in which Petitioner sought an order for payment of medical bills as well as prospective medical treatment (Arbitrator's Exhibit 1).

Respondent disputed liability in case 18 WC 36958 on the basis of accident, notice and causal relationship. In case 18 WC 36959, Respondent stipulated Petitioner sustained a work-related accident and gave notice of same, but disputed liability on the basis of causal relationship (Arbitrator's Exhibit 1).

Petitioner worked for Respondent as a Correctional Officer, a position which he has held for approximately nine years. In regard to the accident of May 15, 2018, Petitioner testified he stepped up on an elevated pod to get a key and when he stepped down, he sustained a twisting injury to his right knee. The accident occurred at approximately 2:30 PM and Petitioner's shift was scheduled to end at 3:00 PM.

Petitioner stated he was working with Dan Massaro, another Correctional Officer, but Massaro did not witness the accident. At trial, Petitioner's counsel tendered into evidence an Affidavit signed by Massaro which noted that he was working with Petitioner in May, 2018, and Petitioner informed him that he had injured his right knee at work, but he did not witness the accident. Massaro also noted he observed Petitioner limping on his right leg at that time (Petitioner's Exhibit 6).

At trial, Petitioner testified he did not report the accident to his supervisor on the day it occurred because he did not think it was that severe. Petitioner was not scheduled to work on May 16 and May 17. During that time, Petitioner's right knee symptoms worsened and when he returned to work on May 18, he reported the accident to his supervisor, Major Reginald Hammonds.

Petitioner stated that Major Hammonds directed him to go to the health unit where he was evaluated by the nurse on duty. Petitioner did not recall her name; however, he observed the nurse writing what he believed to be a report. When he asked her to give him a copy of the report, she declined to do so. Petitioner testified he subsequently requested a copy of the report on several occasions from both Major Hammonds and Ted McAbee, the Prison Warden, but it was never produced.

Hammonds testified for Respondent at trial and confirmed he was Petitioner's supervisor in May, 2018. He had no recollection of Petitioner reporting an accident to him at that time, but if he had done so, the standard procedure would have been for him to complete an incident report and send the injured employee to the health unit.

Major Paul Mocaby testified for Respondent at trial. He was the shift supervisor in both May and November, 2018. He was not present during either accident. He confirmed that after an accident is reported, an injury report is prepared and the employee is sent to the health unit. He stated the employee is provided with a work comp packet and directed to call an 800 number. He also stated that Petitioner's reaching for the keys in the manner he described was a violation of safety rules and, if Petitioner had been observed doing so, he would have been reprimanded.

Petitioner completed and signed an Employee's Notice of Injury form on June 28, 2018, which described the accident of May, 2018, but erroneously indicated the date of accident was May 18, 2018. However, it also noted Petitioner was off the following two days and thought the condition would improve (Petitioner's Exhibit 1).

Petitioner testified he previously sustained an injury to his right knee in November, 2017, while at work in essentially the same manner he injured his right knee on May 15, 2018. Petitioner did not report the accident to Respondent and his right knee symptoms totally resolved shortly thereafter. He did not seek any medical treatment subsequent to the November, 2017 accident.

Medical records of Paul Williams, a Nurse Practitioner associated with Salem Medical Center were received into evidence at trial. NP Williams previously saw Petitioner on March 16, 2018, and April 30, 2018, for other health issues, specifically, right elbow pain and a cough/fever. Petitioner did not complain of any right knee symptoms on those occasions (Petitioner's Exhibit 3).

Subsequent to the accident, Petitioner was evaluated by NP Williams on May 22, 2018. At that time, Petitioner advised NP Williams he felt a pop in his right knee while turning on May 15. He diagnosed Petitioner with right knee pain and ordered an x-ray (Petitioner's Exhibit 3).

The x-ray was obtained on May 23, 2018. According to the radiologist, it was normal, and Petitioner injured his knee in a twisting injury two to three days prior similar to an injury he had sustained several months ago (Petitioner's Exhibit 3).

NP Williams saw Petitioner on June 20, 2018, and Petitioner continued to complain of right knee pain. He recommended Petitioner be referred to an orthopedic surgeon (Petitioner's Exhibit 3).

Petitioner was subsequently seen by NP Williams on August 17, 2018. At that time, Petitioner advised he was in his yard at home when a goat he was watching rammed the side of his right knee which caused a worsening of his pain (Petitioner's Exhibit 3). At trial, Petitioner testified he was caring for some goats as a favor for a friend when one of them struck him which caused a temporary flare of his right knee symptoms.

Dr. Seth Hahs, a physician associated with Salem Medical Center saw Petitioner on September 24, 2018. At that time, Petitioner advised he had reinjured his knee three days prior and had sustained a work-related injury in March, 2018, but also reported having sustained an injury in November, 2017. He was diagnosed with right knee pain and it was again recommended he be referred to an orthopedic surgeon (Petitioner's Exhibit 3). In regard to the accident of November

2, 2018, Petitioner testified he was outside observing inmates and he walked backward into a small depression in the ground. Petitioner stated this caused him to sustain another twisting injury to his right knee. As noted herein, Respondent did not dispute Petitioner sustained an accident on November 2, 2018, but disputed liability on the basis of causal relationship.

Various reports regarding the accident of November 2, 2018, were received into evidence, most of which were prepared within several days of its occurrence. However, the Employee's Notice of Injury was completed and signed by Petitioner on January 21, 2019 (Petitioner's Exhibit 2).

Petitioner was seen by NP Williams on November 5, 2018. At that time, Petitioner advised his right knee condition had been improving, but the symptoms were worsened after he stepped into a hole at work. NP Williams again diagnosed with Petitioner with right knee pain and recommended referral to an orthopedic surgeon (Petitioner's Exhibit 3).

Petitioner was again seen by NP Williams on November 13, 2018, and advised he had ongoing right knee pain. On examination, NP Williams noted there was decreased range of motion of the right knee (Petitioner's Exhibit 3).

On December 3, 2018, Petitioner was evaluated by Dr. George Paletta, an orthopedic surgeon. Petitioner advised Dr. Paletta of the accidents of May 14, 2018, and November 2, 2018. Petitioner also advised Dr. Paletta he had no right knee problems prior to the accident of May 14, 2018. Dr. Paletta opined Petitioner had a probable medial meniscus tear which he causally related to the accidents of May and November, 2018. He ordered an MRI scan (Petitioner's Exhibit 4; Deposition Exhibit 2).

The MRI was performed on December 12, 2018. According to the radiologist, the MRI revealed a bucket handle tear of the medial meniscus as well as medial tibiofemoral chondrosis (Petitioner's Exhibit 4; Deposition Exhibit 2).

Dr. Paletta reviewed the MRI and his reading was consistent with that of the radiologist. He recommended Petitioner undergo arthroscopic surgery with probable medial meniscectomy versus meniscal repair (Petitioner's Exhibit 4; Deposition Exhibit 2).

At the request of Petitioner's counsel, Dr. Paletta reviewed the medical records for treatment Petitioner received prior to his evaluation. He noted the records made reference to a prior knee injury of November, 2017, but that it did not appear to cause any ongoing knee problems prior to the first accident of May 15, 2018. He also noted the records suggested Petitioner sustained an injury between the two accidents, but that his knee symptoms related to the May, 2018 accident had not resolved. Dr. Paletta's opinion as to causality and Petitioner's need for treatment remained the same (Petitioner's Exhibit 4; Deposition Exhibit 4).

At the direction of Respondent, Petitioner was examined by Dr. Michael Nogalski, an orthopedic surgeon, on March 18, 2019. In connection with his examination of Petitioner, Dr. Nogalski reviewed medical records provided to him by Respondent. When seen by Dr. Nogalski, Petitioner stated he had sustained an injury to his right knee in November, 2017, when he turned his right knee. Petitioner stated his right knee "popped" and was painful but improved afterward.

Petitioner also informed Dr. Nogalski of the circumstances of the two work-related accidents (Respondent's Exhibit 6; Deposition Exhibit 2).

Dr. Nogalski opined Petitioner had a tear of the right bucket handle of the medial meniscus and chondrosis and knee surgery was appropriate. In regard to causality, Dr. Nogalski opined it was more likely that the meniscal tear and chondrosis predated even the November, 2017, accident and developed over time (Respondent's Exhibit 6; Deposition Exhibit 2).

Dr. Paletta was deposed on July 24, 2019, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Paletta's testimony was consistent with his medical records and he reaffirmed the opinions contained therein. In regard to causality, Dr. Paletta testified the meniscal tear was caused by the accident of May 15, 2018, and aggravated by the subsequent accident of November 2, 2018. He further stated the prior accident of November, 2017, was minor which required no medical treatment (Petitioner's Exhibit 4; pp 12-13, 19).

On cross-examination, Dr. Paletta agreed Petitioner did not inform him of the November, 2017, accident and he learned of it when he reviewed Petitioner's medical records. However, he stated that it did not change his opinion in regard to causality and that when Petitioner was seen in March/April, 2018, Petitioner had no right knee complaints. Dr. Paletta also further explained that a bucket handle meniscal tear is usually the result of a twisting or deep flexion injury, but does not necessarily require a violent mechanism of injury (Petitioner's Exhibit 4; pp 30, 42).

Dr. Nogalski was deposed on September 23, 2019, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Nogalski's testimony was consistent with his medical report and he reaffirmed the opinions contained therein. In regard to causality, Dr. Nogalski testified Petitioner had a pre-existing bucket handle tear of the medial meniscus and had, over time, developed chondrosis. He stated it was not related to the accidents of May, 2018, and November, 2018, as well as the prior accident of November, 2017. He stated none of the three accidents involved a significant amount of force sufficient to cause a bucket handle meniscal tear (Respondent's Exhibit 6; pp 16-18).

On cross-examination, Dr. Nogalski agreed there was no evidence Petitioner sought medical treatment after the November, 2017, accident. Further, he agreed that when Petitioner was seen in March/April, 2018, he had no right knee complaints, but consistently had them following the May, 2018, accident (Respondent's Exhibit 6; pp 35-36).

At trial, Petitioner testified he still has right knee symptoms. He wants to proceed with the treatment recommended by Dr. Paletta.

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 is, in part, causally related to the accident of November 2, 2018.

In support of this conclusion the Arbitrator notes the following:

As noted in the Arbitrator's conclusions of law in case number 18 WC 36958, the Arbitrator found Dr. Paletta's opinion in regard to causality to be more persuasive than that of Dr. Nogalski.

Dr. Paletta opined Petitioner's right knee condition was caused by the accident of May 15, 2018, and aggravated by the accident of November 2, 2018.

In regard to disputed issues (J) and (K) the Arbitrator makes no conclusion of law because he has awarded medical bills and prospective medical treatment in case number 18 WC 36958.

William R. Gallagher, Arbitrator

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

Shae R. Jamison,

Petitioner,

20IWCC0408

vs.

NO: 18 WC 36958

State of Illinois-Dept of Corrections,

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 9, 2019, is hereby affirmed and adopted.

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

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

Agradecimentos

20IWCC0408

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

Pursuant to §19(f)(1) of the Act, claims against the State of Illinois are not subject to judicial review. Therefore, no appeal bond is set in this case.

DATED: JUL 17 2020
o7/9/20
DLS/rm
046

Deborah L. Simpson

Barbara N. Flores

Marc Parker

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

20IWCC0408

JAMISON, SHAE R
Employee/Petitioner

Case# **18WC036958**
18WC036959

STATE OF ILLINOIS - DEPT OF CORRECTIONS
Employer/Respondent

On 12/9/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.56% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0299 KEEFE & DePAULI PC
JAMES K KEEFE JR
#2 EXECUTIVE DR
FAIRVIEW HTS, IL 62208

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2101 S VETERANS PARKWAY
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CERTIFIED as a true and correct copy pursuant to 820 ILCS 305/14

DEC -9 2019

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

20IWCC0408

STATE OF ILLINOIS)
)SS.
COUNTY OF WILLIAMSON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Shae R. Jamison
Employee/Petitioner

v.

State of Illinois-Dept. of Corrections
Employer/Respondent

Case # 18 WC 36958

Consolidated cases: 18 WC 36959

An *Application for Adjustment 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 October 16, 2019. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, May 15, 2018, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $60,273.02; the average weekly wage was $1,159.10.

On the date of accident, Petitioner was 28 years of age, single with 1 dependent child(ren).

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

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

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

ORDER

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibit 5 as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit of amounts paid for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall authorize and pay for prospective medical treatment including, but not limited to, the right knee surgery recommended by Dr. George Paletta.

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)

November 30, 2019
Date

DEC 9 - 2019

Petitioner filed two Applications for Adjustment of Claim which alleged he sustained accidental injuries arising out of and in the course of his employment by Respondent. In case 18 WC 36958, the Application alleged that on May 14, 2018, Petitioner sustained an injury "In course of employment" to his "Right knee." At trial, Petitioner's counsel made an oral motion to amend the date of accident to May 15, 2018, which was granted by the Arbitrator (Arbitrator's Exhibit 2). In case 18 WC 36959, the Application alleged that on November 2, 2018, Petitioner sustained an injury "In course of employment" to his "Right knee" (Arbitrator's Exhibit 3). The cases were consolidated and heard in a 19(b) proceeding in which Petitioner sought an order for payment of medical bills as well as prospective medical treatment (Arbitrator's Exhibit 1).

Respondent disputed liability in case 18 WC 36958 on the basis of accident, notice and causal relationship. In case 18 WC 36959, Respondent stipulated Petitioner sustained a work-related accident and gave notice of same, but disputed liability on the basis of causal relationship (Arbitrator's Exhibit 1).

Petitioner worked for Respondent as a Correctional Officer, a position which he has held for approximately nine years. In regard to the accident of May 15, 2018, Petitioner testified he stepped up on an elevated pod to get a key and when he stepped down, he sustained a twisting injury to his right knee. The accident occurred at approximately 2:30 PM and Petitioner's shift was scheduled to end at 3:00 PM.

Petitioner stated he was working with Dan Massaro, another Correctional Officer, but Massaro did not witness the accident. At trial, Petitioner's counsel tendered into evidence an Affidavit signed by Massaro which noted that he was working with Petitioner in May, 2018, and Petitioner informed him that he had injured his right knee at work, but he did not witness the accident. Massaro also noted he observed Petitioner limping on his right leg at that time (Petitioner's Exhibit 6).

At trial, Petitioner testified he did not report the accident to his supervisor on the day it occurred because he did not think it was that severe. Petitioner was not scheduled to work on May 16 and May 17. During that time, Petitioner's right knee symptoms worsened and when he returned to work on May 18, he reported the accident to his supervisor, Major Reginald Hammonds.

Petitioner stated that Major Hammonds directed him to go to the health unit where he was evaluated by the nurse on duty. Petitioner did not recall her name; however, he observed the nurse writing what he believed to be a report. When he asked her to give him a copy of the report, she declined to do so. Petitioner testified he subsequently requested a copy of the report on several occasions from both Major Hammonds and Ted McAbee, the Prison Warden, but it was never produced.

Hammonds testified for Respondent at trial and confirmed he was Petitioner's supervisor in May, 2018. He had no recollection of Petitioner reporting an accident to him at that time, but if he had done so, the standard procedure would have been for him to complete an incident report and send the injured employee to the health unit.

Major Paul Mocaby testified for Respondent at trial. He was the shift supervisor in both May and November, 2018. He was not present during either accident. He confirmed that after an accident is reported, an injury report is prepared and the employee is sent to the health unit. He stated the employee is provided with a work comp packet and directed to call an 800 number. He also stated that Petitioner's reaching for the keys in the manner he described was a violation of safety rules and, if Petitioner had been observed doing so, he would have been reprimanded.

Petitioner completed and signed an Employee's Notice of Injury form on June 28, 2018, which described the accident of May, 2018, but erroneously indicated the date of accident was May 18, 2018. However, it also noted Petitioner was off the following two days and thought the condition would improve (Petitioner's Exhibit 1).

Petitioner testified he previously sustained an injury to his right knee in November, 2017, while at work in essentially the same manner he injured his right knee on May 15, 2018. Petitioner did not report the accident to Respondent and his right knee symptoms totally resolved shortly thereafter. He did not seek any medical treatment subsequent to the November, 2017 accident.

Medical records of Paul Williams, a Nurse Practitioner associated with Salem Medical Center were received into evidence at trial. NP Williams previously saw Petitioner on March 16, 2018, and April 30, 2018, for other health issues, specifically, right elbow pain and a cough/fever. Petitioner did not complain of any right knee symptoms on those occasions (Petitioner's Exhibit 3).

Subsequent to the accident, Petitioner was evaluated by NP Williams on May 22, 2018. At that time, Petitioner advised NP Williams he felt a pop in his right knee while turning on May 15. He diagnosed Petitioner with right knee pain and ordered an x-ray (Petitioner's Exhibit 3).

The x-ray was obtained on May 23, 2018. According to the radiologist, it was normal, and Petitioner injured his knee in a twisting injury two to three days prior similar to an injury he had sustained several months ago (Petitioner's Exhibit 3).

NP Williams saw Petitioner on June 20, 2018, and Petitioner continued to complain of right knee pain. He recommended Petitioner be referred to an orthopedic surgeon (Petitioner's Exhibit 3).

Petitioner was subsequently seen by NP Williams on August 17, 2018. At that time, Petitioner advised he was in his yard at home when a goat he was watching rammed the side of his right knee which caused a worsening of his pain (Petitioner's Exhibit 3). At trial, Petitioner testified he was caring for some goats as a favor for a friend when one of them struck him which caused a temporary flare of his right knee symptoms.

Dr. Seth Hahs, a physician associated with Salem Medical Center saw Petitioner on September 24, 2018. At that time, Petitioner advised he had reinjured his knee three days prior and had sustained a work-related injury in March, 2018, but also reported having sustained an injury in November, 2017. He was diagnosed with right knee pain and it was again recommended he be referred to an orthopedic surgeon (Petitioner's Exhibit 3). In regard to the accident of November

2, 2018, Petitioner testified he was outside observing inmates and he walked backward into a small depression in the ground. Petitioner stated this caused him to sustain another twisting injury to his right knee. As noted herein, Respondent did not dispute Petitioner sustained an accident on November 2, 2018, but disputed liability on the basis of causal relationship.

Various reports regarding the accident of November 2, 2018, were received into evidence, most of which were prepared within several days of its occurrence. However, the Employee's Notice of Injury was completed and signed by Petitioner on January 21, 2019 (Petitioner's Exhibit 2).

Petitioner was seen by NP Williams on November 5, 2018. At that time, Petitioner advised his right knee condition had been improving, but the symptoms were worsened after he stepped into a hole at work. NP Williams again diagnosed with Petitioner with right knee pain and recommended referral to an orthopedic surgeon (Petitioner's Exhibit 3).

Petitioner was again seen by NP Williams on November 13, 2018, and advised he had ongoing right knee pain. On examination, NP Williams noted there was decreased range of motion of the right knee (Petitioner's Exhibit 3).

On December 3, 2018, Petitioner was evaluated by Dr. George Paletta, an orthopedic surgeon. Petitioner advised Dr. Paletta of the accidents of May 14, 2018, and November 2, 2018. Petitioner also advised Dr. Paletta he had no right knee problems prior to the accident of May 14, 2018. Dr. Paletta opined Petitioner had a probable medial meniscus tear which he causally related to the accidents of May and November, 2018. He ordered an MRI scan (Petitioner's Exhibit 4; Deposition Exhibit 2).

The MRI was performed on December 12, 2018. According to the radiologist, the MRI revealed a bucket handle tear of the medial meniscus as well as medial tibiofemoral chondrosis (Petitioner's Exhibit 4; Deposition Exhibit 2).

Dr. Paletta reviewed the MRI and his reading was consistent with that of the radiologist. He recommended Petitioner undergo arthroscopic surgery with probable medial meniscectomy versus meniscal repair (Petitioner's Exhibit 4; Deposition Exhibit 2).

At the request of Petitioner's counsel, Dr. Paletta reviewed the medical records for treatment Petitioner received prior to his evaluation. He noted the records made reference to a prior knee injury of November, 2017, but that it did not appear to cause any ongoing knee problems prior to the first accident of May 15, 2018. He also noted the records suggested Petitioner sustained an injury between the two accidents, but that his knee symptoms related to the May, 2018 accident had not resolved. Dr. Paletta's opinion as to causality and Petitioner's need for treatment remained the same (Petitioner's Exhibit 4; Deposition Exhibit 4).

At the direction of Respondent, Petitioner was examined by Dr. Michael Nogalski, an orthopedic surgeon, on March 18, 2019. In connection with his examination of Petitioner, Dr. Nogalski reviewed medical records provided to him by Respondent. When seen by Dr. Nogalski, Petitioner stated he had sustained an injury to his right knee in November, 2017, when he turned his right knee. Petitioner stated his right knee "popped" and was painful but improved afterward.

Petitioner also informed Dr. Nogalski of the circumstances of the two work-related accidents (Respondent's Exhibit 6; Deposition Exhibit 2).

Dr. Nogalski opined Petitioner had a tear of the right bucket handle of the medial meniscus and chondrosis and knee surgery was appropriate. In regard to causality, Dr. Nogalski opined it was more likely that the meniscal tear and chondrosis predated even the November, 2017, accident and developed over time (Respondent's Exhibit 6; Deposition Exhibit 2).

Dr. Paletta was deposed on July 24, 2019, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Paletta's testimony was consistent with his medical records and he reaffirmed the opinions contained therein. In regard to causality, Dr. Paletta testified the meniscal tear was caused by the accident of May 15, 2018, and aggravated by the subsequent accident of November 2, 2018. He further stated the prior accident of November, 2017, was minor which required no medical treatment (Petitioner's Exhibit 4; pp 12-13, 19).

On cross-examination, Dr. Paletta agreed Petitioner did not inform him of the November, 2017, accident and he learned of it when he reviewed Petitioner's medical records. However, he stated that it did not change his opinion in regard to causality and that when Petitioner was seen in March/April, 2018, Petitioner had no right knee complaints. Dr. Paletta also further explained that a bucket handle meniscal tear is usually the result of a twisting or deep flexion injury, but does not necessarily require a violent mechanism of injury (Petitioner's Exhibit 4; pp 30, 42).

Dr. Nogalski was deposed on September 23, 2019, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Nogalski's testimony was consistent with his medical report and he reaffirmed the opinions contained therein. In regard to causality, Dr. Nogalski testified Petitioner had a pre-existing bucket handle tear of the medial meniscus and had, over time, developed chondrosis. He stated it was not related to the accidents of May, 2018, and November, 2018, as well as the prior accident of November, 2017. He stated none of the three accidents involved a significant amount of force sufficient to cause a bucket handle meniscal tear (Respondent's Exhibit 6; pp 16-18).

On cross-examination, Dr. Nogalski agreed there was no evidence Petitioner sought medical treatment after the November, 2017, accident. Further, he agreed that when Petitioner was seen in March/April, 2018, he had no right knee complaints, but consistently had them following the May, 2018, accident (Respondent's Exhibit 6; pp 35-36).

At trial, Petitioner testified he still has right knee symptoms. He wants to proceed with the treatment recommended by Dr. Paletta.

Conclusions of Law

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

The Arbitrator concludes Petitioner sustained an accidental injury arising out of and in the course of his employment by Respondent on May 15, 2018.

In support of this conclusion the Arbitrator notes the following:

Petitioner credibly testified he sustained a twisting injury to his right knee when he stepped up on an elevated pod to get a key and twisted his knee when stepping down.

Dan Massaro, a co-worker of Petitioner, was working with Petitioner at the time of the accident, but did not witness its occurrence. However, he observed Petitioner limping on his right leg afterward.

Petitioner testified he reported the accident to his supervisor, Major Hammonds, on May 18, 2018. Major Hammonds testified he had no recollection of Petitioner reporting the accident to him; however, he also stated that it would have been standard procedure to direct Petitioner to go to the health unit.

While the Employee's Notice of Injury erroneously indicated the accident occurred on May 18, 2018, it also noted Petitioner was off the following two days because Petitioner thought the symptoms would improve. While the date of accident was in error, Petitioner being off work the following two days after the accident was consistent with Petitioner's testimony.

Petitioner provided a history of the accident of May 15, 2018, to NP Williams, Dr. Paletta and Dr. Nogalski.

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

The Arbitrator concludes Petitioner gave notice to Respondent within the time required by the Act.

In support of this conclusion the Arbitrator notes the following:

Petitioner credibly testified he informed his supervisor, Major Hammonds, of the accident on May 18, 2018, three days after its occurrence.

While the Employee's Notice of Injury was not prepared until June 28, 2018, it would still be within the time limit prescribed by the Act. Further, the Arbitrator notes that, in regard to the undisputed accident of November 2, 2018, the Employee's Notice of Injury was not prepared until January 21, 2019.

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

The Arbitrator concludes Petitioner's current condition of ill-being is causally related to the accident of May 15, 2018.

In support of this conclusion the Arbitrator notes the following:

Petitioner apparently sustained a prior injury to his right knee in November, 2017; however, he did not seek any medical treatment afterward.

When seen by NP Williams in March/April, 2018, he was seen for other health issues and had no complaints of right knee symptoms.

Petitioner's primary treating physician, Dr. Paletta, diagnosed Petitioner with a bucket handle tear of the medial meniscus which he causally related to the accident of May 15, 2018. He reaffirmed this opinion after reviewing medical records and noted the prior accident of November, 2017, did not cause any ongoing knee symptoms and Petitioner had no right knee complaints when evaluated in March/April, 2018.

Respondent's Section 12 examiner, Dr. Nogalski, opined that none of the accidents, including the prior accident of November, 2017, caused the torn meniscus. He opined that none of the accidents had sufficient force to cause a bucket handle tear of the meniscus. However, Dr. Nogalski did not identify any other trauma which would have caused the meniscal tear.

Given the preceding, the Arbitrator finds the opinion of Dr. Paletta to be more persuasive than that of Dr. Nogalski in regard to causality.

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

The Arbitrator concludes that all of the medical treatment provided to Petitioner was reasonable and necessary and 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 5 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 support of this conclusion the Arbitrator notes the following:

There was no dispute that all of the medical treatment provided to Petitioner was reasonable and necessary.

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 right knee surgery recommended by Dr. George Paletta.

In support of this conclusion the Arbitrator notes the following:

There was no dispute Petitioner has a right knee condition which requires surgery.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MARIE ALDUGOM,

Petitioner,

vs. NO: 08 WC 24644; 08 WC 24645

20IWCC0410

CITY OF CHICAGO,

Respondent.

DECISION AND OPINION ON PETITION UNDER SECTIONS 19(h) AND 8(a)

These consolidated matters come before the Commission on Petitioner's Petition for Review under Section 19(h) and Section 8(a) of the Act, filed on March 6, 2015. The cases were continued multiple times at Petitioner's request. Subsequently, Petitioner filed a Petition for Vocational Rehabilitation on May 1, 2017 and a subsequent Request for Hearing before Commissioner Lamborn on June 8, 2017 claiming a material increase in disability, medical benefits and vocational rehabilitation under Section 8(a). The matters were heard by Commissioner Kevin W. Lamborn on May 17, 2018, with both parties represented by counsel.

After considering the totality of the evidence, the Commission finds that Petitioner has failed to prove a material change in her disability, therefore, her request for benefits under Sections 19(h) and 8(a) are denied for the reasons set forth below.

Section 19(h)

The purpose of a proceeding under section 19(h) is to determine if a petitioner's disability has "recurred, increased, diminished or ended" since the time of the original decision of the Industrial Commission. (Ill. Rev. Stat. 1985, ch. 48, par. 138.19(h); *Howard v. Industrial Comm'n* (1982), 89 Ill. 2d 428, 433 N.E.2d 657.) To warrant a change in benefits, the change in a petitioner's disability must

> be material. (*United States Steel Corp. v. Industrial Comm'n* (1985), 133 Ill. App. 3d 811, 478 N.E.2d 1108.) In reviewing a Section 19(h) petition, the evidence presented in the original proceeding must be considered to determine if the petitioner's position has changed materially since the time of the Industrial Commission's first decision. (*Howard*, 89 Ill. 2d 428, 433 N.E.2d 657.)

Gay v. Industrial Comm'n, 178 Ill. App. 3d 129, 132, 532 N.E.2d 1149, 1151, 1989 Ill. App. LEXIS 3, *5-6, 127 Ill. Dec. 320, 322

Gay is otherwise instructive regarding the analysis of a Section 19(h) material change. In *Gay*, the Petitioner underwent a total left knee replacement, however, the Court held surgery alone was not a basis, in and of itself, to find there was a material change in the Petitioner's condition. The *Gay* Court addressed Petitioner's evidence that she had a total left knee replacement, still suffered pain in her left knee, her hips, her lower back and her diagnosis of post-traumatic arthritis of her left knee, and held the following:

> From this evidence, we find that petitioner failed to present evidence of a substantial difference between her pre- and post-surgery disability. Petitioner still had a limited range of motion in her left knee, she still had pain, she still used a cane for ambulation, and she continued to take medication. These same symptoms of petitioner's disability were apparent at her original hearing before the Industrial Commission, and the diagnosis of her disability was substantially the same at the section 19(h) petition hearing as at the original hearing before the Industrial Commission.
> Petitioner urges this court to conclude that the replacement of a natural part with a prothesis alone is sufficient to show a material increase in a petitioner's disability. There is no mechanical test for determining whether the Commission should measure a disability with or without a corrective prosthesis. (*Gilbert & Shughart Painting Contractors v. Industrial Comm'n* (1985), 136 Ill. App. 3d 163, 483 N.E.2d 392; *Motor Wheel Corp. v. Industrial Comm'n* (1979), 75 Ill. 2d 230, 388 N.E.2d 380 (measure of damages is between uncorrected vision at time of accident and uncorrected vision thereafter); see also 2 A. Larsen, The Law of Workmen's Compensation § 58.13(f) (1987) (similar questions may arise as to prosthetic devices other than eyeglasses).) This is because neither the "uncorrected impairment" rule nor the "corrected impairment" rule adequately covers all cases. (*Motor Wheel Corp.*, 75 Ill. 2d 230, 388 N.E.2d 380, citing *Lambert v. Industrial Comm'n* (1952), 411 Ill. 593, 104 N.E.2d 783.) How correctability should be weighed is a factual question. (*Walker v. Industrial Comm'n* (1978), 72 Ill. 2d 408, 381 N.E.2d 238.) In this case, the Industrial Commission made the factual determination that petitioner's prosthesis did not materially increase her disability. Further, we find that the Industrial Commission's decision of a 50% left leg disability took into consideration the future need for a total knee replacement for a progressive condition. Thus, the Industrial Commission's decision that petitioner

> had no material increase in her disability was not against the manifest weight of the evidence.

Gay v. Industrial Comm'n, 178 Ill. App. 3d 129, 132-134, 532 N.E.2d 1149, 1151-1152.

In the subject case, Petitioner sustained injuries in 2007 and 2008 while working for Respondent as a Watchman for the Department of Water Management. As a result of those injuries, Petitioner underwent an L5-S1 microdiscectomy on August 7, 2008 performed by Dr. Theodore Fisher. Following surgery, and continued complaints, Dr. Fisher recommended an additional procedure consisting of an L5-S1 decompression and fusion. An Arbitration Hearing was held before Arbitrator David Kane on March 5, 2009. Petitioner testified that she had constant pain in her low back radiating into her right leg. An Arbitration Decision issued on March 10, 2009, awarding prospective medical treatment to include the lumbar fusion surgery at the L5-S1 level as prescribed by Dr. Fisher. (5/17/18 Commission Hearing, PX1) The Decision was not reviewed by either party. Petitioner underwent the prescribed surgery consisting of a posterolateral interbody and posterolateral spinal fusion at L5-S1 on May 12, 2009.

Thereafter, at follow-up visits with Dr. Fisher, Petitioner continued to complain of right-sided lower back pain extending into the right lower extremity in the L5 nerve root distribution. On August 25, 2010, Dr. Fisher reviewed a CT Scan and lumbar MRI. Dr. Fisher noted at L4-L5, there is a right paracentral disc herniation resulting in subarticular stenosis which on sagittal images of the MRI reveals stenosis affecting the L5 nerve root. His plan was to send her for facet injections at the L5-S1 level. Depending on the results, she would be a candidate for radiofrequency ablation at the L4-L5 facet joints or, if no improvement, she would be a candidate for L3-L4 and L4-L5 discogram. If her discogram is positive, she would be a candidate for extension of the fusion at the L4-L5 level. (5/17/18 Commission Hearing T, PX14)

On January 5, 2011, Petitioner attended a Section 12 evaluation at Respondent's request with Dr. Carl Graf at Illinois Spine Institute. At the evaluation Petitioner complained that she had pressure in the back, that it feels "like a rock in the back." She reported she has pain and tingling in her big toe on the right, occasional anterior thigh and groin pain and she could not feel her anterior thigh and that her back is burning. She complained of pain of a 10/10 which is constant. She noted her back was equal to her leg pain. Dr. Graf authored a report regarding Dr. Fisher's recommendation, finding that Petitioner demonstrated multiple non-organic pain signs bringing forward the possibility of symptom magnification and/or fabrication. Dr. Graf further opined:

> Regarding Dr. Fisher's recommended possible third surgery, it is my opinion that this holds an extremely low likelihood of symptom improvement given her history and examination. It continues to be my opinion that she is not a surgical candidate. (5/17/18 Commission Hearing T, PX14, RX1)

Petitioner underwent a Work Capacity Evaluation Report dated February 15, 2011. The therapist concluded that the results of the evaluation appeared to be invalid, "as supported by her

pain focused and self-limiting behavior on variety of objective functional tests." Petitioner was also positive in several symptom magnification tests. (5/17/18 Commission Hearing T, PX14). On March 1, 2011, Dr. Fisher noted that he reviewed Petitioner's work capacity evaluation report/functional capacity evaluation. He noted that the results of the tests were found to be invalid and, in that situation, results in the minimal level of functioning which still meets the job description. (5/17/18 Commission Hearing T, PX14)

On August 25, 2011, Petitioner consulted Dr. Fisher in follow-up with continuous complaints of low back pain worse on the right at the level of L5-S1. She also complained of right posterior thigh pain and anterior leg pain. Dr. Fisher documented that "aggravating factors include any activity while alleviating factors include rest." Dr. Fisher reviewed her MRI studies of the lumbar spine dated October 9, 2009, prior to the L5-S1 fusion surgery. He noted a broad-based disk bulge with a right paracentral component resulting in right subarticular stenosis. He also reviewed a lumbar spine dated July 26, 2011 which revealed a similar right paracentral disk herniation at L4-5. There was no evidence of hardware failure or loosening. Dr. Fisher recommended additional surgery in the form of an L4-5 fusion. (5/17/18 Commission Hearing T, PX14)

The Commission notes that prior to the July 2, 2012, Arbitration Hearing, Dr. Fisher's March 1, 2012 office visit documents that Petitioner reported pain of "10 out of 10" and at rest "6 out of 10." Petitioner agreed to additional surgical intervention at that time. (5/17/18 Commission Hearing T, PX14) However, at the July 2, 2012 Arbitration Hearing, Petitioner testified that she did not wish to undergo the third surgery. (5/17/18 Commission Hearing T, PX14, 7/2/12 Arb. Hearing T, pp. 16, 25)

At the time of the second Arbitration Hearing held before Arbitrator Joann Fratianni on July 2, 2012, Petitioner testified that she had constant pain in her lower back and down her right leg, that sitting, standing, and walking make her pain worse and she has to change position after 20 minutes of sitting, standing or walking. Petitioner further testified that her permanent restrictions were no lifting greater than five pounds, no bending, no stairs, and that at its best her pain level is three to four on a scale of one to ten, and at its worst, her pain level is eight to ten. (5/17/18 Commission Hearing T, PX14, 7/2/12 Arb. Hearing T, pp. 17-22)

At the Arbitration Hearing on July 2, 2012, Petitioner further testified that she uses a medication and heat patch every 12 hours a couple of times per week, and takes medications including Hydrocodone, 800 milligrams, Lyrica, twice per day, and Ibuprofen, 800 milligrams. (5/17/18 Commission Hearing T, PX14, 7/2/12 Arb. Hearing T, pp. 23- 25)

The Arbitrator's Decision, filed on October 25, 2012, noted Dr. Fischer prescribed surgery in the form of an L4-L5 fusion and that on June 16, 2012, Dr Fisher was advised by Petitioner that she wished to hold off on surgery. The Arbitrator then noted that Dr. Fisher placed her at maximum medical recovery and indicated that Petitioner may proceed with surgery in the form of an L4-L5 fusion at a later date. With respect to the nature and extent of Petitioner's injuries, the Arbitrator

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noted Dr. Fisher prescribed permanent restrictions of no lifting greater than five pounds, no bending, and avoidance of stairs. The Arbitrator further noted that Petitioner testified that she continues to experience constant pain in her lower back and right leg. Petitioner testified that any physical activity causes an increase in her lower back and right leg pain that frequently escalates. Petitioner testified that prolonged sitting and standing or walking increases her pain level, and she has to change her position frequently. Finally, the Arbitrator noted that Petitioner takes pain medication in the form of Hydrocodone, Ibuprofen and Lyrica daily. Based on the afore-referenced, the Arbitrator awarded 40% loss of use of a person pursuant to §8(d)2. (5/17/18 Commission Hearing T, PX2)

Dr. Fisher's January 18, 2014, phone note documents that Petitioner was experiencing arm pain and was diagnosed as having lymphoma and a tumor only in the bilateral arms. She was scheduled for radiation therapy, and was holding off on chemotherapy as she only has one kidney. She reported continuous pain in the lower back and lower extremities. Dr. Fisher noted that Petitioner's back pain and lower extremity radicular symptoms would be treated after lymphoma treatment unless the PET scan revealed lesions in her back that can explain her symptoms. (5/17/18 Commission Hearing T, PX3)

Petitioner saw Dr. Edward Goldberg at Respondent's request on June 6, 2015 for a §12 evaluation. Dr. Goldberg documents that Petitioner reported she underwent a fusion by Dr. Fisher in May 2009. Dr. Goldberg also documented, "[s]he states that since that surgery, she has had no improvement in her back and right leg radicular pain. She continues to have low back pain and right leg radicular pain with numbness in the foot." Dr. Goldberg further notes that he asked Petitioner on three occasions at the evaluation, and she stated she has had those symptoms prior to either surgery. She reported taking Hydrocodone and Lyrica, a topical patch and OxyContin and that Dr. Fisher recommended a surgery at the level above at L4-L5.

After reviewing Petitioner's medical records and the March 6, 2015 lumbar spine MRI, Dr. Goldberg noted that Petitioner reported her symptoms were unchanged from preop status and he opined that Petitioner was at maximum medical improvement (MMI) for her low back. Dr. Goldberg further opined that Petitioner did not require any further surgical intervention. He appreciated she had some disk degeneration with mild bulging at L4-L5, but he found no evidence of herniation on the most recent MRI. Dr. Goldberg noted that Petitioner's symptoms did not improve after the two surgeries, hence he felt this was an incidental radiographic finding. (5/17/18 Commission Hearing T, RX2)

On December 4, 2015, Petitioner consulted Dr. Benson Yang at Northwestern Neurosurgical Associates for a second opinion. She reported taking Hydrocodone, Oxycodone, Metaxolone, and a Flector patch. Petitioner's past medical history was positive for chronic kidney disease, malignant lymphoma and asthma. Dr. Yang's assessment was lumbar degenerative disc disease. The Plan documents that her discogram shows an interesting result in that injection at L4-5 caused her back pain. However, there was concordant more severe pain with radiation down her leg with injection at L5-S1- a level which is already fused. Dr. Yang noted that he did not see any

obvious nerve impingement so he was not sure whether her right sided leg pain would improve after surgery. He deferred to Dr. Fisher regarding consideration of an EMG/NCS prior to surgery. Dr. Yang counseled Petitioner on 30-40% chance she would not have significant pain relief with surgery. (5/17/18 Commission Hearing T, PX6)

On February 4, 2016, Petitioner was discharged from a hospital stay at Presence St. Francis Hospital after losing consciousness and falling. Petitioner's past medical history was positive for primary cutaneous follicular B cell lymphoma status post chemotherapy and radiation (last cycle of Rituximab in May 2015).

Petitioner underwent a third surgery on April 4, 2016, consisting of an L5-S1 pedicle screw removal and exploration of spinal fusion, L4-L5 right hemilaminotomy, foraminotomy, medial facetectomy, microdiscectomy-separate and distinct from the discectomy used to prepare the interspace for fusion, L4-5 posterolateral interbody fusion with instrumentation, insertion of biomechanical device L4-L5. (5/17/18 Commission Hearing T, PX3)

Dr. Fisher's March 9, 2017 office note documents that Petitioner rated her pain as moderate. (5/17/18 Commission Hearing T, PX3)

The physical therapy discharge note and letter addressed to Dr. Fisher dated September 7, 2016 notes that Petitioner was self-limiting. The therapist's assessment states "She appears to be self- limiting and her symptoms very irritable. She continues to use her back brace and ambulate with a cane, sometimes without AD but significantly slower cadence than expected. (5/17/18 Commission Hearing, PX3)

Dr. Goldberg examined the Petitioner a second time on August 21, 2017 and authored a second opinion report. At the evaluation, Petitioner reported that she continues to have low back and right leg radicular pain. She reported that she underwent lumbar spine surgery, a fusion at L4-5 approximately two years ago. Preoperatively, she had low back and right leg radicular symptoms. "She reports that she had no improvement since the time of the surgery until today. She is on various medications, but does not know the names." Dr. Goldberg reiterated his belief that the original discectomy and fusion at L5-S1 were appropriate. He did not believe that the fusion at L4-5 was indicated. The diagnostic test that he outlined in his evaluation of June 2015 did not find any pathology at L4-5 which would require additional surgery. He further opined, "[a]dditionally, the patient states that she really had no improvement after her surgery at L5-S1 on either occasion, i.e., discectomy and fusion. Furthermore, the patient states that she has had no change in symptoms since the fusion at L4-5. I do not believe that the fusion at L4-5 was required." Dr. Goldberg opined that Petitioner should undergo an FCE to determine if she can return to work as a watchman. She would be at MMI after the FCE. Dr. Goldberg opined that Petitioner can work with a 10 pound lifting restriction. (5/17/18 Commission Hearing T, RX3)

Dr. Goldberg authored a Section 12 Addendum dated August 21, 217. Given that he did not believe the L4-5 lumbar fusion was indicated secondary to the work accident, he did not believe

any time off from the lumbar fusion at L4-5 would be due to the accident of March 3, 2008. (5/17/18 Commission Hearing T, RX4)

At her last follow-up visit with Dr. Fisher on November 29, 2017 the CT scan revealed a solid fusion through the disc space and facets at L5-S1. The L4-L5 did not show solid fusion through the disc space, however, a solid fusion across the spinous processes. She reported continued back pain, right greater than left and right lower extremity radiculopathy, moderate to severe, worse with any activity, alleviated with nothing. Her physical examination showed negative straight leg raise testing, 5/5 strength throughout with normal reflexes, negative Babinski, and negative ankle clonus. (5/17/18 Commission Hearing T, PX3)

At the most recent Commission Hearing that took place on May 17, 2018, Petitioner testified, in pertinent part, that she has had no other treatment since November 29, 2017. She had no scheduled appointments. (Commission Hearing 5/17/18 T, p. 44)

At the Commission Hearing, Petitioner also testified to pain and restrictions very similar to those she described in the July 2, 2012, Arbitration Hearing regarding pain with sitting, standing and walking, the need to change positions and taking the same medications. Petitioner testified that she cannot sit more than 20 minutes without pain. She can only walk a short distance before increased pain, 10 minutes, and if she is walking longer than that she will bring a cane with her.

The Commission notes Mr. Steven Blumenthal authored a report only three months prior to the Commission Hearing, dated February 14, 2018, outlining the vocational rehabilitation assessment results from an interview and testing completed with Petitioner. According to his report, Petitioner told Mr. Blumenthal "that she will use the cane approximately once every day or two days dependent on her pain. Blumenthal noted that Petitioner was not using her cane at the time of her interview or vocational testing. No other assistive device use was reported." (PX13, pp. 3, 4)

Mr. Blumenthal's report documents Petitioner's self- reported physical tolerances as follows:

- Is able to sit 20 minutes at home, will walk for a short period of time and will then reseat herself.
- Petitioner reported she avoids standing in one position without having the ability to move about.
- She is unable to walk more than 10-15 minutes and then pain then increases.
- She can walk up or down the four stairs into her home but not those stairs that lead to the basement.
- She is unable to forward bend from a standing position to retrieve an object from the ground.
- Cannot crouch or kneel due to back pain.
- She can carry one gallon milk reporting it is heavy but is unable to lift and carry heavier pots. (5/17/18 Commission Hearing T, PX13, pp. 4, 5)

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The Commission notes that the above self-reported tolerances are substantially the same as those reported at the July 2012 Arbitration Hearing. Petitioner testified at the Commission Hearing that the surgery did not improve her symptoms. Petitioner testified that she feels worse since the surgery. (Commission Hearing 5/17/18 T, p. 56) However, the Commission notes that the evidence and testimony at the July 2, 2012 Arbitration Hearing and the evidence and testimony at the Commission Hearing on May 17, 2018 show substantially similar complaints and restrictions. At the July 2, 2012 Hearing, the Arbitrator noted that Dr. Fisher prescribed permanent restrictions of no lifting greater than five pounds, no bending, and avoidance of stairs and that Petitioner testified that she continues to experience constant pain in her lower back and right leg and that any physical activity causes an increase in her lower back and right leg pain. Petitioner further testified in 2012 that prolonged sitting and standing or walking increases her pain level, and she has to change her position frequently. Finally, the Arbitrator noted that Petitioner takes pain medication in the form of Hydrocodone, Ibuprofen and Lyrica daily. Based on the afore-referenced, the Arbitrator awarded 40% loss of use of a person pursuant to §8(d)2.

At the Commission Hearing on May 17, 2018 Petitioner also testified that she had to change positions frequently, has trouble with too many stairs, avoids bending and that she takes pain medications including Hydrocodone, Lyrica and a muscle relaxer. The Petitioner also testified that that her family helps her shower, dress, clean and cook. The Commission notes however, Dr. Goldberg recommended an FCE and without it, a 10 pound lifting restriction, less than the Arbitrator noted in the 2012 Decision. Regarding Petitioner's last office visits with Dr. Fisher, there is little indication that Petitioner requires help for those activities. On April 27, 2017 Petitioner reported continued back pain. Dr. Fisher recommended an exercise program and his plan was to write her permanent restrictions of sedentary job without walking without doing rounds around the building and he opined that she was at MMI. Nonetheless, Petitioner returned to Dr. Fisher on July 5, 2017 and reported continued back pain and right lower extremity radicular symptoms, rated as moderate to severe, worse with activity, better with medications. She reported she was walking for exercise. Dr. Fisher recommended that she increase her exercise program to three times per day and additional walking Dr. Fisher's plan states that "[g]iven her pain and limited physical capabilities, I do not foresee her being able to go back to working as she cannot sit or stand long periods of time or lift and bend." Dr. Fisher again opined that Petitioner was at MMI and follow-up on an "as needed" basis. The Commission notes that those are similar limitations that Petitioner had at the time of the 2012 hearing. Also included in Petitioner's Exhibit three was the October 17, 2017 letter Petitioner's attorney sent to Petitioner including Dr. Goldberg's August 21, Section 12 opinion report and Addendum opinion report. Despite Dr. Fisher's opinion that Petitioner was at MMI at her visits in April and July 2017, Petitioner then returned to Dr. Fisher on two more occasions, on November 2, 2017 and November 29, 2017. At both visits, Petitioner complained of continued back pain, more on the right side and lower extremity radiculopathy, rating her symptoms as moderate to severe, worse with any activity, alleviated with nothing. She reported she is on disability. The Commission fails to appreciate a substantial and material change in Petitioner's condition.

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After hearing the parties arguments and carefully reviewing the record, the Commission finds the Petitioner has failed to prove a material change in her disability since the Arbitration Hearing on July 2, 2012.

If there is no substantial and material change in Petitioner's condition, then the Petitioner is not entitled to vocational rehabilitation. In a similar case, *Murff v. Ill. Workers' Comp. Comm'n,* where the Court found that Petitioner failed to show a substantial and material change under Section 19(h), the Court held as follows:

> In so holding, we note that we agree with the claimant's assertion that maintenance and vocational rehabilitation benefits may be available under section 19(h). As this court stated in *Curtis v. Illinois Worker's Compensation Comm'n*, 2013 IL App (1st) 120976WC, ¶ 15, 987 N.E.2d 407, 369 Ill. Dec. 780, "when section 19(h) is read as a whole, it is clear that the legislature did not intend to limit the scope of section 19(h) to only permanency benefits. Rather, the statute was meant to cover TTD benefits as well." As a consequence, in order for the claimant to obtain maintenance and vocational rehabilitation benefits after a final award, he must satisfy the preliminary requirements of section 19(h) by showing a substantial and material change in his disability. However, as we already discussed, the claimant failed to make this showing.

Murff v. Ill. Workers' Comp. Com., 2017 IL App (1st) 160005WC, P31, 70 N.E.3d 273, 281, 2017 Ill. App. LEXIS 6, *18, 410 Ill. Dec. 456, 464

Finally, regarding Petitioner's claim for Section 8(a) medical benefits, the Commission notes that Arbitrator Fratianni found that Petitioner's condition at the time of the 2012 Hearing was causally related to her work accidents. Because the Petitioner declined surgery at that time, the Arbitrator found her condition was permanent in nature. The Arbitrator made no finding with respect to Dr. Graf's opinion that the Petitioner would not be a good surgical candidate for a third procedure given her failure to experience symptom relief from the first two surgeries. The Commission notes Dr. Graf examined the Petitioner on January 5, 2011, and Petitioner complained that after her second surgery, her pain was "worse than before surgery." She complained that she had pressure in the back, that it feels "like a rock in the back." She reported she has pain and tingling in her big toe on the right, occasional anterior thigh and groin pain and she could not feel her anterior thigh and that her back is burning. She complained of pain of a 10/10 which is constant. She noted her back was equal to her leg pain. Dr. Graf noted Petitioner demonstrates multiple non-organic pain signs bringing forward the possibility of symptom magnification and/or fabrication. Dr. Graf found that Petitioner demonstrated no objective findings on evaluation despite subjective complaints of pain and extensive symptom magnification. Although Dr. Graf recommended Petitioner undergo a new CT scan with thin cuts and coronal and sagittal reconstruction, he also opined given the number of non-organic pain signs as well as Petitioner's lack of improvement with now two lumbar surgeries, she is a poor surgical candidate. (5/17/18 Commission Hearing, PX14, RX1) The Commission finds that between the Arbitration Hearing

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in 2012 and when Petitioner was examined by Dr. Goldberg in August 2017, Dr. Yang had examined Petitioner and noted that her discogram result was unusual. Dr. Yang described that although she reported concordant pain at L4-L5, "there was concordant more severe pain with radiation down her leg with injection at L5-S1- a level which is already fused." Dr. Yang's observation, gives the Commission reason to question the validity of the Discogram. Given Dr. Graf's findings, and the invalid 2011 Work Capacity Evaluation/FCE, the Commission finds Petitioner is not credible, and that Dr. Goldberg's opinion that the third surgery was not reasonable or necessary is more credible than Dr. Fisher's opinion that the third surgery was warranted. Therefore, the Petitioner's Petition for medical benefits under Section 8(a) is denied.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's Petition for benefits pursuant to Section 8(a) and Section 19(h) is denied.

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

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

The bond requirement in Section 19(f)(2) is applicable only when "the Commission shall have entered an award for the payment of money." *820 ILCS 305/19(f)(2)*. As there are no monies due and owing, there is no bond set by the Commission for the removal of this cause to the Circuit Court by Respondent. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUL 2 0 2020
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Kathryn A. Doerries

Maria E. Portela

DISSENT

I respectfully dissent from the opinion of the majority. After carefully considering the evidence, I believe Petitioner met her burden of proving her level of disability has significantly increased since the issuance of the October 25, 2012, Arbitration Decision. Thus, I would grant Petitioner's Section 19(h)/8(a) Petition.

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On December 22, 2007, and March 26, 2008, Petitioner sustained work-related injuries to her lumbar spine. She underwent a lumbar micro-discectomy in August 2008 and underwent a single-level lumbar fusion surgery at L5-S1 in May 2009. In August 2011, Dr. Fisher, Petitioner's treating physician, recommended a lumbar fusion surgery at L4-L5. Petitioner decided to not pursue the recommended surgery and continued to work in her position as a watchman for Respondent. After reviewing all the evidence, including the recent surgery recommendation, the Arbitrator determined Petitioner's current condition of ill-being was causally related to the work injuries. A close review of the Decision shows the Arbitrator found the recommended lumbar fusion surgery at L4-L5 is causally related to Petitioner's work injuries. In relevant part, the Arbitrator wrote,

> "...On August 25, 2011, Dr. Fisher reviewed the results of the CT myelogram and again recommended a fusion at L4-L5 due to ongoing symptoms and the failure of more conservative measures to relieve them.
> On March 1, 2012, Dr. Fisher again prescribed surgery. When seen on June 16, 2012, Dr. Fisher was advised by Petitioner that she wanted to hold off on surgery. Dr. Fisher then placed her at maximum medical recovery and indicated that she may proceed with surgery in the form of an L4-L5 fusion at a later date.
> *Based upon the above*, the Arbitrator further finds that the condition of ill-being as described above is causally related to the accidental injury of March 26, 2008." (emphasis added).

Neither party appealed the Decision of the Arbitrator; therefore, the Arbitrator's conclusions are the law of the case. The majority's opinion is critically flawed because it fails to recognize that the causal relationship of Petitioner's need for the additional fusion surgery was fully and finally determined by the Arbitrator in 2012. Respondent is prohibited from now trying to relitigate the causal relation of the surgery.

Following the arbitration hearing, Petitioner's physical condition continued to worsen. On March 5, 2015, Dr. Slack took Petitioner off work and Dr. Fisher continued to keep her off work. Finally, due to her deteriorating condition, Petitioner underwent extensive lumbar spine surgery at L4-L5 including the recommended fusion on April 4, 2016. As the fusion surgery at L4-L5 is causally related to the work injuries, clearly Petitioner is entitled to TTD benefits for the time she was restricted from work as a result of the surgery. At the time of the arbitration hearing, Petitioner was able to continue working in her original position as a watchman with certain restrictions. However, the credible evidence shows that Petitioner physically is no longer able to continue working in that position.

On April 27, 2017, Dr. Fisher placed Petitioner at MMI and prescribed permanent work restrictions of sedentary work with no walking. These permanent restrictions prevented Petitioner form returning to work as a watchman. Then, on July 5, 2017, Dr. Fisher determined Petitioner is

unable to return to work in any capacity as she is unable to tolerate prolonged periods of sitting or standing and could not lift or bend. Mr. Blumenthal, Petitioner's vocational rehabilitation expert witness, credibly testified that Petitioner lost access to her normal occupation as a watchman. Furthermore, Mr. Blumenthal concluded no stable labor market existed for Petitioner. His opinion was based on the level of her physical impairment and the results of the vocational testing he performed on Petitioner.

After carefully weighing the totality of the evidence, I believe Petitioner more than met her burden of proving her level of physical disability has significantly increased since the issuance of the Decision of the Arbitrator. Her worsening condition led to her decision to finally undergo the lumbar fusion surgery the Arbitrator found to be causally related to Petitioner's work injuries. Unfortunately, the surgery did not improve her condition and Petitioner is now permanently restricted from pursuing her usual employment. Petitioner has also met her burden of proving no stable labor market exists for her due to the combination of her permanent physical impairment and her lack of transferable skills.

For the forgoing reasons, I would grant Petitioner's Section 19(h)/8(a) Petition and find the lumbar fusion surgery Petitioner underwent following the arbitration hearing was reasonable and causally related to her work injuries. As such, I would award the related medical expenses, TTD, and vocational assessment expenses. Finally, I would find Petitioner met her burden of proving she is permanently and totally disabled.

Thomas J. Tyrrell

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JAIME DELGADO,

Petitioner,

vs. NO: 14 WC 034591

CHICAGO TRANSIT AUTHORITY,

20IWCC0411

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 Section 19(l) penalties and being advised of the facts and law, vacates the award of Section 19(l) penalties, 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 Respondent appeals from the Arbitrator's award of Section 19(l) penalties for non-payment of Petitioner's prescription pain medications. Petitioner was treating with pain management specialist, Dr. Marie Kirincic beginning on October 16, 2016, through the date of the Arbitration hearing. Dr. Kirincic submitted the Petitioner's pain medication drug prescriptions directly to the Injured Worker's Pharmacy. Petitioner filed his Penalties Petition, along with Sections 19(b) and 8(a) petitions, on July 20, 2018, which the Arbitrator viewed as the "demand for payment" thereby awarding Section 19(l) penalties from July 20, 2018 through the date of the hearing, September 26, 2018, a period of 69 days.

Section 19(l) provides,

> If the employee has made written demand for payment of benefits under Section 8(a) or Section 8(b), the employer shall have 14 days after receipt of the demand to set forth in writing the reason for the delay. In the case of demand for payment of medical benefits under Section 8(a), the time for the employer to respond shall not commence until the expiration of the allotted 30 days specified under Section 8.2(d). In case the employer or his or her insurance carrier shall without good and just cause fail, neglect, refuse, or unreasonably delay the payment of benefits under Section 8(a) or Section 8(b), the Arbitrator or the Commission shall allow to the employee additional compensation in the sum of $30 per day for each day that the benefits under Section 8(a) or Section 8(b) have been so withheld or refused, not to exceed $10,000. A delay in payment of 14 days or more shall create a rebuttable presumption of unreasonable delay. *820 ILCS 305/19(l)* (West 2012)

The Courts have defined the standard which would justify the delay in payment as follows,

> Penalties under section 19(*l*) are in the nature of a late fee and are mandatory [i]f the payment is late, for whatever reason, and the employer or its carrier cannot show adequate justification for the delay.'" *Jacobo v. Illinois Workers' Compensation Comm'n*, 2011 Il App (3d) 100807WC, ¶ 20, 959 N.E.2d 772, 355 Ill. Dec. 358 (quoting *McMahan v. Industrial Comm'n*, 183 Ill. 2d 499, 515, 702 N.E.2d 545, 552, 234 Ill. Dec. 205 (1998)). "The standard for determining whether an employer has good and just cause for a delay in payment is defined in terms of reasonableness." *Id.* ... "The employer has the burden of justifying the delay, and the employer's [***8] justification for the delay is sufficient only if a reasonable person in the employer's position would have believed that the delay was justified." *Jacobo*, 2011 IL App (3d) 100807WC, ¶ 20, 959 N.E.2d at 777-78.

Theis v. Ill. Workers' Comp. Comm'n, 2017 IL App (1st) 161237WC, P19, 74 N.E.3d 468, 471, 2017 Ill. App. LEXIS 145, *7-8, 412 Ill. Dec. 1, 4

When awarding §19(l) penalties, the Arbitrator cited, "Dr. Ackerman's concession that it is appropriate for Petitioner to be obtaining medication from a pain physician rather than an orthopedic surgeon like himself." (Arb. Dec. p. 25) The Arbitrator noted that the Respondent did not offer any opinion from a pain physician indicating that Petitioner's medication regimen is excessive or otherwise unreasonable. The Commission notes that Dr. Ackerman never responded to the question of whether or not the medications that Petitioner was taking were reasonable or necessary, and answered instead, "[h]e was on a lot of pain medication." (T, p. 56) When pressed for which medications were or were not necessary, Dr. Ackerman responded, "[b]ased on the amount of narcotics he's requiring, he was ---pain was managed by an anesthesia pain specialist, which I felt was appropriate." He added, "[b]ut appropriately managed by anesthesia pain specialist because it's probably too much narcotics to be managed by an orthopedic surgeon." The Commission finds that Dr. Ackerman's comments cannot be construed to mean that without a counter opinion by a pain specialist the amount of narcotics Petitioner was being prescribed were reasonable and necessary. In fact, Dr. Ackerman opined that the amount of narcotics Petitioner

was taking was not appropriate, thus, the Commission finds his comments are not a basis for awarding Section 19(l) penalties.

The Petitioner testified that the pain medications he was prescribed prior to treating with Dr. Kirincic were reviewed by the Respondent's medical reviewer and were denied. (T, p. 92) Petitioner further testified, "[m]y pain doctor started me through the IWP program. That's how I have been getting the medications refilled. " *Id.* Review of the Hinsdale Orthopaedics ledgers confirms that medical bills were paid by the workers' compensation carrier, however, no charges were listed for prescription pain medications. A review of the records also confirms Dr. Domb's notes regarding pain prescriptions were being given to the Petitioner, however, there is no notation in Dr. Kirincic's records indicating that the prescription pain medication expenses were ever submitted to the carrier or even given to the Petitioner, instead they were being submitted directly to the Injured Workers' Pharmacy.

The Petitioner's Penalties Petition and Petition for Medical Benefits alleged that Respondent refused to pay for pain prescriptions, however, no pain medication bills were attached to either of the Petitions. Petitioner did not produce evidence that bills for prescription medications were tendered to the Respondent. Therefore, Respondent had adequate justification for nonpayment of bills they never received. The Respondent had no duty to actively seek out a claimant's medical bills through the use of a subpoena or other method in order to comply with Section 19(l). *Theis v. Ill. Workers' Comp. Comm'n,* 2017 IL App (1st) 161237WC, P19, 74 N.E.3d 468, 471, 2017 Ill. App. LEXIS 145, *7-8, 412 Ill. Dec. 1, 4

In *Thies*, the First District found that claimant's failure to tender medical bills to the Respondent caused the delay in payment, and thus there was adequate justification for the delay. Here, similarly, there is no evidence that the bills for prescription medication were ever tendered to Respondent. Further, based upon Dr. Ackerman's comments regarding the inappropriate amount of narcotics Petitioner was requiring and Petitioner's testimony that the pain prescriptions had been denied by a medical review, there were sufficient questions of causation, and reasonableness and necessity of the ongoing medications to justify the delay in payment.

The Commission finds that the Petition for Penalties upon which the Arbitrator relied was devoid of a bill or itemization of the amount of prescription bills that were unpaid. Arbitrator's Exhibit One, the Request for Hearing form and trial stipulations, does not list the unpaid prescription medical bills. The record is devoid of an Injured Workers' Pharmacy exhibit or any exhibit reflecting the amount paid for prescriptions by the Injured Workers' Pharmacy. Even if the bills were admitted into Arbitration, there is still no proof that the bills were ever tendered to Respondent. The *Theis* Court held that, "the act of submitting medical bills into evidence during arbitration is not the same as tendering them to the employer for payment." *Theis v. Ill. Workers' Comp. Comm'n*, 2017 IL App (1st) 161237WC, P23, 74 N.E.3d 468, 472, 2017 Ill. App. LEXIS 145, *10, 412 Ill. Dec. 1, 5

Therefore, the Commission affirms and adopts the Arbitrator's Decision except the Commission vacates the Arbitrator's Order with respect to the Section 19(l) penalties, and strikes the last paragraph on page 25 of the Arbitrator's Decision.

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IT IS THEREFORE ORDERED BY THE COMMISSION that that the Arbitrator's award of Section 19(l) penalties is vacated, and the Arbitrator's Decision filed on October 15, 2018, is hereby modified for the reasons stated herein, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall provide and pay for prospective medical treatment in the form of the right hip replacement recommended by both the treating physicians and Respondent's Section 12 orthopedic expert/hip examiner, Dr. Ackerman, and for left hip replacement revision surgery pursuant to §8(a) and §8.2 of the Act.

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

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

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

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

Based upon the named Respondent herein, no bond is set by the Commission. *820 ILCS 305/19(f)(2)* (West 2012) The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUL 20 2020
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Kathryn A. Doerries

Maria E. Portela

DISSENT

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I wholeheartedly agree with the Arbitrator's decision to award additional compensation pursuant to §19(l) of the Act in this case based on Respondent's unreasonable refusal to pay benefits in the form of prescription pain medication.

§19(l) provides, in pertinent part, that "[i]n case the employer or his or her insurance carrier shall without good and just cause fail, neglect, refuse, or unreasonably delay the payment of benefits under Section 8(a) or Section 8(b), the Arbitrator or the Commission shall allow to the employee additional compensation in the sum of $30 per day for each day that the benefits under Section 8(a) or Section 8(b) have been so withheld or refused, not to exceed $10,000. A delay in payment of 14 days or more shall create a rebuttable presumption of unreasonable delay."

In this case, Respondent failed to overcome this presumption by providing adequate justification for its refusal to pay for the prescription medication in question. Indeed, at the very least, Respondent should have been aware of these claimed prescription expenses given pain specialist Dr. Kirincic's ongoing references to same in her records and the fact that Petitioner continued to present these bills for approval, only to be told that a CTA medical reviewer had denied the medications and forcing Petitioner to obtain same through the Injured Workers' Pharmacy. Furthermore, this is not a case where Respondent's conduct might be excused due to differing medical opinions. Instead, Dr. Ackerman, Respondent's §12 examining physician, conceded during the course of his deposition that it was appropriate for Petitioner to treat with and receive medication through a pain specialist. Thus, Respondent failed to show that it had good and just cause for delaying and/or refusing to pay for the medical benefit in question, especially since Respondent did not dispute that Petitioner suffered an accidental injury arising out of and in the course of his employment on May 29, 2014 and that his current condition of ill-being relative to his left hip injury was causally related to the accident in question.

Furthermore, it was reasonable for the Arbitrator to view Petitioner's filing of his penalties petition, along with his Petition pursuant to §§19(b) and 8(a), as a written demand for payment of said benefits, and as such satisfied the requirements of §19(l) of the Act.

Therefore, the Arbitrator was entirely justified in awarding additional compensation pursuant to §19(l) of the Act, and I would have affirmed the Arbitrator's decision in its entirety.

Thomas J. Tyrrell

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

DELGADO, JAIME
Employee/Petitioner

Case# **14WC034591**

CHICAGO TRANSIT AUTHORITY
Employer/Respondent

20IWCC0411

On 10/15/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.38% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5512 SHANNON LAW GROUP PC
JONATHAN J SVITAK
3550 HOBSON RD SUITE 203
WOODRIDGE, IL 60517

0515 CHICAGO TRANSIT AUTHORITY
ANDREW ZASUWA
567 W LAKE ST 6TH FL
CHICAGO, IL 60661

20 IWCC0411

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)

Jaime Delgado
Employee/Petitioner

v.

Chicago Transit Authority
Employer/Respondent

Case # **14** WC **034591**

Consolidated cases: **D/N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Molly Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **8/17/18 and 9/26/18**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **05/29/14**, 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.

Respondent does not dispute causation insofar as Petitioner's left hip and lumbar spine conditions are concerned. Respondent also concedes that Petitioner has the same condition of ill-being, i.e., avascular necrosis, in his right hip that he has in his left. Respondent disputes causation with respect to the right hip. For the reasons set forth in the attached decision, the Arbitrator finds that Petitioner also established causation as to his right hip condition of ill-being.

In the year preceding the injury, Petitioner earned **$50,272**; the average weekly wage was $1,256.80.

On the date of accident, Petitioner was **39** years of age, ***single*** with **0** dependent children.

The parties deferred the issue of incurred medical expenses with one exception. Petitioner contends Respondent has unreasonably failed to pay for his prescription pain medication.

The parties agree Petitioner was temporarily totally disabled from May 30, 2014 through September 26, 2018. They also agree Respondent was continuing to pay temporary total disability benefits as of the September 26, 2018 hearing.

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

ORDER

The Arbitrator finds that Petitioner established causation as to his right hip condition of ill-being. The Arbitrator awards prospective care in the form of the right hip replacement recommended by both the treating physicians and Respondent's hip examiner, Dr. Ackerman.

The Arbitrator finds that Petitioner established reasonableness and necessity with respect to the recommended left hip replacement revision surgery. The Arbitrator awards Petitioner prospective care in the form of this surgery.

The Arbitrator awards Section 19(l) penalties in the amount of $30/day from July 20, 2018 (the day Petitioner filed his penalties petition, Arb Exh 2) through the hearing of September 26, 2018, a period of 69 days.

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.

20 IWCC0411

Molly C Mason

Signature of Arbitrator

10/12/18
Date

ICArbDec19(b)

OCT 15 2018

Jaime Delgado v. Chicago Transit Authority
14 WC 34591

20IWCC0411

Summary of Disputed Issues

The parties agree Petitioner sustained an accident on May 29, 2014, while working as a tower man for Respondent. They also agree Petitioner established causation as to his left hip (avascular necrosis) and lumbar spine conditions of ill-being. Respondent authorized and paid for a left hip replacement. The parties further agree Petitioner was temporarily totally disabled from May 30, 2014 through the continued hearing of September 26, 2018. Respondent was paying weekly benefits as of that hearing. Respondent does not dispute that Petitioner also has avascular necrosis of the right hip but disputes causation with respect to that condition. As of August 2018, Petitioner's hip specialist was recommending both a right hip replacement and revision of the left replacement procedure due to suspected loosening of the implant. Respondent disputes the reasonableness and necessity of the revision surgery. Arb Exh 1. Petitioner seeks prospective surgery along with Section 19(l) penalties based on Respondent's refusal to pay for certain prescription medication.

Summary of Petitioner's Testimony

Petitioner testified he was born in Chicago and graduated from Lane Tech High School. For the last twelve years, he has lived in Bolingbrook with his girlfriend, Carmen Ramos, and son. His parents are deceased. He has siblings in the Chicago area.

Records in evidence reflect Petitioner was involved in a serious motor vehicle accident in July 1999. The accident resulted in a rupture of the aorta and a left femur fracture. Petitioner underwent surgery to repair the rupture as well as an open reduction/internal fixation of the femur fracture.

Petitioner testified he was 39 years old as of the May 29, 2014 work accident. He is now 43.

Petitioner testified he began working for Respondent in December 2006. Prior to being hired by Respondent, he worked for his brother for two years. His job involved booking gigs and studios, putting out advertisements and transporting equipment such as speakers. Prior to that, he worked for Jewel between 1992 and 2004. He eventually became an assistant grocery manager. His duties included ordering produce and setting up displays.

Petitioner testified he was classified as a "CRO" when he started working for Respondent. He filled in as needed, working as a train operator, flagman, customer assistant, switchman or tower man. He would receive a call the day before he was scheduled to work, telling him where to go. By 2010, he had accumulated enough time to pick the tower man job but he was subsequently "bumped out" of this job. In 2012, he became a tower man on a permanent basis. He worked at one of two locations downtown. His job was similar to that of

a crossing guard in that he helped route trains coming through the Loop. In winter, he sometimes had to brush ice and snow off the tracks.

Petitioner testified he was still working as a tower man as of Thursday, May 29, 2014, the date of his accident. He drove to his assigned location, Tower 18, at Harlem and Lake, and parked his car underneath a structure at Wells and Lake. At 4:45 AM, he relieved the tower man who was on duty and started his shift. He left at 1 PM, came down to track level and started walking down a catwalk. He was carrying his work radio at that time. The catwalk was greasy because preventative maintenance personnel had recently lubricated the switch points. He slipped but managed to avoid falling. He twisted his lower back in the process. He resumed walking and got into his car. As he drove home, he realized he was not able to put weight on his left side. He struggled to walk into his house and went to his couch. By that time, he was experiencing throbbing pain in his left leg and pressure in his lower back, from the mid-buttock are to the thigh.

Petitioner testified he was not scheduled to work the following day. He bought some Icy Hot and applied it to the affected areas. By now, he was experiencing pain radiating down his left leg. He contacted Respondent in the afternoon and spoke with a terminal manager. At her direction, he went to the Harlem and Lake location the next day and completed a report. His girlfriend drove him there. He spoke with someone who recommended he seek medical care. Later the same day, his girlfriend took him to the Emergency Room at Adventist Bolingbrook Hospital. At the hospital, he was examined, given Hydrocodone and Valium for pain and told to remain off work and see his primary care physician.

The Emergency Room records of May 31, 2014 reflect a complaint of constant left-sided lower back and radiating left leg pain secondary to slipping on grease at work two days earlier. The Emergency Room physician, Dr. Ruff, noted differential diagnoses of lumbar strain, disc herniation, sciatica and spinal stenosis. He prescribed Norco, Valium and Ibuprofen. He directed Petitioner to stay off work for three days and follow up with his primary care physician, Dr. Shih. PX 3.

Petitioner testified he saw Dr. Shih on Monday, June 2, 2014. He felt worse at this point. He was not able to bend, stretch or take stairs two at a time. Dr. Shih increased his Hydrocodone dosage and directed him to stay off work. He continued seeing Dr. Shih throughout June and July 2014. Lumbar spine X-rays performed on June 11, 2014 showed sacralization of the L5 transverse processes, with degenerative changes at the sacroiliac joints. PX 3.

Dr. Khanna, a physiatrist, performed an EMG on June 24, 2014. In his report of that date, Dr. Khanna recorded a consistent history of the 1999 motor vehicle accident and the 2014 work accident. He noted that Petitioner complained of left-sided lower back pain radiating down to his foot along with left calf pain and numbness and paresthesias in the left foot. He described Petitioner's gait as "shuffling" and noted he was having problems with balance. He noted that the only comfortable position for Petitioner was lying on a bed with his legs

suspended off the bed. He indicated that Petitioner took 10 mg of Prednisone daily for autoimmune enteritis. He described pinprick sensation is diminished at the anterior aspect of the left thigh and the left lower leg below the knee. He described straight leg raising as negative. He found the EMG results "consistent with a left-sided sub-acute L5 radiculopathy. He found it concerning that "there was not a significant amount of motor units that were visible in the L5 distribution on the left side when [Petitioner] attempted to contract these muscles." He indicated this finding pointed to the likelihood of a severe radiculopathy. PX 8.

A lumbar spine MRI, performed with and without contrast on July 10, 2014, showed spondylotic changes at the lower lumbosacral spine, most prominent at L4-L5, with intervertebral disc desiccation and a diffuse disc bulge, mildly impinging upon the ventral surface of the thecal sac. PX 3, 14.

Petitioner testified his condition continued to worsen during this period. Dr. Shih referred him to Dr. Pilcher, a neurologist.

Dr. Pilcher's initial note of July 31, 2014 sets forth a consistent history of the work accident and subsequent treatment. The doctor noted that, following the accident, Petitioner initially experienced left-sided lower back pain which worsened and started radiating down his left leg into the foot. She also noted that Petitioner complained of numbness under the foot. She indicated Petitioner was taking Valium, Norco and Ibuprofen for pain. Based on her review of the MRI and EMG, she felt it was likely Petitioner had left-sided radiculopathy due to the bulging disc at L4-L5. She prescribed Gabapentin, Lidocaine patches and physical therapy. PX 7.

Petitioner testified he started a course of therapy at PT Solutions in late July 2014. The therapy consisted of core strengthening and stretching.

Petitioner returned to Dr. Pilcher on August 28, 2014 and reported a little benefit from the Gabapentin. The doctor increased the dosage and recommended Petitioner continue therapy. PX 7. At the next visit, on September 24, 2014, Dr. Pilcher referred Petitioner to Dr. Hong, a pain specialist, for possible injections. PX 7.

Petitioner testified he participated in 48 therapy sessions at PT Solutions in 2014. Petitioner testified that the therapists who were treating him noticed he was having left hip issues and relayed this to him. Since he is not a doctor, it was not possible for him to determine whether his pain was originating in his hip.

The Arbitrator has reviewed the PT Solutions therapy records in detail. At the initial assessment, on August 7, 2014, the therapist noted reports of 8/10 lumbar pain and left leg radiculopathy of two months' duration due to an injury. She described Petitioner as presenting with a guarded posture and "antalgic gait on LLE." On August 12, 2014, the therapist noted "no relief of radicular symptoms." She described Petitioner as walking "with limp on LLE due to decreased sensation." On August 27, 2014, after eight sessions, the therapist noted that Petitioner was still guarded with left leg weight bearing due to constant radicular symptoms

along the sciatic nerve. She also noted pain ratings of 7-8/10 in the low back and left leg. On September 10, 2014, the therapist noted a continued antalgic gait, tenderness over the left hip and left L5-S1 level and "referred pain down RLE" [emphasis added]. On September 11, 2014, the therapist noted that Petitioner presented with "+ trigger point over right L5-S1 area, right piriformis" and tenderness over the posterior right hip [emphasis added]. On September 15, 2014, the therapist noted that Petitioner was having more difficulty negotiating stairs, particularly when picking up his left leg. On September 18, 2014, the therapist recommended "diagnostic testing to rule out hip joint dysfunction." PX 3. On October 13, 2014, the therapist noted complaints of 6-7/10 low back and left hip pain. On October 14, 2014, Petitioner reported his pain was gradually decreasing but his left foot numbness was unchanged. The therapist indicated he was limited with weight bearing on his left leg and "guarded with hip abduction." On October 21, 2014, the therapist noted tenderness over the right LS and SI joint areas along with tenderness over the piriformis and posterior lip of the right hip joint. On November 4, 2014, Petitioner complained of 3/10 left hip soreness and tingling on the bottom of his foot. PX 3.

Petitioner testified he underwent three lumbar epidural steroid injections at Gateway. The injections provided some relief of his pain. The records reflect Dr. Malhotra administered on October 8 and 23 and November 6, 2014.

On October 25, 2014, Petitioner saw Dr. Chmell, an orthopedic surgeon, for a second opinion. The doctor's note of that date sets forth a consistent account of the work accident and subsequent care. The doctor indicated that, following the accident, Petitioner experienced an immediate onset of lower back pain that worsened and began radiating down his left leg, with accompanying numbness and tingling in the left foot. He noted that Petitioner had undergone two epidural steroid lumbar injections to date and was awaiting a third. He indicated that Petitioner denied any pre-accident lower back or left leg problems and was now experiencing pain, difficulty balancing and walking and left leg weakness for which he was using Lidocaine patches and taking Ibuprofen, Valium, Norco and Gabapentin. He noted that Petitioner has "autoimmune enteritis for which he is on a number of medications, including Prednisone, folic acid, Vitamin D and Nanaprazil."

Dr. Chmell described Petitioner as walking "with a very prominent limp on the left side" and "strongly favoring his left lower extremity as he stands, walks and gets on and off the examining table." He also noted "very prominent left-sided lumbar spasm and tenderness with reduced lordosis and motion." He described straight leg raising as positive on the left at 70 degrees and accomplished to 90 degrees on the right. He noted "visible and palpable atrophy" in Petitioner's left thigh and left calf compared to the right. The left thigh measured 3 centimeters less than the right in circumference. The left calf measured 2.5 centimeters less than the right in circumference. He noted diminished sensation along the medial and plantar aspects of the left foot. He described strength in the left leg as "diffusely diminished."

Dr. Chmell diagnosed a herniated disc with left lower extremity radiculopathy. He told Petitioner he felt the present treatment was "satisfactory" but expressed concern about the

atrophy and weakness. He indicated he wanted to review Petitioner's past records, MRI scan and EMG. He felt that Petitioner was at risk for falling and thus needed to be off work. PX 14.

Petitioner testified his therapy came to an end in November 2014, due to lack of authorization. On November 5, 2014, Dr. Shih referred him to Dr. Lee, a hip specialist. In her note of November 5, 2014, Dr. Shih indicated that "the PT mentioned that [Petitioner] had hip issues." PX 4. Petitioner testified that Respondent authorized him to see Dr. Lee on an "evaluation only" basis. Dr. Lee recommended additional physical therapy.

Dr. Lee's note of November 20, 2014 sets forth a history of the 1999 motor vehicle accident and the work accident. The doctor noted complaints of piercing left hip pain radiating to the left leg, along with left leg weakness. He indicated that Petitioner's lower back pain had improved following injections. On examination, he noted weak hip abductors and decreased left hip strength. He recommended therapy to strengthen the abductors and indicated Petitioner might need an EMG to rule out a nerve root injury if the therapy did not help. PX 12.

At Respondent's request, Petitioner underwent a Section 12 examination by Dr. Forman of the Illinois Bone & Joint Institute on December 3, 2014. Petitioner testified that Dr. Forman focused on his back. The examination lasted 20 to 30 minutes.

Dr. Forman's report of December 3, 2014 (RX 1) reflects he saw Petitioner "for left leg pain and sciatica." The report sets forth a history of the work accident and subsequent care. It also reflects a history of the July 1999 aortic and left femur surgeries. The doctor noted that Petitioner had participated in therapy and undergone three lumbar epidural steroid injections. He indicated that Petitioner reported obtaining relief from the injections. He also indicated that therapy was interrupted due to lack of authorization. He noted that Petitioner was currently taking Norco, Flexeril, Valium and Gabapentin and using Lidocaine patches.

Dr. Forman described Petitioner as being able to heel and toe walk and get from a supine to a seated position without difficulty. He described straight leg raising as negative. He indicated he examined Petitioner's left leg and lumbar spine. He did not reference either hip.

Dr. Forman indicated he reviewed the June 11, 2014 lumbar spine X-rays and the lumbar spine MRI, along with occurrence reports, Emergency Room records, records from Dr. Shih and a neurologist's note. He indicated he had no records concerning the recent injections.

Dr. Forman diagnosed left leg pain with sciatica. He characterized the treatment to date as reasonable and necessary. He found a causal connection between Petitioner's current complaints and the work accident, based on Petitioner's history and the records he reviewed.

Dr. Forman did not find Petitioner capable of resuming full duty. He recommended four weeks of work hardening and indicated this would likely enable Petitioner to resume full duty. RX 1.

Petitioner testified that during November and December 2014, all of his physicians were recommending additional physical therapy but Respondent would not approve it. By December 2014, he needed a cane to walk and could no longer climb stairs. He was able to put weight on his left leg "but not easily." He leaned on the cane and relied primarily on his right leg when trying to walk. His symptoms persisted. Between January and April 2015, Respondent continued to deny the recommended therapy.

On January 2, 2015, Dr. Emran, a board certified family medicine practitioner affiliated with Network Medical Review Company, issued a report non-certifying additional physical therapy. Dr. Emran indicated he had reviewed a clinical note dated November 20, 2014 along with Dr. Forman's examination report. He further indicated he had not been provided with the MRI or EMG. He stated that Petitioner had attended 48 sessions of physical therapy for his lumbar spine and continued to have back pain. He saw no indication of Petitioner having returned to work in any capacity. He stated that "evidence-based guidelines" supported up to 10 sessions of therapy over 8 weeks for the type of injury Petitioner sustained. He described the additional recommended therapy as "not medically necessary." PX 3.

Petitioner testified that, in March 2015, he began experiencing pain in his right hip, groin and trochanter.

Petitioner testified he returned to Dr. Shih in April 2015. The doctor raised the issue of his right hip and recommended right hip therapy. Dr. Shih's note of April 8, 2015 reflects that Petitioner "continues to have L sided buttock and hip pain with probable compensatory pain on the R side." The doctor recommended additional therapy and adjusted Petitioner's medication. She noted that Dr. Lee had also recommended therapy but "the CTA has not OK [sic] this and he is just waiting." On examination, she noted both left hip tenderness and a reduced range of motion and tenderness in the right lateral hip.

Petitioner testified that Dr. Forman re-examined him in May 2015, again focusing on his back.

Dr. Forman's report of May 27, 2015 reflects that Petitioner was still off work and denied having undergone additional care since the original examination of December 3, 2014. Dr. Forman indicated that, according to Petitioner, "everything has been denied," including the four weeks of work hardening the doctor had recommended in December. The doctor also indicated that Petitioner described his pain as worse than it was in December.

Dr. Forman indicated that Petitioner was able to heel and toe walk but was "awkward doing this." He again described straight leg raising as negative. He noted a subjective complaint of pain in the left buttock going down the lateral aspect of the leg. The report contains no specific mention of either hip.

Dr. Forman noted that, since the original examination, he had received only one new record, namely Dr. Emran's utilization review report non-certifying additional therapy.

Dr. Forman again characterized the treatment to date as reasonable and necessary but indicated he could not comment on the fact that "nothing has been done in the last six months." He again causally linked Petitioner's condition to the work accident. He did not find Petitioner to be at maximum medical improvement, indicating that the recent gap in care had put a "very interesting twist" in the case. He noted that, while he had previously recommended four weeks of work hardening, he was now recommending an EMG and nerve conduction studies. He stated it would be appropriate for Petitioner to undergo a functional capacity evaluation if these studies were negative. He did not find Petitioner capable of full duty. RX 2.

On June 29, 2015, Petitioner underwent an initial evaluation at PT Solutions. The evaluating therapist recorded a history of the work accident. She noted that Petitioner "was last seen in therapy last November and was doing better [but was] not able to continue due to denial from insurance." She indicated that Petitioner had continued performing home exercises but had not progressed. She noted complaints of "low back, left hip joint and at times right hip pain." She described Petitioner's gait as antalgic. She indicated that Petitioner had started using a straight cane a month earlier due to fear of falling. She measured left quadriceps girth at 16 ¾ inches versus 17 ½ inches on the right.

Petitioner returned to Dr. Pilcher on July 15, 2015. The doctor noted that Petitioner had derived some benefit from the injections and therapy performed in 2014 "but then his insurance stopped covering PT and things got worse again." She noted that Petitioner still had left-sided symptoms but that his pain "now also seems to be spreading towards the right side." She indicated he had seen an orthopedist and that there were "perhaps also some hip joint issues." She recommended he restart physical therapy and undergo a repeat lumbar spine MRI. PX 7.

Petitioner testified he returned to Dr. Shih in August 2015. He complained of pain in his lower back and both hips. Dr. Shih recommended additional physical therapy (PX 3, 4) and referred him to Dr. Chmell.

A physical therapy re-evaluation note of November 5, 2015 reflects that Petitioner was still using a cane and exhibiting an antalgic gait on the left. The therapist indicated that Petitioner was compliant but continued to have pain and dysfunction. She noted a complaint of 4/10 right groin pain in addition to various left-sided complaints. She recommended an evaluation by a hip specialist to rule out acetabular dysfunction in addition to a lumbar deficit.

On November 5, 2015, Dr. Pilcher noted that Petitioner reported having had left hip pain "from the beginning, starting after the fall," and that this pain was now severe. She also noted that the pain was causing Petitioner's gait to be leaning and that he was now also developing right hip pain. She prescribed a repeat EMG and an orthopedic evaluation of the hp pain. PX 7.

On November 13, 2015, Petitioner underwent repeat EMG and nerve conduction studies. Dr. Siddiq performed these studies. In his report, he documented a history of the remote motor vehicle accident and the May 2014 work accident. He noted that Petitioner had been experiencing lower back and radiating left leg pain since the work accident. He indicated that Petitioner walked with a cane and that straight leg raising was positive on the left at 70 degrees. He described the EMG/NCV results as normal, indicating he found no conclusive or definite evidence of lumbosacral radiculopathy affecting either leg and no definite evidence of peripheral neuropathy. PX 3, 7.

On November 19, 2015, Dr. Shih noted complaints of back and bilateral hip pain. She recommended that Petitioner see Dr. Domb of Hinsdale Orthopaedics for further hip evaluation. PX 4.

Petitioner returned to Dr. Chmell on December 30, 2015. The doctor noted that Petitioner had seen physical therapists who felt some of his pain originated in his hips. The doctor noted complaints of "continued low back pain, radiating down the left leg, as well as left hip pain and sometimes right hip pain." On re-examination, he noted prominent left-sided lumbar spasm and tenderness, reduced hip range of motion and diminished strength and sensation in the left leg. He diagnosed a herniated disc with left-sided radiculopathy and "bilateral hip derangement, possible avascular necrosis." He prescribed X-rays of the pelvis and hips and MRIs of the hips. The bilateral pelvis and hip X-rays, performed on January 15, 2016, showed abnormalities consistent with bilateral femoral avascular necrosis "with subchondral fractures and flattening of the superior femoral heads bilaterally" along with bilateral hip and SI joint arthropathy with some ankylosis across the SI joints. The interpreting radiologist also noted evidence of the prior left femoral surgery and related hardware. The right hip MRI, performed without contrast on January 15, 2016, also showed evidence of avascular necrosis with subchondral collapse and moderate osteoarthritis with joint effusion. The left hip MRI, performed without contrast on January 15, 2016, showed evidence of avascular necrosis with suggestion of subchondral collapse of the femoral head and moderate osteoarthritis with mild joint effusion along with metallic artifacts emanating from a rod and screws traversing the left femur. PX 14. On January 28, 2016, Dr. Chmell called Petitioner and "explained to him that he has avascular necrosis of both femoral heads with collapse." He described Petitioner's pain as "not controlled and getting worse." He informed Petitioner he would need bilateral hip replacement surgery. PX 14.

Petitioner testified that, at this point, no physician had released him to work.

Dr. Domb's initial note of February 22, 2016 sets forth a consistent history of the work accident and subsequent care. The note also reflects a history of "autoimmune disease of the intestines" for which Petitioner had been taking 2 milligrams of Prednisone daily. The doctor noted that the initial post-accident care focused on the back but that Petitioner's hips were bothering him in "August and September while he was in physical therapy." He indicated that Petitioner described his left hip pain as worse than his right.

Dr. Domb noted he reviewed X-rays and MRIs which Petitioner brought with him to the appointment. He interpreted the X-rays as showing bilateral arthritic changes from avascular necrosis and a femoral rod from a previous left femur fracture. He interpreted the MRI images as showing bilateral femoral head avascular necrosis. He informed Petitioner he would need to have the femoral rod removed before he could undergo hip replacement surgery. He referred Petitioner to Dr. Dougherty for this surgery. He indicated he planned to replace the left hip first and the right hip six weeks later. PX 5.

Petitioner testified he was told he needed to undergo surgery to have an intermedullary nail removed from his left leg before he could undergo the hip replacement. The nail had been inserted in 1999, following a motor vehicle accident in which a drunk driver hit him. He had never had any problems with the nail but was told it had to be removed to allow space for the hip prosthesis. At Dr. Domb's recommendation, he saw Dr. Dougherty, a nail removal specialist. Dr. Dougherty surgically removed the nail in February 2016.

Dr. Dougherty's initial note of February 23, 2016 sets forth a "distant history of a left femur fracture treated with intramedullary nailing" as well as a history of the work accident. The note reflects that Petitioner described the prior left femur fracture as having healed uneventfully. It also reflects that Petitioner "was completely pain free" prior to the work accident. He indicated that Petitioner initially experienced back pain after the work accident, with that pain "giving way to bilateral hip pain." He recommended that the intramedullary nail be removed as soon as possible so that the left total hip replacement could be performed. He noted Petitioner's "understanding that removal of the nail will weaken the overall strength of the left femur."

Dr. Dougherty surgically removed the left femoral intramedullary nail on March 16, 2016. At the first post-operative visit, on April 6, 2016, he noted that Petitioner was able to walk on his own but was using a walker "to build up his upper body strength in preparation for" the left total hip replacement. He informed Petitioner he could progress to full weight bearing and prescribed Norco. He released Petitioner from care on a PRN basis, noting he would need three or four more weeks of healing prior to the contemplated left total hip replacement.

Dr. Domb performed the left total hip replacement on July 15, 2016. PX 5.

Petitioner testified he needed home health care and used a walker to ambulate following the replacement. He was still in pain.

At the first post-operative visit, on July 28, 2016, Dr. Domb noted that Petitioner was experiencing moderate pain and still using a walker. He ordered X-rays, which showed "good position of the implants with a displaced greater trochanteric fracture." He recommended additional surgery, namely an open reduction/internal fixation of the greater trochanter. PX 5.

Petitioner testified that, after Dr. Domb took X-rays, he recommended Petitioner undergo surgical repair of the greater trochanter fracture as soon as possible. Dr. Domb

performed this procedure on August 1, 2016 and inserted more hardware. At the first post-operative visit, on August 16, 2016, he noted that Petitioner was complaining of low back pain as well as "numbness or tingling over the incision and down to the knee" in his left leg. He obtained pelvic and hip X-rays. He interpreted the films as showing "satisfactory component placement" and "good positioning" of the fracture hardware. He recommended that Petitioner continue using a walker, with 20 pounds of weight bearing, for four more weeks.

Petitioner returned to Dr. Domb on September 22, 2016. The doctor noted that Petitioner "was not feeling well" and complained of pain and stiffness in his hip. He obtained more X-rays and noted a new finding of "some lucency in the anterior stem." He prescribed Norco and Flexeril, along with physical therapy. He directed Petitioner to stay off work, undergo a pain management consultation and return in six weeks for "X-rays to evaluate anterior stem lucency." PX 5.

On September 27, 2016, Petitioner underwent an initial evaluation at ATI Physical Therapy. The evaluating therapist noted complaints of pain everywhere in the left hip, pain in the right hip and pain in the lower back and down the left leg. The therapist also noted that Petitioner was using a walker and exhibited a "swing gait pattern" bilaterally.

Petitioner testified the therapy at ATI consisted of core strengthening and exercises simulating stair climbing and rising from a chair. Petitioner testified he was still favoring his right hip and leg at this point. He began experiencing a lot of right hip pain.

Petitioner testified he underwent a Section 12 examination by Dr. Ackerman in October 2016. The doctor obtained X-rays and spent about 15 to 20 minutes examining him.

Dr. Ackerman's examination report of October 10, 2016 sets forth a consistent account of the work accident. The doctor indicated he reviewed various treatment records but did not have records from Dr. Domb. He also indicated that Petitioner attributed a gap in care between November 2014 and April 2015 to a denial of recommended therapy. He noted that Petitioner reported first experiencing right hip pain in May 2015.

Dr. Ackerman noted that Petitioner was still experiencing severe left hip pain, pain radiating down the left leg into the foot, paresthesias in the left foot and severe, persistent right hip pain.

Dr. Ackerman indicated he questioned Petitioner about "possible etiologies of his avascular necrosis," with Petitioner reporting a history of autoimmune enteritis, diagnosed six years earlier, for which he had been taking "high dose steroids on and off since 2013." He indicated Petitioner had taken 6 mercaptoprine in the past and was "currently on a maintenance dose of 10 mg of Prednisone a day."

Dr. Ackerman also recorded a history of "polytrauma . . . in 1999 from a motor vehicle accident," with Petitioner sustaining a left femoral shaft fracture and undergoing

cephalomedullary nail fixation for this. He indicated Petitioner "recovered well" from this surgery "with no subsequent hip pain." He stated that Petitioner denied having pain in either hip or leg prior to the work accident.

Dr. Ackerman noted that Petitioner walked with a "severe antalgic gait favoring his left lower extremity" but also experienced right leg pain when walking.

On examination, Dr. Ackerman noted symmetric sensation from L1 to S2 bilaterally except for the L5 left dermatome, with Petitioner reporting 25% sensation compared to the right side. He also noted reduced motion in both hips. He indicated he "could not test hip abduction strength secondary to [Petitioner's] pain and inability to lie on his side."

Dr. Ackerman obtained AP films of the pelvis and frog lateral views of the left hip. He described the AP films as showing "evidence of right hip avascular necrosis with a collapse of the femoral head, flattening of the femoral head and cystic changes of the femoral head consistent with Ficat Stage IV avascular necrosis." He saw no fractures or avulsion injuries around the right hip. On the left hip, he noted a cementless total hip arthroplasty, with "additional cable claw-plate fixation of the trochanter." He described the overall position of the trochanter as appropriate and the leg lengths as symmetric.

Dr. Ackerman also obtained full length left femur X-rays. On review of the films, he noted sequelae of a well-healed left midshaft femur fracture and removal of the prior cephalomedullary nail. He saw no additional fractures, avulsion injuries or osseous lesions.

Dr. Ackerman's impression was:

1) Exacerbation of previously asymptomatic left hip avascular necrosis from chronic steroid use with retained intramedullary femoral nail status post left total hip arthroplasty complicated by periprosthetic greater trochanteric fracture;

2) Right hip avascular necrosis secondary to chronic steroid use; and

3) Lumbar disc herniation with L5 radiculopathy.

Dr. Ackerman described Petitioner's initial treatment as focusing on lumbar radiculopathy, "consistent with" Petitioner's left leg and foot complaints. He acknowledged that "symptoms of hip pain and lumbar pathology can often overlap" and can be difficult to distinguish. He opined that "the diagnosis of concomitant hip pathology may have been initially missed and the fall may have caused an aggravation of [Petitioner's] previously asymptomatic left hip avascular necrosis." After noting that the right hip pain did not start until about a year after the work accident, he indicated that it could have been related to the progression of the avascular

necrosis "and a manifestation of this disease process that may have been aggravated by his abnormal gait pattern from his left lower extremity pain but not directly related to his May 2014 injury." He indicated he did not know whether Petitioner had avascular necrosis as of the work accident since the first hip imaging did not occur until late 2015. He stated that Petitioner's prior femur fracture, requiring nail fixation, could have contributed to the development of avascular necrosis but that the condition was more likely related to Petitioner's chronic steroid usage, "especially since both hips are equally involved." He noted that Petitioner's radicular complaints had not been addressed since the initial epidural steroid injections. He described these complaints as falling outside of the scope of his independent medical examination.

On October 17, 2016, Petitioner saw Dr. Kirincic, a pain physician affiliated with Hinsdale Orthopaedics. The doctor's note of that date sets forth a lengthy history of the past motor vehicle accident and subsequent care, the work accident and the subsequent treatment. The doctor noted that Petitioner was still using a walker, denied improvement secondary to the left total hip replacement and complained of constant left hip and groin pain radiating down the left leg to the ankle, tingling in the left foot and lateral leg and pain in the right groin and lateral hip. She indicated that any physical activity aggravated this pain and that Petitioner was unable to support himself due to lower extremity weakness at the hips. She noted that Petitioner denied having pain before the work accident. She indicated that Petitioner's current medication included Dilaudid, Percocet, Opana ER, Lorzone, Norco, Cyclobenzaprine, Lidoderm patches, Diazepam, Prednisone, Ibuprofen and Gabapentin. She adjusted this medication and reviewed the Illinois drug monitoring program with Petitioner. She administered trigger point injections and performed acupuncture. She directed Petitioner to stay off work and return in one month. PX 5.

On October 31, 2016, Petitioner returned to Dr. Domb and complained of severe bilateral hip and leg pain along with low back and thigh pain. He also complained of hyperesthesia to the left thigh. The doctor prescribed a bone stimulator device, noting that the X-rays of the greater trochanter fracture showed "little callus formation in comparison" to the previous visit's X-rays. The doctor felt there could be a non-union, given that twelve weeks had passed since the trochanter-related surgery. He directed Petitioner to continue seeing Dr. Kirincic and indicated he would consider performing a right total hip replacement once Petitioner's pain and mobility had improved. PX 5. Petitioner testified he used the bone stimulator device two hours per day between November 2016 and January 2017.

A therapy progress note dated November 14, 2016 reflects complaints of left hip, groin and buttock pain, left hip stiffness, pain in the knee to the foot and right hip weakness. Petitioner indicated he was now able to put more weight on his left leg but continued to rely primarily on his right, despite the weakness. The therapist indicated that Petitioner was now able to walk for short distances using a quad cane but still exhibited an antalgic gait pattern.

On November 17, 2016, Petitioner returned to Dr. Kirincic and indicated that Dilaudid, Percocet and Opana ER "do nothing to help with pain." Petitioner also indicated that the Lorzone samples provided no relief and that the Gabapentin he was taking per a neurologist was not helping. Petitioner reported gaining strength with therapy but continuing to use a walker. The doctor administered acupuncture and trigger point injections. She adjusted the medication and directed Petitioner to stay off work and return in one month. PX 5.

A therapy progress note dated November 30, 2016 reflects that Petitioner complained of left hip weakness, left buttock pain, left anterior thigh/groin pain and numbness, 7/10 right hip pain, right hip stiffness and right groin pain.

On December 1, 2016, Petitioner saw Dr. Darwish for his low back, at Dr. Domb's referral. The doctor recorded a history of the remote motor vehicle accident and the work accident. He indicated that Petitioner described his lower back and left leg pain as unchanged since the work accident. On examination, he described Petitioner's lumbar range of motion as "limited by 70%." He noted tenderness over the left and right paraspinals, the left SI joint and the left buttock. He described seated straight leg raising as positive on the left. He noted decreased sensation and "abnormal" strength in the left leg. He obtained lumbar spine X-rays which showed moderate degenerative changes at L5-L6 and severe degenerative changes at L6-S1. He prescribed a lumbar spine MRI. Petitioner testified this MRI was never performed because a dispute arose as to which facility should perform the scan.

A therapy progress note dated December 28, 2016 reflects that Petitioner's right hip was becoming "more painful" and that he was finding it "difficult to move."

On January 12, 2017, Dr. Domb noted that Petitioner's left hip pain was now 5/10 and "less limiting than the right hip pain." He also noted that Petitioner had previously progressed to a cane but was now back to a walker. He obtained pelvis and hip X-rays. He described the films as showing interval healing of the left greater trochanter, "lucent lines surrounding the implant that may suggest loosening", end-stage right hip degenerative joint disease and healing of the left femur fracture. He was not able to rule out an infection. He prescribed laboratory studies and a bone scan. He recommended that Petitioner stay off work, discontinue physical therapy, continue using a walker to ambulate and see Dr. Alden. PX 5.

The bone scan, performed on January 26, 2017, showed a "small focus of radiotracer uptake in the lateral aspect of the left hip which may represent a previous greater trochanter fracture, no increased radiotracer uptake in the left hip to suggest loosening or infection and significantly increased radiotracer uptake in the right hip, compatible with degenerative changes." PX 3.

Petitioner testified that, on February 23, 2017, Dr. Domb referred him to a hip specialist, Dr. Alden, and directed him to see Dr. Alden the same day. Dr. Alden reviewed the bone scan and X-rays and told him the left hip prosthesis was loose and needed to be replaced.

Dr. Alden's note of February 23, 2017 documents a complaint of persistent left hip pain following a replacement procedure and subsequent greater trochanter open reduction/internal fixation. The doctor noted Petitioner was unable to walk without a walker. He reviewed recent X-rays and indicated the hip implant "appears loose." He recommended removing the cables and revising the femoral stem. He recommended that Petitioner see Dr. Kirincic to monitor his pain medication. PX 5.

On March 9, 2017, Dr. Alden took new X-rays and scheduled the revision procedure for May 15, 2017. PX 5.

Petitioner testified that, as of March 2017, he was still using a walker to ambulate and relying on his right leg. Both of his hips were worse but the focus was on his left leg.

Petitioner testified the revision surgery was initially scheduled for May 2017 at a facility in Munster, Indiana. The surgery did not proceed because the facility's hydraulic bed was not operational. The surgery was rescheduled for June 2017 but, two days before it was to be performed, Dr. Alden's office called him and told him Respondent would not approve it.

At Respondent's request, Dr. Ackerman re-examined Petitioner in November 2017. Petitioner testified the doctor obtained new X-rays and spent about 15 to 20 minutes examining him.

In his re-examination report of November 9, 2017, Dr. Ackerman noted a lapse in care between November 2014 and April 2015. He described Petitioner as complaining of significant bilateral hip pain after this gap. He indicated he "could not find any specific complaints of isolated hip pain during the initial course of treatment."

Dr. Ackerman noted that Petitioner had undergone a bone scan and seen Dr. Alden at Dr. Domb's recommendation. He also noted that Dr. Alden was recommending revision of the left hip replacement.

Dr. Ackerman noted that the radiologist who interpreted the bone scan did not see any increased uptake suggesting loosening or infection. When he himself reviewed the bone scan, he saw "a very small focus of increased uptake within the left greater trochanteric area" and "no signal around the femoral stem or acetabular component."

Dr. Ackerman indicated that Petitioner was undergoing pain management with Dr. Kirincic and taking multiple narcotics, including Morphine and Norco, at her direction.

Dr. Ackerman noted that Petitioner complained of "severe debilitating pain in both hips" as well as low back pain, pain radiating down his leg, hip weakness, "giving out" of the left hip, severe left thigh pain and significant left foot numbness. He also noted that Petitioner described his pain as constant, even when at rest, and affecting his daily activities and sleep.

Dr. Ackerman noted that Petitioner was not able to walk without a walker. He indicated that, with the walker, Petitioner exhibited "almost a swing through gait pattern," meaning that he put pressure on the walker and swung his legs through it.

On examination, Dr. Ackerman noted significantly decreased sensation from the L1 through the L4 dermatomes in the anterior aspect of the left thigh, significant weakness with hip flexion, severe pain with straight leg raising bilaterally, "significant irritability with any range of motion of his right hip," significant hyperesthesias and dysesthesias throughout the left thigh "in which just gentle scratching of the thigh causes exquisite pain" and a positive Tinel's in the area of the lateral femoral cutaneous nerve overlying the anterior aspect of the pelvis.

Dr. Ackerman obtained AP pelvis and "frog lateral" X-rays. With respect to the right hip, he noted "re-demonstration of severe avascular necrosis with collapse of the femoral head, degenerative changes of the acetabulum and "complete obliteration of the joint space." With respect to the left hip, he noted the arthroplasty was in stable position. He saw no lucencies around the acetabular component or the femoral stem.

Based on his records review, Dr. Ackerman indicated that left hip complaints were first documented in May 2015 and that the right hip symptoms "began nearly a year" after the May 2014 work accident. Dr. Ackerman did not find the right hip avascular necrosis to be related to the work accident, based on this perceived timeline. He also attributed the right-sided avascular necrosis to Petitioner's chronic steroid usage due to his autoimmune enteritis. He indicated the work accident could have aggravated the left-sided avascular necrosis, despite what he perceived as a gap occurring before left complaints were noted. Based on his review of the bone scan, along with that of the radiologist, he did not recommend any further left hip surgery. He recommended a right hip replacement but reiterated he did not view the right-sided avascular necrosis as stemming from the work accident. He attributed the severe radicular symptoms and left foot numbness to the lumbar disc herniation. He recommended re-imaging of the lumbar spine and lumbar spine treatment. He also diagnosed meralgia paresthetica of the left hip. He indicated this was difficult to treat but that Petitioner might respond to Lyrica or Neurontin.

Dr. Ackerman indicated that, as the re-examination, Petitioner was not capable of working. He noted that Petitioner had severe difficulty walking even a short distance. He stated it would be difficult for Petitioner to perform even sedentary work. RX 4.

On December 18, 2017, Dr. Kirincic noted complaints of bilateral hip pain and needing to get rides to appointments. She provided Petitioner with a parking placard, administered acupuncture and trigger point injections and adjusted the medication. PX 5.

Dr. Ackerman testified by way of evidence deposition on March 12, 2018. RX 5.

Dr. Ackerman testified he is board certified in orthopedic surgery. He specializes in hip preservation and hip and knee replacement surgery. RX 5, p. 4. He identified Ackerman Dep Exh 4 as his CV. RX 5, pp. 4-5.

Dr. Ackerman testified he performs about 300 hip surgeries annually. He sees about 20 to 30 cases of avascular necrosis per year. Avascular necrosis is "an interruption of the blood supply to the subcondyle surface of the bone." It can occur in various bones, the most common being the hip, shoulder, knee and talus. RX 5, p. 5. It can be caused by chronic steroid use, trauma (such as a prior fracture of dislocation) and chronic alcohol use. It is less commonly caused by a blood clotting disorder or Caissons disease, a disorder relating to diving. It can also be idiopathic. RX 5, pp. 5-6.

Dr. Ackerman testified he performs about 200 hip arthroplasties annually. Arthroplasty is a general term that can include a regular replacement, a partial replacement or resurfacing. RX 5, p. 6.

Dr. Ackerman testified he conducts about 20 independent medical examinations per year. He performs these examinations for both sides. RX 5, p. 7.

Dr. Ackerman testified he has an independent recollection of Petitioner. Petitioner's initial examination was scheduled for September 8, 2016 but Petitioner did not appear on that date. It was on this date that he first reviewed Petitioner's records. He did not actually examine Petitioner until October 10, 2016. On that date, Petitioner provided a history of the May 29, 2014 work accident. Petitioner walked with a severe antalgic gait pattern favoring his left leg. Petitioner had significant hip pain with testing of his hip musculature. His hip range of motion was decreased. Dr. Ackerman testified that significant tenderness throughout the hip musculature prevented him from being able to test Petitioner's hip abduction strength. RX 5, pp. 9-10. He diagnosed Petitioner with: 1) bilateral hip avascular necrosis (untreated on the right), which he attributed to Petitioner's chronic steroid use; 2) status post intramedullary nail removal and left hip replacement, "complicated by a greater trochanteric fracture"; and 3) findings consistent with a lumbar disc herniation and left-sided L5 radiculopathy. RX 5, pp. 11, 14. Petitioner had been taking high dose steroids on and off since 2013, secondary to a diagnosis of autoimmune enteritis, a variant of irritable bowel syndrome. As of the examination, Petitioner was still taking a maintenance dose of 10 milligrams per day. He was not on any of the newer IB disease modifying drugs, such as Enbrel or Humira, "which they commonly use." RX 5, p. 12.

Dr. Ackerman testified that steroid use is a significant factor for avascular necrosis. There is some literature showing that even a single, short-term duration of steroid usage is enough to cause the condition in people who are susceptible to it. RX 5, pp. 12-13.

Dr. Ackerman testified there was a gap in treatment after the first six months of care. It was after this gap, which Petitioner attributed to denial of therapy, that the left hip complaints emerged. During the initial care, Petitioner's primary care physician and a pain medicine doctor

focused on the radicular left leg symptoms. Some of Petitioner's pain "passed his hip." It was "hard to differentiate pain from his back to his hip." RX 5, p. 15. The hip was not specifically mentioned between May and November 2014. RX 5, p. 15.

Dr. Ackerman attributed Petitioner's bilateral avascular necrosis to his chronic steroid use. Because the right-sided hip complaints were not documented until May 2015, a year after the accident, he does not believe the right hip condition stems from the accident. RX 5, p. 16. Petitioner's recovery from the left hip replacement was "significantly complicated" by a fracture of the greater trochanter. Petitioner was "still very debilitated" due to this as of the examination. Petitioner also needed treatment for his radicular symptoms. RX 5, p. 16.

Dr. Ackerman testified Petitioner was not capable of performing full duty as of his initial examination. Petitioner was "severely incapacitated" as of that examination. He required a walker just to get across the examination room and was "otherwise in a wheelchair." It would be difficult to classify him as capable of even sedentary duty. RX 5, p. 17.

Dr. Ackerman testified he re-examined Petitioner on November 9, 2017. He reviewed new records, including notes from Drs. Domb and Alden, along with laboratory results and a bone scan. Petitioner complained of increased pain and had been worked up for a "painful total hip." As of the re-examination, Petitioner exhibited a "swing through gait pattern," meaning he "walked" by swinging his legs through a walker. "Without the walker [Petitioner] was unable to even stand." RX 5, p. 18. On re-examination, he exhibited significantly decreased sensation in the left leg versus the right. He had "severe pain with straight leg raise." His left hip motion had improved but his right hip range of motion was significantly decreased. He had significantly decreased sensation in the left thigh, in what is called the lateral femoral cutaneous nerve distribution. RX 5, p. 19. Repeat X-rays again showed severe avascular necrosis of the right hip, with complete collapse of the femoral head and "complete obliteration of the right hip joint space." The left hip was in a stable position. The films showed healing of the trochanteric fracture. The trochanteric hardware was still in place. He saw no lucency around the acetabular component of the femoral stem. Based on his review of the bone scan and films, he disagreed with the doctors who had expressed concern that the femoral component was loose. If this component was indeed loose, you would see gross changes in its position or lucencies or a space between the bone and the implant interface. He did not see these changes. He compared the films he obtained in 2017 with those he had obtained at the initial 2016 examination. He saw no significant change. He reviewed both the January 26, 2017 bone scan report and the images. When he reviewed the images, he saw a "very small focus in the greater trochanteric region," in the area of the previous fracture, but "no increased signal around the stem itself or acetabular or socket component. He agreed with the radiologist's interpretation of the bone scan. RX 5, pp. 21-22.

Dr. Ackerman testified that, as of the 2017 re-examination, Petitioner was post left anterior total hip replacement. Petitioner also had left hip meralgia paresthetica, continued radicular symptoms secondary to the disc herniation and advanced avascular necrosis of the right hip. Dr. Ackerman testified that meralgia paresthetica is a "constellation of findings" that

can cause significant pain and/or numbness in the area of the lateral femoral cutaneous nerve, which is a nerve that comes out over the anterior aspect of the pelvis and innervates the skin at the anterior aspect of the thigh. When a surgeon performs a total hip replacement, he makes an incision in that area and often retracts that nerve. The nerve is microscopic and "you don't identify it." Retraction can sometimes cause hypersensitivity of the nerve, which can cause significant pain focally in the thigh.

Dr. Ackerman opined that Petitioner had undiagnosed bilateral avascular necrosis before the work accident. The accident caused the lumbar radiculopathy and aggravated the left-sided avascular necrosis, based on the timeline, with left hip complaints noted within six months of the accident. The therapy Petitioner underwent also aggravated the avascular necrosis. The "right hip was not related to the accident because [Petitioner] did not display any right hip symptoms until a year out" from the accident. RX 5, pp. 23-24.

Dr. Ackerman characterized the treatment prior to the re-examination as reasonable and necessary. As of the re-examination, he saw no need for additional left hip surgery. Revision surgery would only be warranted if there was evidence of femoral stem loosening or breakage. He did not see such evidence. RX 5, p. 26. He recommended Petitioner see a pain specialist for further treatment of the meralgia paresthetica. He strongly felt there was a lumbar component to Petitioner's pain. RX 5, p. 27. He recommended a repeat lumbar spine MRI and possibly see a pain specialist or spine surgeon for evaluation of his radicular complaints. Petitioner requires a right-sided total hip replacement but he does not believe this is due to the work accident. RX 5, pp. 25, 27.

Dr. Ackerman testified Petitioner was not able to work as of the re-examination. Petitioner could not stand unassisted and had difficulty sitting during the examination. He thought Petitioner "would still have difficulty performing sedentary work." RX 5, p. 26.

Under cross-examination, Dr. Ackerman testified he obtained board certification in orthopedic surgery in July 2017. RX 5, pp. 27-28. He devotes about 80% of his practice to hip conditions. He performs hip resurfacing, hip replacements and revision replacements. He also performs knee replacements and trauma surgery. RX 5, p. 28. He has privileges at various hospitals, including Illinois Masonic. RX 5, pp. 28-29. He is a partner in Illinois Bone and Joint. RX 5, p. 29. Less than 5% of his patients are referred by attorneys. RX 5, p. 30. He cannot recall which percentage of his independent medical examinations are performed for plaintiffs versus defendants. RX 5, p. 30. Respondent first contacted him prior to September 2015. He did not previously do work for Respondent. He has been compensated for reviewing Petitioner's records and rendering opinions. RX 5, p. 31. With respect to examination fees, he charges $1,000 for the first body part and $250 for each additional body part. There is an additional charge for additional record review. RX 5, p. 32.

Dr. Ackerman testified that, based on his records review, Petitioner first voiced hip complaints on April 8, 2015. He saw no records other than Dr. Lee's indicating that the left hip symptoms started in November 2014. RX 5, p. 33. He first examined Petitioner on October 10,

2015. That examination lasted roughly twenty minutes. RX 5, p. 34. He did not receive any of Dr. Domb's pre-operative notes. He did not review any accident reports. RX 5, pp. 34-35. He has no reason to disagree with the history that Dr. Domb recorded on February 22, 2016. RX 5, p. 35. Petitioner told him the lapse in care between November 2014 and April 2015 was insurance-related. Petitioner had to undergo another surgery about three weeks after the left hip replacement because he was found to have a fracture of the greater trochanter, which is the bone on the side of the hip where all the gluteal muscles attach. Such fractures can occur during hip replacement surgery. RX 5, pp. 36-37. Unless a patient is older or has severe osteoporosis, a hip replacement is "cementless," meaning it is done with "press fit" components. A fracture of the trochanter can occur during a "press fit" replacement, "if the bone is a little bit weaker in that area" or depending on the components themselves. RX 5, p. 37. Such fractures become evident on weightbearing postoperatively. RX 5, p. 37. As of his October 2016 re-examination, Petitioner had completed three weeks of physical therapy following the trochanter surgery. A person who had a trochanter fracture after a replacement could require four to six months of therapy, depending on how debilitated the person was before the replacement. Petitioner was "quite debilitated" before the replacement. RX 5, p. 38. When he re-examined Petitioner in October 2016, Petitioner was not at the stage of most people who are three weeks out from a hip replacement. Petitioner had severe pain when sitting and trouble walking short distances. His right hip and back were also contributing factors. RX 5, p. 39.

Dr. Ackerman acknowledged it is possible that Petitioner's right-sided avascular necrosis was aggravated by his left hip treatment or lumbar therapy. However, the progression of avascular necrosis is "often unpredictable." His right-sided symptoms could have "cropped up" while he was undergoing other treatment. He does not think it is reasonable to attribute those symptoms to the work accident. RX 5, p. 40. The symptoms could certainly be due to rigorous therapy. RX 5, p. 41. Additionally, since Petitioner was favoring his left side and thus not walking appropriately, that could have put excessive stress on the contralateral, i.e., right side. In his October 2016 report he indicated Petitioner's bilateral avascular necrosis could have been aggravated by his abnormal gait. RX 5, pp. 41-42. In his November 2017 report, he indicated Petitioner began complaining of his left hip in December 2016. He has no reason to believe Petitioner was not compliant with therapy between August and December 2016. He believes he reviewed the records concerning this therapy. It is his review of the bone scan and plain films that prompts him to disagree with Dr. Alden's recommendation of a revision of the left hip replacement. RX 5, pp. 42-43. You cannot diagnose aseptic loosening of surgical components on physical examination. You can sometimes diagnose it via history. Petitioner, however, has pain with every step. It is hard to differentiate his symptoms as he has severe constant pain in his hip and low back. RX 5, pp. 43-44. The left hip range of motion that Petitioner exhibited as of the November 2016 re-examination was "within the realm of normal motion" for a patient who was post hip replacement. RX 5, pp. 44-45. Petitioner's left hip strength was 4+/5 but it is difficult to distinguish between weakness and pain. RX 5, p. 45.

Dr. Ackerman testified that, in a patient who does not have a replaced hip, you can distinguish between hip and lumbar pain by performing diagnostic hip injections. If a patient

has avascular necrosis, however, it is sometimes more difficult to distinguish between hip and lumbar pain because the pain from avascular necrosis comes from deeper down within the bone itself. You cannot use hip injections in a patient with a hip replacement but you could send the patient to a pain physician for back injections. RX 5, pp. 46-47. He would recommend this for Petitioner. The January 26, 2017 bone scan was still reliable information as of November 2017. A bone scan can be falsely positive in situations where there is no loosening. You typically do not get a false negative. Based on the plain films, it is unlikely a repeat bone scan would be helpful in determining whether a revision surgery is necessary. RX 5, p. 48. He believes the stem is "well fixed" based on the plain films. RX 5, p. 48. The only area that "lit up" on the bone scan was the area that was fractured during the replacement surgery. That could be indicative of healing or non-healing. RX 5, pp. 48-49. If some doubt remained as to whether the fracture has healed, a CT scan could be done. RX 5, p. 49. He would recommend a CT scan "for completeness sake." RX 5, p. 50. A non-union could be a reason to recommend a revision in a patient who has undergone hip replacement. A non-union refers to the bone itself "where the bone does not heal." There could be a non-union due to lack of sufficient fixation, an infection or too much motion at the fracture site. Bones need to be touching each other to heal. They need to be fixed with appropriate stability. RX 5, p. 50. You need to have a reason to perform a revision. It is not a good idea to perform an exploratory revision surgery. RX 5, p. 51. Petitioner's hip pain could be referred pain from his back. The nerves to the hip come from the back. RX 5, pp. 50-51. If Petitioner had an L5 disc herniation, that could cause hip symptoms. RX 5, p. 52. The treatment Petitioner underwent prior to November 9, 2017 was reasonable and necessary. He did not review any of the bills relating to this treatment. RX 5, p. 53.

Dr. Ackerman opined that Petitioner's right hip was asymptomatic before the work accident. It is Petitioner who provided the history of steroid usage. He does not know the frequency with which Petitioner took steroids. RX 5, p. 54. High-dose steroids are typically given for a short period of time, either orally or via IV. RX 5, p. 54.

Dr. Ackerman testified he was not asked to render opinions concerning Petitioner's lumbar condition. He believes the work accident caused that condition. RX 5, p. 54. Straight leg raising was positive and Petitioner stated his foot fell asleep while he was just sitting in a chair. RX 5, p. 55. It is possible Petitioner needs lumbar surgery. RX 5, p. 55. A person who undergoes hip replacement is at a higher risk for future hip pain and swelling. RX 5, p. 56.

Dr. Ackerman testified he reviewed Petitioner's narcotic regimen. Petitioner is "on a lot of pain medication." RX 5, p. 56. The overall amount of narcotics is not appropriate but it is appropriate for a pain physician to be overseeing Petitioner's medication. It was "probably too much narcotics to be managed by an orthopedic doctor." RX 5, p. 57. He would recommend that Petitioner continue seeing a pain physician. RX 5, p. 57.

Dr. Ackerman testified he does not think he saw any formal description of Petitioner's job. His opinion that Petitioner cannot work is based on a "constellation of symptoms." He believes Petitioner did manual labor. A person who simply underwent a hip replacement would

likely be able to resume manual labor. A person with Petitioner's lumbar condition might "possibly" be able to return to manual labor. RX 5, pp. 57-58.

After Dr. Ackerman reviewed Dr. Alden's note of February 23, 2017, he testified that Dr. Alden documented a normal neurological examination on two occasions while he himself did not. When he examined Petitioner, he noted decreased sensation in the left leg. RX 5, p. 60. He did not assess whether there was tenderness around the greater trochanter. RX 5, p. 61. Petitioner complained of diffuse pain all over the various aspects of his hip. RX 5, p. 61.

Dr. Ackerman testified that meralgia paresthetica is a "stretch injury to the lateral femoral cutaneous nerve or the nerve that runs out over the anterior aspect of the pelvis and innervates the anterior lateral aspect of the thigh." Based on his examination, with Petitioner complaining of exquisite pain with just scratching of the anterolateral aspect of his thigh, he believes Petitioner was meralgia paresthetica. RX 5, p. 61. Tapping on the nerve also produced symptoms. The replacement surgery caused the meralgia paresthetica. RX 5, p. 62. It is a "relatively rare" result of replacement surgery. It is difficult to treat. Sometimes a pain specialist can administer injections around the nerve. It is also possible Petitioner has a "double crush" syndrome, with his lumbar disc herniation sensitizing the nerve. RX 5, p. 62.

On redirect, Dr. Ackerman reiterated that the first time anyone documented right hip pain was on April 8, 2015, when Dr. Shih noted bilateral hip pain, left worse than right. RX 5, pp. 63-64. Nothing about Dr. Domb's note of February 22, 2015 prompts him to change his causation opinion as to the right hip. Dr. Alden's note did not prompt him to change his opinions as to the need for revision surgery on the left hip. RX 5, pp. 64-65. He did not review any records specifically documenting a therapy-related right hip injury. RX 5, pp. 65-66. He believes the right hip avascular necrosis would have progressed regardless of the work accident. RX 5, pp. 66-67.

Under re-cross, Dr. Ackerman testified that, going forward, he would recommend Petitioner follow the treatment recommendations of a pain physician and any lumbar specialist he might see. RX 5, p. 67.

On June 18, 2018, Dr. Kirincic noted that Petitioner was "miserable" due to bilateral hip pain and had tapered his Prednisone intake. She described Petitioner as "screaming in pain" and requiring two crutches to walk. She provided acupuncture and trigger point injections and adjusted Petitioner's medication. PX 5.

Petitioner testified he returned to Dr. Alden in July 2018. At that visit, the doctor again recommended the left-sided revision surgery and also recommended a right hip replacement. Respondent would not approve either of these procedures.

Dr. Alden's note of July 19, 2018 documents a complaint of 9/10 bilateral hip pain. The doctor described the left hip implant as loose. He recommended that Petitioner undergo a

right total hip replacement followed by a left hip revision surgery. He indicated the right-sided surgery should be performed first "due to the severity of the right hip pain.

On July 20, 2018, Petitioner filed a Petition for Penalties Pursuant to Section 19(l) (Arb Exh 2) alleging, inter alia, that Respondent is liable for Section 19(l) penalties, dating back to Dr. Ackerman's deposition, based on its refusal to pay for prescription pain medication.

Petitioner returned to Dr. Alden on August 22, 2018, with the doctor indicating he still did not have authority from the workers' compensation carrier to proceed with the right hip replacement. He described Petitioner as "in a considerable amount of pain" and "basically housebound and unable to function." He wanted Petitioner to proceed with the replacement on September 24th. PX 5.

At the original hearing, on August 17, 2018, Petitioner rated his current left hip pain at 8 on a scale of 1 to 10, with 10 being the worst. His left hip pain is constant. It hurts to move in any way. It hurts when he sits, gets up from a seated position or lifts his left leg. The pain affects his sleep. His left hip is unstable. He cannot bend, lift or climb stairs. He is able to drive but only drives if he has to. His right hip is worse than his left. He feels right hip pain when sitting, trying to lift his right leg or rotate in any direction.

Petitioner testified he wants to return to work but does not know if his body will allow him to do so.

Petitioner denied having any low back or hip problems before the accident.

Petitioner testified he has taken Prednisone for gastrointestinal issues and an autoimmune disorder since 2013. He began taking Prednisone after an Emergency Room visit in April 2013. His original dosage was 16 milligrams. The dosage was reduced to 10 milligrams. He was told he would not experience any serious side effects from a 10-milligram dosage. His current dosage is 2 milligrams and he is being weaned down from that.

Petitioner testified he has seen Dr. Kirincic for pain management since October 2016. He currently takes Hydrocodone, Morphine, Ibuprofen and Gabapentin for pain. He also uses pain patches. Respondent denied all of these medications. He was able to obtain them through the Injured Workers Pharmacy program. He obtains refills from Dr. Kirincic. The doctors are worried about his medications.

Petitioner testified that Respondent terminated him in mid-2017, three years after the accident. He has had no health insurance since being terminated.

Under cross-examination, Petitioner testified he was truthful with Respondent's examining physicians, Drs. Forman and Ackerman. He has a past medical history of psoriasis. He used to use topical creams for this condition but does not currently use any psoriasis-related

medication. His Prednisone dosage was 10 milligrams from mid-2013 until approximately late July 2018, at which point it was reduced to 2 milligrams.

Arbitrator's Credibility Assessment

The Arbitrator found Petitioner highly credible and remarkably resilient, despite a virtual cascade of medical complications. None of the many physicians and other providers who have evaluated him since the work accident have raised any questions about the legitimacy of his pain complaints.

Arbitrator's Conclusions of Law

Did Petitioner establish causal connection as to his claimed right hip condition of ill-being?

There is no dispute that the May 29, 2014 work accident resulted in significant lumbar spine and left hip conditions of ill-being. In reliance on Dr. Ackerman, Respondent agrees that the accident aggravated an underlying, previously asymptomatic condition of avascular necrosis in the left hip and brought about the need for the left total hip replacement Dr. Domb performed in 2016. Respondent also agrees that Petitioner has avascular necrosis in his right hip but disputes causation as to that condition. In taking this position, Respondent again relies on Dr. Ackerman. Dr. Ackerman described the onset of avascular necrosis as "unpredictable." He was unable to directly link the right-sided avascular necrosis to the work accident based on his conclusion that no one documented right hip complaints until April 2015. RX 5.

The Arbitrator, having considered Petitioner's credible testimony and the 2014 therapy records, views the timeline differently. Right hip and leg complaints are documented several times in the September and October 2014 records from PT Solutions, with the therapist describing those complaints as "referred" from the left hip. This "synchs" with Dr. Ackerman's significant concession that the lumbar therapy and left hip treatment could have aggravated the right-sided avascular necrosis.

The Arbitrator further notes Dr. Ackerman's concession that the right-sided avascular necrosis could have been aggravated by the gait alteration resulting from the left-sided symptoms. Gait-related problems were noted as early as one month after the accident. When Dr. Khanna performed an EMG, on June 24, 2014, he described Petitioner's gait as "shuffling" and noted Petitioner was having balance issues. Both he and Dr. Pilcher documented left foot numbness. On October 25, 2014, Dr. Chmell noted significant atrophy of Petitioner's left thigh and calf. It stands to reason that a person who is experiencing significant left-sided back and leg pain, along with reduced sensation in his left foot, would attempt to shift his weight to his right side. The significant left-sided atrophy constitutes objective evidence of disuse.

While Dr. Ackerman identified other factors that could have contributed to Petitioner's avascular necrosis, namely his 1999 left femur fracture and his use of steroids for his autoimmune disorder, a claimant seeking benefits under the Act need only show that a work

accident was a cause of his condition of ill-being. He is not required to establish that the accident was the sole, or even a significant cause. Nor is he obligated to exclude all other possible causes of the condition. See Sisbro, Inc. v. Industrial Commission, 207 Ill.2d 193, 205 (2003) and Schroeder v. IWCC, 2017 IL App (4th) 160192WC. There is no evidence suggesting that Petitioner was experiencing hip symptoms secondary to avascular necrosis before the work accident. The accident brought about an abrupt change in his ability to work and, indeed, function.

Did Petitioner establish the reasonableness and necessity of the left hip replacement revision surgery recommended by Drs. Domb and Alden? Is Petitioner entitled to prospective care in the form of a right total hip replacement and a left hip revision?

The Arbitrator finds the left hip replacement revision surgery recommended by Drs. Domb and Alden to be reasonable and necessary. The Arbitrator assigns weight to Dr. Domb's recommendation of this surgery since he performed the left hip replacement (which Respondent authorized) and has thus visualized the hip. The Arbitrator views Dr. Domb as acting prudently in directing Petitioner to see another hip specialist, Dr. Alden, to obtain a second opinion, in light of the complexity of Petitioner's medical situation. Dr. Alden agreed with the need for revision surgery.

The Arbitrator recognizes that the radiologist who interpreted the bone scan did not see uptake consistent with loosening of the implant and that Respondent's hip examiner, Dr. Ackerman, agreed with this interpretation. Dr. Domb, however, saw lucency "suggestive of loosening" when he reviewed plain films in 2016 and 2017. Drs. Domb and Alden also reviewed the bone scan before they recommended the revision.

Finally, the Arbitrator notes Dr. Ackerman's concession that loosening of a hip implant can be diagnosed clinically. The doctor acknowledged that loosening would be suspected if a patient had pain with every step. Petitioner has such pain. Dr. Ackerman described Petitioner as being unable to walk even a short distance in his office hallway.

The Arbitrator awards prospective care in the form of the left hip revision surgery recommended by Drs. Domb and Alden.

The Arbitrator, having found causation as to the right hip condition of ill-being, also awards prospective care in the form of the replacement surgery recommended by Drs. Domb and Alden. As of July and August 2018, Dr. Alden was recommending that the right hip replacement surgery be performed before the left hip revision since Petitioner was "basically housebound and unable to function" secondary to right hip pain. As of August 22, 2018, the right hip replacement was scheduled to proceed on September 24th but it is not clear whether it proceeded on that date. Petitioner last testified on August 17, 2018.

Is Respondent liable for Section 19(l) penalties?

Petitioner maintains Respondent is liable for Section 19(l) penalties based on its unreasonable refusal to pay for prescription pain medication. Petitioner has asked the Arbitrator to award these penalties from the date of Dr. Ackerman's deposition through the date of hearing. He testified he is only able to obtain the medication that Dr. Kirincic is prescribing because Injured Workers Pharmacy provides it despite lack of payment.

Petitioner filed his penalties petition, along with Section 19(b) and 8(a) petitions, on July 20, 2018. Arb Exh 2. The Arbitrator views this petition as the "demand for payment" required by Section 19(l). The Arbitrator finds Respondent liable for Section 19(l) penalties in the amount of $30 per day from July 20, 2018 through September 26, 2018, a period of 69 days. The Arbitrator notes Dr. Ackerman's concession that it is appropriate for Petitioner to be obtaining medication from a pain physician rather than an orthopedic surgeon like himself. Respondent did not offer any opinion from a pain physician indicating that Petitioner's medication regimen is excessive or otherwise unreasonable.

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 Choose direction	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

BOBBY SIMS,

Petitioner,

vs.

NO: 16 WC 33680

20IWCC0412

SOUTH BERWYN SCHOOL DISTRICT #100,

Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission finds that Petitioner established that he suffered accidental injuries arising out of and in the course of his employment on August 2, 2016, that his condition is causally related to the work accident, that Petitioner is entitled to an award of temporary total disability benefits under §8(b) of the Act, that Petitioner is entitled to an additional award of permanent partial disability benefits and that Respondent shall pay for the medical expenses under §8(a) and §8.2 of the Act, limited to the amount paid by the group provider, for the reasons set forth below.

Statement of Facts

Petitioner is a 50 year old male, employed as a safety coordinator by Respondent. (T. 16, 17) His job duties entailed anything safety related within the District, security matters, and anything asked of him. In his job, Petitioner was in charge of conducting the safety and the security inspections for all the schools in the District. (T. 17) Petitioner worked at the District's Administrative Office. (T. 17) Petitioner testified he travels for safety inspections to and from the

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District Office and the schools, and between the schools, as part of his job duties for Respondent. The District provides him with a District owned pick-up truck. On August 2, 2016, his shift started around 9:00 a.m.

Petitioner testified on August 2, 2016, he went directly to Piper School to inspect the "safety burglar alarm," AED instrument, and check for safety hazards because school was opening about two weeks later. (T. 18-19) Those are monthly inspection duties required for safety. (T. 19) Petitioner testified he checked the burglar alarm, which was located in the 5 South Stairwell. (T. 20) Petitioner testified the burglar alarm was in the middle of the stairwell. To the right of the burglar alarm is an exterior door, and to the left of the burglar alarm was another stairwell. (T. 20) Petitioner testified he needed to traverse the first set of stairs to access the burglar alarm, which was located on the middle landing, and was able to traverse those stairs without any issue or accident. (T. 22)

Petitioner testified in his position as safety and security coordinator, he knew the policy regarding conserving the use of lights in the area of the stairwell during the summer break. In his capacity as safety and security coordinator, he understood that the District's policy was to keep the lights off to conserve energy when there were no students or staff in the building. Petitioner testified that in his position as safety and security officer, he has occasion to review policies and activities of the school. He brought the issue of the "lights off" policy to the Director of Buildings and Grounds about six to eight months prior to his injury. (T. 23-24) Petitioner advised them that he thought the policy should be changed or altered from a safety and security standpoint. That was part of his job. When he sees a safety and/or security issue, he brings them forward. He suggested they put motion sensors in the areas. So if someone walked into an area that was poorly lit, it would light up. Based on Petitioner's understanding, the lighting policy throughout the District is to turn off lights when the school is not in session, the staff is not there, and there's minimal lighting on. (T. 26-30) Petitioner testified that as part of his job he takes notes and carries a notepad with him. He has a clipboard that he carries with him. He testified he is making notes of anything that he see that's a hazard, trip hazards, dangers. Sometimes he makes written reports of his inspections and sometimes they will discuss it; if it's an easy fix it will be taken care of. Over a certain dollar amount and they have to go through a process. (T, 35-37) To have these discussions he takes notes as he notices things. He is constantly looking to see if he needs to make note of something. He does inspections of more than just one school during the day. He also testified he carried two rings of keys. "Probably about 40 keys on --between both rings. I've got keys to every lock in the District." (T, pp. 37-38)

Petitioner testified when he was in the Piper Elementary School building on August 2, 2016, he was carrying a notepad and a clipboard, that was about three by five inches in size. (T. 37) Petitioner testified he also carried two sets of keys on his left pinky finger. (T. 37-39)

Petitioner testified that on August 2, 2016, he "fell down the stairs." (T. 38) Petitioner alleged he thought he was even with the floor, but " missed two to three stairs" and twisted his right knee. (T. 38-40) When he misjudged the stairs he was looking around with

his clipboard in his left hand, and his pen and the keys on his left pinky. (T. 39-41) Petitioner alleged he could not see the last two to three stairs because they were dark. (T. 39) He reported the accident. *Id.* Petitioner's Exhibit 3 consisted of five pictures. The first picture is a light switch at the top of the stairs to the gymnasium. The lights are manually turned on and off. (T. 42-43) The second picture is a different light switch in the middle of the platform going down the stairs that controls the bottom lights. There is another switch that is not supposed to be there that controls the outside light. Picture 3 is a picture of a safety light, which was on "24-7" in the subject stairwell. The safety light is really old, "the original light in the building probably." (T. 44) That light is located below the platform where Petitioner fell/tripped. (T. 44-45)

Picture 4 is the stairwell depicting where Petitioner was walking down at the time. It's a picture that depicts no lights on. Number 5 is a picture of a double light switch. That is at the bottom of the stairs. If you turn to your right, it is on the wall. (T. 45-46) Petitioner's Exhibit 4 is another picture of the stairwell from the gym point looking down the stairs. The one light is showing. (T. 46-47) Petitioner did not recall the date he took the pictures but estimated about four to six weeks after the accident. (T. 47) He took the pictures during in the day but could not recall the time he took the pictures. He testified that you can't see the bottom two or three stairs when the light is off. It does not mater what time of day it is. (T. 48) After he fell, he reported the accident and the injury to the Director of Buildings and Grounds, George Lambesis, and to Jennifer Hosty, the business manager. He told them both the same day that he fell down the stairs, twisted his knee, and it was not feeling good. (T. 48,49)

Petitioner filled out a written Report of Injury, and Respondent's form, a Loss Fund Report. Petitioner testified that he agreed to give a verbal recorded statement to the insurance adjuster. (T. 50) Petitioner testified that he told the adjuster what occurred. The lights were off, that he was carrying his clipboard and it was unsafe with the lights off. (T. 51) He told his foreman that he had an injury, and remembered she asked if he was carrying things. He reported that everything he had in his hands he lost control of when he landed and twisted his knee. He recalled mentioning that the lights were not on. (T. 51)

Petitioner testified that in his written report he did not detail the fact that the lights weren't on because it was a small paragraph, and it was an oversight. The adjuster asked about other injuries he had and Petitioner testified he was very upfront, forthright, and cooperative with the adjuster answering everything she had asked him. She called back and told him that "they're accepting my first statement, not my second." She could not give Petitioner a reason. (T. 52, 56-57) Petitioner explained that he gave a written statement requested by the District, then an interview on the phone some days later to the insurance adjuster. (T. 53) Petitioner tendered a memo to Cate Mukite, the administrative assistant that handled workers' comp. (T. 56)

Petitioner testified regarding medical treatment he received after his alleged accident for his right knee and calf. Petitioner admitted he did not seek treatment until six to eight

weeks after the alleged accident. (T. 60) Petitioner testified he went for medical attention because the pain got worse and worse. He "couldn't deal with it anymore." (T. 60) Petitioner testified he underwent an MRI examination of his right knee and eventually surgery to this right knee on March 17, 2017 at DuPage Surgical Center. (T. 60-61) Petitioner testified he was returned to work at full-duty and without restriction on May 1, 2017. He was off from March 17th until his return to work on May 1, 2017. (T. 61; T. 72) Petitioner did not receive pay while he was off or payment for the medical costs. He submitted the medical costs to his group insurance. There are some balances and bills that remain unpaid. There has been reimbursement to his group insurance. (T. 62)

Subsequent to his full duty release, Petitioner testified he has soreness and some pain in his right knee that he did not have prior to injuring it. He testified he is pretty healthy. (T. 63) Petitioner acknowledged he can perform all his day-to-day and work activities. (T. 63) Petitioner testified that there were no glow in the dark strips on the stairs on August 2, 2016. (T. 71) Petitioner has not sought any medical treatment to his right knee since his full-duty release. (T. 72)

On cross-examination, Petitioner testified that he inspects multiple different buildings within the District. At least once a month he goes to each school building to test everything and sometimes he is in more buildings than others, depending on what's going on. He is in the middle schools more because of activities. If there is no summons or extra activity, it would be standard to be in the elementary schools once per month. (T. 74, 75) As it related to the Piper Elementary School, he went to the building approximately once per month for his duties as a safety coordinator; but testified he presented to pick up money from each school, including Piper, once per week. (T. 75) When he goes for inspections, he go through different doors. At Piper, he enters through the front of the building or the rear at his discretion. He has swipe cards and keys to every lock in the District. (T. 76)

As it related to the Five South Stairwell, Petitioner agreed that there are four separate routes which can be taken to the subject stairwell. (T. 77-78) Petitioner also agreed that he can take any of the three paths that isn't the exterior door without reuse of a swipe card, once he is in the building. (T. 78)

On August 2, 2016, it was summer and the sun had already come up; Petitioner did not recall it being rainy that day. On that day the emergency running light was on in that stairwell. Petitioner agreed that there is a window on the exterior door at the 5 South Platform, which is at the middle of the stairwell. Petitioner came from the gymnasium, walking through the gymnasium area to the 5 South top area of the stairwell. (T. 80)

Petitioner did not have any difficulty seeing any of the stairs leading to the platform. Petitioner testified he doesn't use the handrail and recalled there was one, but was uncertain if there were two handrails. He testified that after you get to the platform, there is a second staircase that goes down to what is the first floor, but looks like a sub-basement. (T. 81) When shown

Respondent's Exhibits, 6-A, 6-D and 6-K Petitioner agreed that was the way the stairwell looked on August 2, 2016. He testified that he never noticed what the door shown in 6-D looked like when it was sunny because he doesn't have time to look at a window and sun. He could not recall if sunlight was coming through the door on August 2, 2016. He "wasn't geared on the sunlight. He was geared on the safety issues and the alarm panel which you could see in 6-K. 6-K is the stairwell leading down from the gymnasium. 6-A was the photograph from the bottom landing where he would say he fell, looking upwards towards the landing. (T. 87-88)

Petitioner agreed that on Respondent's picture 6-E, there was a landing then eight steps. He fell on just the last two to three steps. (T, 91) Structurally that was what the staircase looked like. All the light were off in the hallway. The running light is the only one that was on. (T. 93) Petitioner reiterated he had keys and had a clipboard and pen in his right hand. 6-E is the second stairwell which he fell in and shows where he missed the last two or three steps. Petitioner confirmed the left side staircase going up is the one that goes into the gymnasium and confirmed the middle landing. (T. 97-98) Petitioner confirmed that in 6-E the things shown in the picture at the bottom of the staircase, the boxes of materials, the desk were there when he fell, but he did not recall if the mop was there. (T. 101) None of those things, or water or food on the stairs caused his fall. He was performing his job tasks and taking his time. (T. 102) Petitioner 's portion of the School Employees Lost Fund Report stated that he missed two or three stairs and fell. Nothing said there was a defect in the stairwell. (T. 103-104) He omitted putting anything about lighting and the accident. The next day he walked through with Ms. Hosty and showed her where he fell and he told her the lights were out. He did not ask her to change his report. (T. 104)

6-E is an email that he gave to Cat Mukite and he did not discuss the lighting and did not indicate there were any defects in the stairs. This was the only written report and he signed the School Employees Lost Fund Report and thus there are two separate documents identifying what he said happened that he signed off on, specifically, Respondent's Exhibit 4 and the Employee's Report of Injury. He never asked to amend either. (T. 106-109)

On cross-examination, Petitioner also testified regarding his medical treatment. Petitioner presented to the emergency room on September 21, 2016 at Central DuPage Hospital. (T. 111) Petitioner admitted while in the hospital, he informed the hospital staff he had been exercising regularly, including the elliptical machine, approximately 7-10 miles per week after his alleged accident but before his hospitalization. (T. 113) Petitioner testified he did not recall if he presented to the hospital with anxiety and breathing problems due to frequently walking up and down stairs. (T. 113) Petitioner testified he could not recall whether he discuss his alleged right knee injury. (T. 111-112)

Petitioner testified that he returned to the emergency room on October 6, 2016. (T. 114) Petitioner presented because of chest pains and lightheadedness from traversing stairs "continually." Petitioner admitted he underwent a stress test where he walked on a treadmill, with a "fast walk" during his admission. (T. 115) Petitioner admitted he did not seek treatment

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for his right knee. *Id.*

Petitioner testified his primary care physician was Dr. Delew. (T. 115) Petitioner admitted he treated with Dr. Delew for a number of years. (T. 115) Petitioner acknowledged he could have told him whatever he wanted about his alleged condition. (T. 116) Petitioner admitted he did not tell his physician about his allegations of lighting defects contributing to his alleged accident. (T. 117)

Petitioner testified that as part of his job he walks around the sub-basement for safety hazards, security hazards, any type of issues. The 5-S door exits to the parking lot but he would have to walk around the building to the front. Although there is a parking lot in the rear, Petitioner testified that he parked his truck in the front on Kenilworth and went in the front of the building. (T. 121-122) Petitioner testified he checks the whole building on inspections but there was no other instrument other than the AED and the burglar alarm which needed to be specifically checked at the Piper Elementary School. (T. 122)

Petitioner conceded he could have turned around and left through the gymnasium to exit through the front door of the building after checking the alarm. (T. 123)

On re-direct examination, Petitioner testified that he was in physical therapy for four to six weeks after the accident, and one of the activities working his knee was on a treadmill. He did elliptical and strengthening exercises and worked hard. The conservative treatment failed and that was the reason Petitioner underwent surgery. The school does not provide Petitioner with a checklist or guidelines of all things he is supposed to check. He is responsible to verify that the buildings are safe and secure for all students and the faculty and teachers which entails looking at various things. (T. 125-126)

On recross-examination, Petitioner testified that he could not have turned around and exited through the gymnasium without issue or fear that he did not complete his job. He explained he does not know what is going to be there and if he walks out of a building and doesn't make a thorough check, if something happens, "then it's on me. I'm responsible for that."(T. 128) Petitioner testified that he reported the dark stairwell he encountered on August 2, 2016 previously as a hazard, six to eight months prior to his own accident. (T. 129) If he had not fallen Petitioner planned to walk through the rest of the building and check for safety and security problems, issues, hazards. (T. p. 130)

Testimony of Jimmy Ortiz (Petitioner's Witness):

Mr. Jimmy Ortiz ("Ortiz") testified he was an employee of Respondent. (T. 132) He testified he worked at the Pershing School. (T. 133) He testified he did not work in the subject school (Piper Elementary) at the current time. (T. 133) Ortiz testified that he viewed that stairwell around August 2nd, 2016. (T. 135) On questions from the Arbitrator, Ortiz was asked, "before or on August 2nd, 2016, did you have an opportunity to see this staircase?" (T. 139)

Ortiz responded, "Yes." ..."That was probably sometime in 2015... " (T. 138) Ortiz answered "Yes" when asked if he was ever back in Piper school after '15 until '17. (T. 139)

Ortiz testified he cleaned the subject staircase and when he used to clean it, the lights were not on. He turned them on to do his work. (T. 135-136) Ortiz testified he worked in the Piper school as a "part-time sub" doing custodial duties late in the 2015 calendar year. (T. 139) He turned the lights off when he was done. (T. 141-142) He turned them on to clean and off when he was done, maybe about 30 times. (T. 141, 143-144)

Ortiz agreed on cross-examination that the emergency running light was always on in the Piper 5 South stairwell. (T. 152) He admitted the running light is shining right on top of the middle landing which is between the two staircases. (T. 154) He testified the light is directly above the staircase on the right hand side, walking down to the area where Petitioner alleged he fell, and which was depicted in Respondent Exhibit 6-H. (T. 154-156)

Testimony of Jennifer Hosty (Respondent's Witness):

Ms. Jennifer Hosty ("Hosty") testified she currently works as the business manager for Respondent. (T. 164) Hosty testified that in her capacity as the business manager, she was tasked with securing the report of accident from Petitioner, which was not necessarily part of her job, but something she had to do if an immediate supervisor was not available. (T. 165-166) Hosty testified she completed both the "Illinois Form 45: Employer's First Report of Injury," and the "SELF Supervisor's Investigation Report" in conjunction with Petitioner's alleged accidental injuries, which the Arbitrator accepted into evidence as Respondent's Exhibit #3 and #4, respectively. (T. 166-168) Hosty testified Petitioner reported the alleged accident. (T. 166) Hosty testified Petitioner reported that he was at Piper School and he missed the step. He "thought he was at a different school and he missed the step," and she could not recall if he fell down stairs. She recalled him saying that he was walking through the school and he thought he was in a different school and he missed the step and tripped. (T. 166-167) Hosty and Petitioner walked over to the school together that day or the next and walked through the property together. According to Hosty, Petitioner showed her where he entered the building, what panels he was checking, and where he approximately fell on the stairs. (T. 167) Hosty testified Petitioner completed the Incident Reports after the walk-through. (T. 166-167)

Hosty also testified Petitioner provided a memorandum regarding his alleged accident, which the Arbitrator accepted into evidence as Respondent's Exhibit # 5. (T. 168) Hosty testified Petitioner's memorandum did not report any alleged lighting defect. (T. 191)

During the 2015 and 2016 school year, part of Hosty's responsibilities were oversight of the whole custodial unit including operations and maintenance. She was the supervisor of George Lambesis who supervised the entire unit. Part of that at that time, the safety coordinator's position was to do safety checks, but the safety check was done at the end of the

day. Hosty testified during that period she was never made aware of issues regarding the subject 5-S stairwell. (T. 175- 176)

Hosty testified she did not know if Mr. Jimmy Ortiz worked in the Piper Elementary School during the 2016 school year. (T. 177) Ms. Hosty testified that until June of 2016, or two months prior to the alleged accident, it was part of her job duties to know that information. (T. 176-177)

Hosty testified that in the report Petitioner tendered to her on the day that three reports were filled out, the Investigative Report, another report filled out and signed by Petitioner and the authorization for records, Petitioner gave her a memo and she read it. (T. 182-183) Petitioner could not recall if the memo said the lighting was not good. The Supervisor's Investigative Report and the Form 45 were done the same day, then Hosty met with Petitioner and he tendered her another report and in that report he notes the memo he wrote; the memo dated August 5 was given to Cat Mukite. (T. 184-185) Hosty reviewed the memo but had sent the initial report to "workmen's comp." Hosty did nothing else after she submitted the First Report of Injury even though Petitioner submitted a memo with his other reports which said the lights were not on. (T. 187)

Hosty testified she asked Petitioner whether the lights were off or on, and he responded, "Oh maybe the lights were off." (T. 187) On the day she and Petitioner went to Piper to look at the stairwell, Hosty could not recall if the lights were on. (T. 190)

Hosty identified Respondent's Exhibit 5 as the memorandum Petitioner gave to her with no information in the memo about whether the lights were on or off. (T. 191)

Testimony of Juan Ortiz (Respondent's Witness):

Mr. Juan Ortiz ("Juan") testified he works as the head custodian at Piper, and worked in that capacity on August 2, 2016. (T. 194-195) Juan testified regarding his normal schedule each morning when he arrives at the school, and confirmed he followed the exact schedule on August 2, 2016. (T. 195) Juan testified he arrived at the school on August 2, 2016, at approximately 6:00 A.M., which was approximately three hours prior to Petitioner's alleged accident. (T. 196) Juan testified when he arrived at 6:00 A.M., he entered into the 5 South Stairwell. (T. 196) He testified his first task of the day was to turn on the lights in the school. (T. 197)

Juan testified he first turns on the lights in the first hall of the Five South Stairwell, then the gym, which is adjacent to the subject stairwell, and also turns on the lights in the upper half of the subject stairwell. (T. 198-199) Juan testified he then goes around the building and turns on the remaining lights in the hallways, stairwells, and other open areas of the building. (T. 200) He testified the entire routine takes approximately twenty minutes to

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complete. (T. 200)

Juan testified he performed this routine on August 2, 2016, and within approximately twenty minutes of his arrival at the school, he turned on all of the lights in the subject stairwell, or near the stairwell, which would light the stairwell. (T. 201) Specifically, he testified while referencing photographs admitted as Respondent's Exhibits 6B and 6E, that the photos show the lights in the subject stairwell, including the bottom of the second stairwell, where Petitioner alleged the accident occurred. (T. 210) He first testified these were turned on the morning of August 2, 2016. (T. 210) Specifically, he testified the lights were turned on within twenty minutes of his arrival at the Piper Elementary School. (T. 210-211)

Juan testified regarding Respondent's Group Exhibit #6, which showed the subject stairwell at the Piper Elementary School. Juan testified he was present when all of the photographs were taken, and testified the photographs were taken on either June 21, 2017 or August 2, 2017. (T. 217-218) He testified the photographs taken on August 2, 2017 were taken at 9:00 A.M. (T. 218) Juan testified the Respondent's Exhibit 6E, as well as 6B through 6G, depict the subject stairwell as it appeared, in terms of lighting, on August 2, 2016 prior to Petitioner' s alleged accident. (T. 211; 224)

Regarding lighting in the subject stairwell, Juan testified that at the bottom of the subject stairwell's second set of stairs, where the Petitioner alleges the accident occurred, there is an exit sign overhead. (T. 214-215) Juan testified the exit sign is always on and cannot be turned off. (T. 215) Juan testified it was sunny on the morning of August 2, 2016. (T. 197) He testified in morning hours, the sun shines through the window in the Five South Stairwell. (T. 202) The window faces the southeastern direction. (T. 202-204)

When asked about the light illuminating the area where the Petitioner fell, Juan testified that the light is above when you turn, in a hallway. The closest light that would illuminate this area comes from a room around the corner and little exit sign. The running light above the staircase is always on. (T. 215)

Juan reviewed Petitioner's Exhibits 3 and #4 and testified the photographs did not depict the subject stairwell correctly. (T. 241) Specifically, Juan testified he believed "somebody covered the window and took the rest of the lights off." (T. 241) Juan testified the exit sign cannot be seen in the picture and looked blocked. (T. 260)

The Commission finds that the medical evidence supports the fact that Petitioner had documented subjective complaints of acute right knee pain when Petitioner saw Dr. Huynh at DuPage Medical Group (DMG) on August 16, 2016, two weeks after the incident. (PX1) He was told to try Tylenol as needed for knee pain, Ice 20 minutes 3/daily and to follow-up with DMG P.T.

On August 22, 2016, there is evidence that a right knee x-ray was taken on that date at DuPage and referred by Dr. Huynh. The radiologist's impression was mild degenerative changes right knee; nonspecific foci of ossification within the soft tissue of the right proximal calf.

When Petitioner returned with his persistent headache complaints on August 24, 2016, he reported right knee pain and that he used ice for relief. He gave a history of "Tripping downstairs at work, 2-3 steps." He reported sharp and dull intermittent pain, no radiation, worse with movement. He had been icing and taking Advil. The Assessment and Plan noted that the knee x-ray did not show any fracture or dislocation, and that the patient could try ibuprofen up to 800 milligrams up to three times per day, ice and rest. He was to be referred to DMG physical therapy.

Although Petitioner was then referred for therapy, it appears that he did not start therapy until November 16, 2016. On August 30, 2016 Petitioner saw Dr. Raikar at DMG for his persistent headache complaints. The notes indicate "unspecified derangement of medial meniscus." (PX1) Petitioner had a CT scan of his brain and was referred to neurology. On September 21, 2016, Petitioner consulted the emergency room at Northwestern Medicine at Central DuPage Hospital complaining of shortness of breath on exertion and chest discomfort. (RX9)

On October 4, 2016, Petitioner had an NUC Exercise stress myocardial perfusion imaging test which showed evidence of myocardial ischemia. (PX1) On October 6, 2016 he again went to the emergency department at Northwestern Medicine Central DuPage Hospital for chest pain. (RX9) On October 7, 2016 he had an angiogram. (PX1)

On November 15, 2016, Petitioner saw Dr. J. Delew at DMG. Petitioner reported pain in his right knee and that he fell at work on some stairs last month (sic) and he had been referred for physical therapy. He reported it was difficult to exercise due to right knee pain. He also reported that he had been admitted for chest pain the prior months and was diagnosed with nonobstructive coronary artery disease (CAD) and up to 50% CAD. He was diagnosed with primary osteoarthritis of his right knee. Dr. Delew administered a cortisone injection at that visit. (PX1) The Physical Therapy Initial Evaluation notes encounter was 3-1/2 months after the work accident, on November 18, 2016. (PX1) He reported that he fell down some stairs at work, missed three steps while going downstairs in August 2016 and he felt a tweak on the inner side of his right knee. He reported getting the cortisone injection and that his knee still hurt. The therapist noted that the right knee pain was impacting his functional ability to squat, manage stairs and walk. Petitioner continued to undergo therapy reporting increased pain after walking a lot more at work. (Px1)

On December 12, 2016, the physical therapy notes document Petitioner was put on increased pain medication after he reported increased pain which he attributed to a lot of walking at work the prior Thursday and Friday.

Petitioner first saw Dr. Marc Asselmeier, an orthopedic surgeon at DMG, on referral from Dr. Delew on January 25, 2017. An MRI was ordered and Petitioner underwent the right knee MRI procedure on January 20, 2017. The radiologist's MRI Impression was: 1) Longitudinal tear

of the body and posterior horn of the medial meniscus extending from the inferior articular surface of the posterior horn and involving the free edge of the body; 2) Chondromalacia and early osteoarthritis of the patellofemoral compartment; and 3) Small reactive joint effusion and popliteal cyst. Surgery was performed by Dr. Asselmeier on March 17, 2017 consisting of arthroscopic partial medial meniscectomy of the right knee and arthroscopic chondroplasty, patella. The surgical findings noted a complex tear of posterior horn, evidence of internal derangement, second fracture and deep lateral femoral notch sign. (PX1)

Petitioner resumed physical therapy on March 28, 2017. Petitioner reported that he was a safety coordinator and he has to walk around nine (9) schools and only four (4) with elevators. He was working up to the day of surgery and had not worked since surgery. Petitioner continued with therapy. At session five of eight authorized visits, on April 18, 2017, Petitioner reported post-surgical pain and tightness. The pain was located in his medial and inferior joint. He reported he would need to walk up to one hour and climb repetitive stairs. Petitioner saw Dr. Asselmeier on April 20, 2017. Her reported his pain was significantly improved and he was finishing up his therapy. He had mild limitations of flexion. Dr. Asselmeier gave him permission to return to work on May 1, 2017 as tolerated. (PX1

Conclusions of Law

Accident

When Petitioner filed his Application for Adjustment of Claim only four weeks after his accident, he alleged that, "During safety walk, tripped, poorly lit."

Injuries sustained by employees away from the workplace during travel to and from work are generally not compensable except when duties require travel away from the work site. If an employee is required to travel and is involved in the performance of reasonable services for the employer at an appropriate time and place, an injury that occurs will be considered to be in the course of the employment. As explained in *Hoffman v. Industrial Comm'n*,

> We agree with the Appellate Court that claimant's status was that of a "traveling employee" and that courts generally consider such employees differently from other employees when considering whether an injury arose out of and in the course of employment. (*Wright v. Industrial Com.* (1975), 62 Ill. 2d 65, 68; *David Wexler & Co. v. Industrial Com.* (1972), 52 Ill. 2d 506, 510.) However, a finding that a particular claimant is a traveling employee does not exempt the claimant from proving that an injury arose out of and in the course of employment, and some injuries, even when incurred by traveling employees, are not compensable under the Act. See, *e.g., U.S. Industries v. Industrial Com.* (1968), 40 Ill. 2d 469 (injuries suffered as the result of midnight pleasure drive into the mountains not compensable under the Act).

> In each instance where this court has considered whether a particular injury arose out of and in the course of employment, it has emphasized that the Act was not intended to insure employees against all accidental injuries. (*Robinson v. Industrial Com.* (1983), 96 Ill. 2d 87, 91; *David Wexler & Co. v. Industrial Com.* (1972), 52 Ill. 2d 506, 510.) Rather, the Act was intended to compensate only those injuries which arise out of (1) acts which the employee was instructed to perform by his employer, (2) acts which he has a common law or statutory duty to perform while performing duties for his employer, or (3) as explained below, acts which the employee might be reasonably expected to perform incident to his assigned duties. *Robinson v. Industrial Com.* [*200] (1983), 96 Ill. 2d 87, 91; *Ace Pest Control, Inc. v. Industrial Com.* (1965), 32 Ill. 2d 386, 388.

*Hoffman v. Industrial Com*m'n., 109 Ill. 2d 194, 199-200, 486 N.E.2d 889, 891, 1985 Ill. LEXIS 314, *5-7, 93 Ill. Dec. 356, 358

The Commissions finds that Petitioner was a traveling employee and that he was injured in the course and scope of his employment with Respondent on August 2, 2016. Petitioner testified he uses a District truck to travel between his office and the schools in the district. The Commission finds that at the time Petitioner fell, he was doing what he was instructed to do by his employer and further, he was also performing an act that he would reasonably be expected to perform incidental to his assigned duties, which was walking down stairs and looking for safety and security issues.

The Arbitrator made findings regarding Petitioner's lack of credibility based upon testimony from the head custodian concerning a supposition about the Petitioner's pictures and further that the Petitioner's pictures of the stairwell lacked credibility because they do not depict the natural light from the door, the emergency running light or the exit sign at the bottom of the stairwell. The Commission does not agree. The Commission finds Petitioner to be credible. He was forthright about his accident, reporting it immediately, showing Ms. Hosty where he fell, and the reason he thought he fell. Petitioner agreed to give a recorded statement in which he said nothing that would cast aspersion upon his credibility.

The Commission finds that the lighting issue is not dispositive of the reason the Petitioner fell but based upon his testimony could have been a contributing cause despite the emergency running lights which were described as, at best, the oldest lights in the school, a small exit sign and some natural light that entered through a door window located at the middle landing, at the bottom of the eight stairs where the accident occurred. The Arbitrator dismissed the fact that Petitioner had work-related items in his hand, however, Petitioner testified he did not hold the handrails and the Commission finds that would have been difficult with his hands full with the clipboard in one hand and his two key rings carrying 40 keys in the other. More importantly, Petitioner testified he was "looking around" and that activity is the very definition of his job. Petitioner was doing his job looking for safety hazards and security concerns.

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It is clear that the Petitioner was a traveling employee at the time he fell down the stairs on August 2, 2016. His job involves traveling to various school buildings to ensure the safety and security of the staff, students and visitors. The test for determining whether an injury to a traveling employee arose out of and in the course of his employment is the reasonableness of the conduct in which he was engaged and whether the conduct might normally be anticipated or foreseen by the employer. *Cox v. Illinois Workers' Compensation Comm'n*, 406 Ill App. 3d 541, 941 N.E2d 961 (2010). Under such an analysis, a traveling employee may be compensated for an injury as long as the injury was sustained while he was engaged in an activity which was both reasonable and foreseeable.

The Commission finds that walking down a staircase of any of these District's schools is reasonable and foreseeable when, as Petitioner told his physical therapist, he had to walk around nine schools, and only four with elevators, as part of his job. (PX1, 3/28/17)

Petitioner testified he goes to each of those nine school once a month, therefore, he has to go on average to two or three schools each week to do a safety and security check on the AED instruments and burglar alarms, in addition to general walking inspections, traversing multiple stairs in five of those buildings without elevators. In addition, Petitioner makes Friday visits to all nine schools to pick up money.

The Commission finds that the Petitioner, as a traveling employee, sustained his burden of proving an accident arising out of and in the course of his employment with Respondent on August 2, 2016.

Causal Connection

The Commission finds that the Petitioner's present condition of ill-being is causally related to the injury. Even without medical proof on the issue of causation, the chain of events demonstrating a previous condition of good health, accident and subsequent injury to Petitioner's right knee resulting in disability may be sufficient circumstantial evidence to prove a causal nexus between the accident and the employee's injury. *International Harvester v. The Industrial Commission*, 93 Ill. 2d 59, 442 N.E.2d 908 (1982). The medical records are consistent with Petitioner's testimony and prove that Petitioner was in good health before the accident as it concerns his right knee, and his right knee pain started immediately after the reported accident, got progressively worse and the right knee MRI demonstrated a meniscus tear.

Temporary Total Disability

Given the Commission's findings regarding accident, the Commission finds that Petitioner is entitled to Temporary Total Disability benefits for the period he was off work beginning March 17, 2016 through April 30, 2016.

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Medical Expenses

The medical bills are awarded pursuant to §8(a) and §8.2 of the Act, which allows for the rate as paid by Petitioner's group health insurance carrier, Blue Cross/Blue Shield, to represent the negotiated rate. (See *Perez v. Ill. Workers' Comp. Comm'n*, 2018 IL App (2d) 170086WC, 96 N.E.3d 524, 2018 Ill. App. LEXIS 10, 420 Ill. Dec. 439) To the extent any balances remain regarding the awarded bills which stem from Petitioner's deductible, co-payments and/or co-insurance, the Respondent shall reimburse Petitioner accordingly pursuant to §8(a) of the Act. The Respondent is entitled to credit for medical bills paid under the Respondent's group carrier pursuant to §8(j) per the trial stipulation. (ARBX1)

Permanent Partial Disability

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

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

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

(i) No AMA impairment rating was submitted by either party, so this factor is given no weight.

(ii) Petitioner was employed as a safety and security coordinator. He returned to full-duty work in his prior capacity. He is required to be on his feet throughout the workday. Thus, this factor is assigned greater weight.

(iii) Petitioner was 50 years old at the time of the accident and has approximately 15-20 years of work life remaining until retirement. This factor is assigned some weight.

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

(v) Regarding evidence of disability corroborated by the treating medical records, as a result of the work-related accident of August 2, 2016, Petitioner's MRI confirmed: 1) Longitudinal tear of the body and posterior horn of the medial meniscus

extending from the inferior articular surface of the posterior horn and involving the free edge of the body; 2) Chondromalacia and early osteoarthritis of the patellofemoral compartment; and 3) Small reactive joint effusion and popliteal cyst. Petitioner underwent surgery on March 17, 2017 consisting of arthroscopic partial medial meniscectomy of the right knee and arthroscopic chondroplasty, patella. The surgical findings noted a complex tear of posterior horn, evidence of internal derangement, second fracture and deep lateral femoral notch sign. Petitioner was off work 6-3/7 weeks, from March 17, 2017, through April 30, 2017, at which time he returned to work full duty as a safety/ security coordinator for Respondent. Petitioner testified at Arbitration he experiences pain and soreness that he did not have prior to the injury. The Commission viewed Respondent's Exhibits 8a and 8b as showing Petitioner has the ability to ride a motorcycle and perform daily activities. The activities were performed without any visible problems but it is noted that none of the activities encompassed heavy labor. When Petitioner last saw Dr. Asselmeier on April 20, 2017, he reported his pain was significantly improved and he was finishing up his therapy. He had mild limitations of flexion. Dr. Asselmeier gave him the permission to return to work on May 1, 2017 as tolerated. Based on the treating medical records, this factor is assigned moderate weight.

After considering the entire record, the Commission reverses the decision of the Arbitrator and finds Petitioner established that he suffered accidental injuries arising out of and in the course of his employment on August 2, 2016, that Petitioner is entitled to an award of 6- 3/7 weeks of temporary total disability benefits at a rate of $455.01 per week under §8(b) of the Act, that Petitioner is entitled to an additional award of 26.875 weeks of permanent partial disability benefits at a rate of $409.51 per week for the reason Petitioner's work related injuries resulted in a 12.5% loss of use of a right leg under §8(e) of the Act and that Respondent shall pay for the reasonable related medical expenses under §8(a) and §8.2 of the Act, limited to the amount paid by the group provider.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on May 3, 2018, is hereby reversed on the issue of accident for the reasons stated herein.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $455.01 per week for a period of 6-3/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay reasonable, necessary and related medical expenses for services provided by DuPage Medical Group and DuPage Surgical Center pursuant to §8(a) of the Act, subject to the Medical Fee Schedule pursuant to §8.2 of the Act for medical expenses under §8(a) of the Act and limited to the amount paid by Petitioner's group health insurance carrier, Blue Cross/Blue Shield. To the extent any balances remain regarding the awarded bills which stem from Petitioner's deductible,

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co-payments and/or co-insurance, the Respondent shall reimburse Petitioner accordingly pursuant to §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is entitled to a credit under §8(j) of the Act; provided that Respondent shall hold Petitioner harmless from any claims and demands by any providers of the benefits for which Respondent is receiving credit under this order.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $409.51 per week for a period of 26.875 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the 12.5% loss of use of the right 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.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $22,180.00. 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: JUL 20 2020
KAD/bsd
O5/19/20
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Maria Elena Portela
Maria E. Portela

Thomas J. Tyrrell
Thomas J. Tyrrell

DISSENT

The Majority finds the case compensable under a traveling employee theory, however, as Petitioner was neither traveling nor on the street when the injury occurred, I would not find the traveling employee doctrine applicable. By itself, the act of walking up a staircase does not expose an employee to a risk greater than that faced by the general public. [Citations omitted]." *Baldwin v. Illinois Workers' Compensation Commission,* 409 111. App. 3d 472, 478, 949 N.E.2d 1151 (2011).

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Similarly, in *Nee v. Ill. Workers' Comp. Comm'n*, the Petitioner tripped on a curb when he walked to his car to go to an inspection assignment and injured his knee. The Court held that his employer knew he drove to multiple inspection sites daily, thus "no reasonable argument can be made that the claimant's conduct in traversing a curb as he walked to his car was neither reasonable nor foreseeable. The only legitimate issue for analysis in this case is whether the claimant's injuries arose out of his employment." *Nee v. Ill. Workers' Comp. Comm'n,* 2015 IL App (1st) 132609WC, P24, 28 N.E.3d 961, 966, 2015 Ill. App. LEXIS 131, *8-9, 390 Ill. Dec. 308, 313 (Ill. App. Ct. 1st Dist. February 27, 2015)

The Court then went on to analyze the facts under a risk analysis. The *Nee* Court held, "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. *Nee v. Ill. Workers' Comp. Comm'n,* 2015 IL App (1st) 132609WC, P24, 28 N.E.3d 961, 966, 2015 Ill. App. LEXIS 131, *8-9, 390 Ill. Dec. 308, 313 (Ill. App. Ct. 1st Dist. February 27, 2015)

As in *Nee*, the Petitioner in the instant case was exposed to a neutral risk when walking on the stairs. As such, I would adopt the Arbitrator's well-reasoned risk analysis and find that Petitioner did not sustain his burden of proving accident.

Kathryn A. Doerries

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SIMS, BOBBY D
Employee/Petitioner

Case# **16WC033680**

SOUTH BERWYN SCHOOL DISTRICT #100
Employer/Respondent

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On 5/3/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.99% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1404 BARRY A KETTER PC
221 E LAKE ST
SUITE 202
ADDISON, IL 60101

1120 BRADY CONNOLLY & MASUDA PC
NICHOLAS RUBINO
10 S LASALLE ST SUITE 900
CHICAGO, IL 60603

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STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Bobby D. Sims,
Employee/Petitioner

v.

Berwyn South School District #100,
Employer/Respondent

Case # **16** WC **33680**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Robert M. Harris**, Arbitrator of the Commission, in the city of **Chicago**, on **March 22, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **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 not*** sustain an accident that arose out of and in the course of employment.

ORDER:

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Petitioner failed to prove he sustained an accidental injury arising out of and in the course of his employment for Respondent on August 2, 2016; therefore, his claim for compensation is denied.

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

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

Robert M. Harris

Signature of Arbitrator

May 2, 2018

Date

MAY 3 - 2018

ILLINOIS WORKERS' COMPENSATION COMMISSION

MEMORANDUM IN SUPPORT OF ARBITRATION DECISION

20IWCC0412

BOBBY D. SIMS,
Employee/Petitioner

v. Case No.: 16 WC 33680

BERWYN SOUTH SCHOOL DISTRICT #100,
Employer/Respondent

I. STATEMENT OF FACTS:

Petitioner's Testimony:

The Arbitrator has highlighted certain facts seen below as being significant in this claim. Petitioner was employed by Respondent on August 2, 2016. (T. 16). Petitioner testified he worked as a safety coordinator for the Berwyn South School District as a safety coordinator. (T. 17). Petitioner's job required him to perform safety and security inspections of multiple schools in the district. (T. 17). Petitioner worked at the district's administrative building and not directly in any specific school. (T. 17).

Petitioner testified on August 2, 2016, he went to the Piper School to inspect the "safety burglar alarm," AED instrument, and check for safety hazards. (T. 18-19). Petitioner testified he checked the burglar alarm, which was located in the 5 South Stairwell. (T. 20). Petitioner testified the burglar alarm was in the middle of the stairwell; to the right of the burglar alarm is an exterior door, and to the left of the burglar alarm was another stairwell. (T. 20). Petitioner testified he needed to traverse the first set of stairs to access the burglar alarm, which was located on the middle landing, and he was able to traverse those stairs without any issue or accident. (T. 22).

Petitioner testified when he was in the Piper Elementary School building on August 2, 2016, he was carrying a notepad on a clipboard, that was about three by five inches in size. (T. 37). Petitioner testified he also carried two sets of keys on his left pinky finger. (T. 37-39).

Petitioner testified that on August 2, 2016, he "fell down the stairs." (T. 38). Petitioner alleged he thought he was even with the floor, but "missed two to three stairs" and twisted his right knee. (T. 38; T. 40). **Petitioner alleged he could not see the last two to three stairs because**

they were dark. (T. 39). **Petitioner acknowledged there was a safety light, which was on "24-7" in the stairwell in question.** (T. 44).

Petitioner testified regarding his opinions generally as to the lack of lighting in the District. (T. 23-30). Petitioner alleged he believed a policy to turn off lights during the summer existed, but he acknowledged there was no specific district rule or policy to this affect. (T. 23-30).

Petitioner testified he believed the photographs he took of the subject stairwell, which were admitted into evidence as Petitioner's Exhibits #3 and #4 depict the lighting at the time of his accident. (T. 47). **Petitioner acknowledged he did not know when he took the photographs, and he could not provide a date or time of day when he took the alleged photographs.** (T. 46-47).

Petitioner testified regarding medical treatment after his alleged accident. Petitioner admitted he did not seek treatment until six to eight weeks after the alleged accident. (T. 60). Petitioner testified he underwent an MRI examination of his right knee and eventual surgery to this right knee on March 17, 2017. (T. 60-61). Petitioner testified he was returned to work at full-duty and without restriction on April 17, 2017. (T. 61; T. 72). Petitioner testified he was off work for a period of time, but did not provide the dates of his alleged time off work. (T. 61).

Subsequent to his full duty release, Petitioner testified his right knee is "sorer" and he has some pain. (T. 63). Petitioner acknowledged he can perform all his day-to-day and work activities. (T. 63). Petitioner acknowledged has not sought any medical treatment to his right knee since his full-duty release. (T. 72).

On cross examination, Petitioner admitted he only goes to each elementary school in the district approximately once per month. (T. 75). As it related to the Piper Elementary School, Petitioner likewise only went to the building approximately once per month for his duties as a safety coordinator but testified he presented to pick up money from each school, including Piper, once per week. (T. 75).

As it related to the Five South Stairwell at issue where the alleged accident occurred, Petitioner acknowledged there are four separate routes which can be taken to the subject stairwell. (T. 77-78). Petitioner acknowledged he can take any of the four routes to the subject stairwell without the use of a swipe card, once he is in the building. (T. 78). Petitioner also acknowledged after he checked the burglar alarm on the subject stairwell landing, there were no further instruments which needed to be specifically checked at the Piper Elementary School. (T. 122).

Petitioner acknowledged he could have turned around and left through the gymnasium to exit through the front door of the building after checking the alarm. (T. 123).

Petitioner testified he arrived at the Piper Elementary School on August 2, 2016 at **9:00 in the morning, that it was a sunny day**, and it was not rainy outside. (T. 79). **Petitioner also testified the emergency running light was on in the subject stairwell on August 2, 2016.** (T. 80). **Petitioner testified a window existed in the exterior door on the landing between the two staircases in the subject stairwell.** (T. 80). **Petitioner acknowledged nothing was obstructing the window in that stairwell.** (T. 80).

Petitioner testified he had no problem seeing the first set of stairs in the subject stairwell, or the platform in the subject stairwell. (T. 81). Petitioner testified he traversed the first staircase and platform without issue, and he further testified when he approached the second stairwell, he could see the first portion of that stairwell without any issues. (T. 82). Petitioner testified there were handrails on both sides of the stairwell, both on the first, and also the second set of stairs in the subject stairwell. (T. 86). Petitioner further agreed Respondent's Exhibit 6A, 6D, and 6K, accurately depicted the subject stairwell, from a structural perspective, as they appeared on August 2, 2016. (T. 86). Petitioner testified from a structural perspective, Respondent's photograph 6E depicted the stairwell and landing where he alleged he fell on August 2, 2016. (T. 98).

When discussing the subject stairwell, Petitioner testified he did not know how the subject stairwell looks when lights comes through the window of the exterior door, despite testifying as to his knowledge of the stairwell. (T. 87). Petitioner could not testify if photographs depicting light coming through the subject stairwell were accurate. (T. 87).

Petitioner testified regarding a table and mop bucket at the bottom of the subject stairwell landing, which is depicted in Respondent's Exhibit 6E. (T. 102). Petitioner acknowledged none of the objects caused or contributed to his alleged accidental fall. (T. 102). Petitioner further acknowledged no water, food, or material was on the stairs, and no such object caused or contributed to the alleged accidental fall. (T. 102). Petitioner acknowledged the stairs themselves did not cause or contribute to his alleged accidental fall. (T. 102). Petitioner acknowledged he was in no way rushed to perform his job, nor did any time restrictions cause or contribute to his alleged accidental fall. (T. 102).

Regarding Petitioner's accident reporting to Respondent, Petitioner testified he did not provide a written report claiming a lighting defect in the subject stairwell. (T. 104). **Petitioner testified he did not ask to change or amend his accident reports after the alleged accident.** (T. 104). **Petitioner further acknowledged he provided a written and signed memorandum after he completed his accident report and did not allege any lighting defect in the subject stairwell. (T. 106). Petitioner testified he did not ask to change or amend the memorandum after the alleged accident. (T. 107). Petitioner signed both the accident report and his memorandum.** (T. 109)

Petitioner also testified regarding his medical treatment. Petitioner acknowledged he presented to the emergency room on September 21, 2016 at Central DuPage Hospital. (T. 111). Petitioner acknowledged while in the hospital, he informed the hospital staff he had been exercising regularly, including using the elliptical approximately 7-10 miles per week after his alleged accident but before his hospitalization. (T. 113). Petitioner testified he did not recall if he presented to the hospital with anxiety and breathing problems due to frequently walking up and down stairs. (T. 113). Petitioner further testified he could not recall whether he discuss his alleged right knee injury. (T. 111-112).

Petitioner testified he return to the emergency room on October 6, 2016. (T. 114). Petitioner acknowledged he presented because of chest pains and light-headedness from traversing stairs "continually." (T. 114). Petitioner acknowledged he underwent a stress test where he walked on a treadmill, with a "fast walk" during his admission. (T. 115). Petitioner acknowledged he did not seek treatment for his right knee. (T. 115).

Petitioner testified his primary care physician was Dr. Delew. (T. 115). Petitioner agreed he treated with him for a number of years. (T. 115). Petitioner agreed he could have told the doctor whatever he wanted about his alleged condition. (T. 116). Petitioner agreed he did not tell his physician about his allegations of lighting defects contributing to his alleged accident. (T. 117).

Testimony of Jimmy Ortiz (Petitioner's Witness):

Ortiz testified he was an employee of Respondent. (T. 132). Ortiz testified he worked at the Pershing School. (T. 133). Oritz testified he did not work in the subject school (Piper Elementary) at the current time. (T. 133). Ortiz testified he worked in the subject school as a "fill-in" late in the 2015 calendar year. (T. 139). On questioning from the Arbitrator, Ortiz was asked, "before or on August 2nd, 2016, did you have an opportunity to see this staircase?" (T. 139). Ortiz responded, "That has to be in 2015..." (T. 139) Ortiz testified that he was also in the subject school in "late last year like about Christmastime..." (T. 135).

Ortiz acknowledged the emergency running light was always on in the subject stairwell. (T. 152). Ortiz acknowledged the running light is "shinning right on top of the landing." T. 154). Ortiz testified the light is directly above the staircase after the landing, on the right hand side, walking down to the area where Petitioner alleged he fell, and which was depicted in Respondent Exhibit 6H. (T. 154-156).

Testimony of Jennifer Hosty (Respondent's Witness):

Hosty testified she currently works as Respondent's business manager. (T. 164). Hosty testified that in her capacity as business manager, she was tasked with securing the report of accident from Petitioner. (T. 166). Hosty testified she completed both the "Illinois Form 45: Employer's First Report of Injury," and the "SELF Supervisor's Investigation Report" in conjunction with Petitioner's alleged accidental injuries, which the Arbitrator admitted into evidence as Respondent's Exhibit #3 and #4, respectively. (T. 166-168).

Hosty testified Petitioner reported the alleged accident. (T. 166). Hosty testified Petitioner reported that he "thought he was at another school," and that he "misjudged" the stairs, and fell. Hosty testified Petitioner did not report any issues with the lighting of the subject stairwell or any defect in the stairwell at that time. (T. 166-167).

Hosty testified Petitioner provided a memorandum regarding his alleged accident, which the Arbitrator admitted into evidence as Respondent's Exhibit #5. (T. 168). Hosty testified Petitioner's memorandum did not report any alleged lighting defect. (T. 191).

Hosty testified that around the time Petitioner provided his reports of alleged accident, she and Petitioner did a "walk-through" in the subject stairwell. (T. 167). Hosty testified Petitioner did not specifically allege any issues with the lighting of the subject stairwell or any defect in the

stairwell. (T. 167). Hosty testified she asked Petitioner whether the lights were off or on, and he responded to her, "oh maybe the lights were off." (T. 187). There was no direct report to Ms. Hosty the lights caused the fall. (T. 187).

Hosty testified Petitioner never requested to amend his report of alleged accident subsequent to the completion of the accident report or submission of his memorandum. (T. 168). Hosty testified she never received a complaint from Petitioner concerning the subject stairwell, or the lighting in the subject stairwell prior to the alleged accident. (T. 175-176).

Hosty testified she has no recollection that Ortiz worked in the Piper Elementary School during the 2016 school year. (T. 177). Hosty testified until June of 2016, or two months prior to the alleged accident, it was part of her job duties to know that information. (T. 176-177).

Finally, Hosty testified she has never been to the Piper Elementary School and seen the lights off. (T. 190).

Testimony of Juan Ortiz (Respondent's Witness):

Juan Ortiz testified he works as the head custodian at the subject school (Piper Elementary), and worked in that capacity on August 2, 2016. (T. 194-195). Juan Ortiz testified regarding his normal schedule each morning when he arrives at the subject school, and confirmed he followed the exact schedule on August 2, 2016. (T. 195). Juan Ortiz testified he arrived at the subject school on August 2, 2016 at approximately 6:00 A.M., which was approximately three hours prior to Petitioner's alleged accident. (T. 196). Juan Ortiz testified when he arrived at 6:00 A.M., he entered into the Five South Stairwell. (T. 196). Ortiz testified his first task of the day was to turn on the lights in the subject school. (T. 197).

Juan Ortiz testified he first turns on the lights in the first hall of the Five South Stairwell, then the gym, which is adjacent to the subject stairwell, and also turns on the lights in the upper half of the subject stairwell. (T. 198-199). Ortiz testified the then goes around the building and turns on the remaining lights in the hallways, stairwells, and other open areas of the building. (T. 200). Ortiz testified the entire routine takes approximately twenty minutes to complete. (T. 200).

Ortiz testified he performed this routine on August 2, 2016, and within approximately twenty minutes of his arrival at the subject school he turned on all of the lights in the subject stairwell, or near the stairwell, which would light the stairwell. (T. 201). Specifically, Ortiz

testified while referencing photographs admitted as Respondent's Exhibit 6B and 6E, that the photos show the lights in the subject stairwell, including the bottom of the second stairwell, where Petitioner alleged the accident occurred. (T. 210). Ortiz first testified these were turned on the morning of August 2, 2016. (T. 210). Specifically, Ortiz testified the lights were turned on within twenty minutes of his arrival at the Piper Elementary School. (T. 210-211).

Ortiz testified regarding Respondent's Group Exhibit #6, which showed the subject stairwell at the Piper Elementary School. Ortiz testified he was present when all of the photographs were taken, and he testified the photographs were taken on either June 21, 2017 or August 2, 2017. (T. 217-218). Ortiz testified the photographs taken on August 2, 2017 were taken at 9:00A.M. (T. 218). Ortiz testified the Respondent's Exhibit 6E, as well as 6B through 6G, depicted the subject stairwell as it appeared, in terms of lighting, on August 2, 2016 prior to Petitioner's alleged accident. (T. 211; 224).

Juan Ortiz testified it was sunny on the morning of August 2, 2016. (T. 197). Ortiz testified in the morning hours, the sun shines through the window [in the door] in the Five South Stairwell. (T. 202). The window faces in the southeastern direction. (T. 202-204).

Regarding lighting in the subject stairwell, Ortiz testified that at the bottom of the subject stairwell's second set of stairs, where Petitioner alleges the accident occurred, there is an exit sign overhead. (T. 214-215). Ortiz testified the exit sign is always on and cannot be turned off. (T. 215). Ortiz reviewed Petitioner's Exhibits 3 and #4 and testified the photographs did not depict the subject stairwell correctly. (T. 241). Specifically, Ortiz testified he believed "somebody covered the window and took the rest of the lights off." (T. 241). Ortiz testified the exit sign cannot be seen in the picture and looked blocked. (T. 260).

Exhibits Admitted at Trial:

The Arbitrator finds the following exhibits to be pertinent to the decision rendered.

Arbitrator's Exhibit #2:

Arbitrator's Exhibit #2 purports to be Petitioner's Application for Adjustment of Claim. The Arbitrator finds Petitioner's described mechanism of injury was a "missed step."

Arbitrator's Exhibit #3:

Arbitrator's Exhibit #3 are almanac findings for which the Arbitrator took judicial notice. The Arbitrator finds on the date of the alleged accident, August 2, 2016, the sun rose at

approximately 5:55 A.M. and that it was a sunny morning, without inclement weather the entire day. The Arbitrator also finds on the date of the photographs submitted by Respondent, August 2, 2017, the sun rose at approximately 5:55 A.M. and that it was a sunny morning, without inclement weather the entire day. The Arbitrator finds the weather documentation indicates that natural light would have been present in the subject stairwell by the time of the alleged accident on August 2, 2016, at approximately 9:00 A.M. Petitioner offered no objections to the admission of the exhibit or any objections or arguments that the day of the alleged accident was not clear and sunny.

Petitioner's Exhibits #3 and #4:

Petitioner submitted alleged photographic evidence of the subject stairwell. Petitioner testified the photos were taken after the alleged accident. The Arbitrator finds these photographs do not accurately depict the subject stairwell as it would have appeared on August 2, 2016. The photograph depicts the subject stairwell; however, the Arbitrator finds it does not actually and accurately depict the lighting in the subject stairwell, which Petitioner encountered on the date of the alleged accident. The Arbitrator finds the photograph clearly does not depict the lighting which enters the subject stairwell through the window of the exterior door in the stairwell.

Petitioner admitted it was a sunny day on August 2, 2016. The Arbitrator finds light clearly would have come through the exterior door window, but none can be seen in the photographs. Additionally, the Arbitrator finds the photograph has been manipulated, as the "exit" sign, which is at the end of the subject stairwell, does not appear in these photographs, but exists in the subject stairwell and is seen in other photographs admitted into evidence of the subject stairwell.

Respondent's Exhibit #2:

Respondent's Exhibit Number 2 is the work log of Respondent's witness, Juan Ortiz. The Arbitrator finds Juan Ortiz was working on the date of the alleged accident, on August 2, 2016. The Arbitrator finds this exhibit supports Ortiz's testimony, as it confirms Ortiz was working in the building on the date of the alleged occurrence and enhances the credibility of his testimony regarding the actions he took upon arrival at Piper Elementary School on August 2, 2016 at 6:00 A.M. Petitioner offered no evidence to rebut this conclusion that Ortiz was working on August 2, 2016 and was at Piper Elementary School as he testified.

Respondent's Exhibit #3/Petitioner's Exhibit #2:

Respondent's Exhibit #3 and Petitioner's Exhibit #2 are the same document, which purports to be Petitioner's initial report of accident to Respondent. The Arbitrator finds the report

indicates Petitioner "missed a step" and fell. The Arbitrator finds Petitioner did not report any defect in the subject stairwell. The Arbitrator finds Petitioner did not report the lighting of the subject stairwell impacted the alleged occurrence. Moreover, the Arbitrator finds Petitioner's report did not describe any specific mechanism of injury, or how the alleged "missed step" caused any injury to his right lower extremity or right knee.

Respondent's Exhibit #4:

Respondent's Exhibit #4 is the Supervisor Accident Report. The Arbitrator finds Respondent's representative, Jennifer Hosty, testified consistent with the accident report. The Arbitrator finds Petitioner did not report any defect in the subject stairwell. The Arbitrator finds Petitioner did not report the lighting of the subject stairwell impacted the alleged occurrence. Moreover, the Arbitrator finds Petitioner's report did not describe any specific mechanism of injury, or how the alleged "missed step" caused any injury to his right lower extremity or right knee.

Respondent's Exhibit #5:

Respondent's Exhibit #5 purports to be a subsequent memorandum of correspondence from Petitioner to Jennifer Hosty regarding supplemental facts of his alleged accident from August 2, 2016. The memorandum was provided on August 5, 2016. The Arbitrator finds the memorandum does not report any defect in the subject stairwell. The Arbitrator finds Petitioner did not report the lighting of the subject stairwell impacted the alleged occurrence. Moreover, the Arbitrator finds Petitioner's report did not describe any specific mechanism of injury, or how the alleged "missed step" caused any injury to his right lower extremity or right knee. Finally, the Arbitrator finds the memorandum directly contradicts the testimony of Petitioner and aided in the Arbitrator's findings that Petitioner did not testify credibly.

The Arbitrator finds Petitioner testified he supplied the memorandum to Jennifer Hosty, identified the memorandum during his trial testimony, and admitted to the authenticity of the memorandum. The Arbitrator finds Petitioner then testified the memorandum alleged a lighting defect in the subject stairwell. However, the Arbitrator on review of the memorandum finds the memorandum does not contain any allegations of defective lighting in the subject stairwell.

Respondent's Exhibit #6:

Respondent's Exhibit #6 represents a series of photographs of the subject stairwell. The Arbitrator finds the photographs submitted by Respondent accurately depict the subject stairwell

as it appeared on August 2, 2016. The Arbitrator finds that the photographs depict the natural light, as it would have appeared in the subject stairwell coming through the window of the exterior door. The Arbitrator finds the photographs further depict how the subject stairwell appeared on August 2, 2016, with the hallway and overhead lights having been turned on at that time. Finally, the Arbitrator finds the photographs accurately depict the exit sign at the bottom of the stairs.

Respondent's Exhibit #8:

Respondent's Exhibit #8 purports to be surveillance footage of Petitioner subsequent to the alleged accident and subsequent to Petitioner's right knee arthroscopy. The Arbitrator finds the surveillance depicts Petitioner engaging in activities of daily living such as riding a motor cycle, shopping in a sporting goods store, emptying groceries from a vehicle, and cleaning his garage. All of the activities appear to be performed without any physical restrictions or limitations as to Petitioner's right knee.

The Arbitrator finds the surveillance evidence would have been instructive as to the issue of nature and extent; however, the Arbitrator finds Petitioner did not sustain a compensable accident, so the Arbitrator finds the surveillance inapplicable to that moot issue. However, the surveillance reflects negatively on Petitioner's overall credibility.

Respondent's Exhibit #9:

Respondent's Exhibit #9 purports to be medical evidence from Central DuPage Hospital from September 21, 2017 and October 6, 2017. The Arbitrator finds the records instructive as to the finding of no accident and a potential dispute as to causation. The Arbitrator finds these records reveal Petitioner failed to allege any knee injury for several weeks, and also indicated regular use of the right knee without any issue.

I. CONCLUSIONS OF LAW

C. Whether an accident occurred that arose out of and in the course of Petitioner's employment with Respondent?

The Arbitrator finds and concludes Petitioner failed to establish and prove by a preponderance of the evidence that he sustained an accidental injury arising out of and in the course of his employment with Respondent on August 2, 2016.

Credibility Assessments of the Trial Witnesses:

The Arbitrator finds and concludes Petitioner's testimony lacked credibility. In the context of all the facts and evidence presented, Petitioner's testimony fails to persuade the Arbitrator that his version of the alleged event carries greater weight than the weight and credibility of the collective evidence and testimony that weighs against his claim. Specifically, but not exclusively, the Arbitrator is not persuaded by Petitioner's assertions that the stairs where he alleges he missed 2 or 3 stairs were "dark". This incident therefore did not "arise out of" his employment. Petitioner failed to prove he was exposed to any employment hazard or any increased risk of employment under any risk theory. The Arbitrator finds this testimony to be lacking credibility and accordingly does not adopt it.

The Arbitrator further finds and concludes the testimony of Jimmy Ortiz lacks relevance and does not assist Petitioner's claim. Credibility. Ortiz did not see the staircase at issue on the date of accident so he is not aware of its condition at the time of the accident. Ortiz acknowledged the emergency running light was always on in the subject stairwell. (T. 152). Ortiz acknowledged the running light is "shining right on top of the landing." T. 154). Ortiz testified the light is directly above the staircase after the landing, on the right hand side, walking down to the area where Petitioner alleged he fell, and which was depicted in Respondent Exhibit 6H. (T. 154-156). This testimony works against Petitioner's claims that the stairs were "dark."

The Arbitrator finds and concludes Hosty's trial testimony to be credible. The Arbitrator further finds Hosty's testimony to be persuasive regarding the threshold accident issue. (T. 164). Hosty testified she completed both the "Illinois Form 45: Employer's First Report of Injury," and the "SELF Supervisor's Investigation Report" (T. 166-168). Hosty testified Petitioner reported that he "thought he was at another school," and that he "misjudged" the stairs, and fell. Hosty testified Petitioner **did not report any issues with the lighting of the subject stairwell or any defect in the stairwell at that time**. (T. 166-167).

Hosty testified Petitioner's memorandum (RX 5) did not report any alleged lighting defect. (T. 191). Hosty testified that around the time Petitioner provided his reports of alleged accident, she and Petitioner did a "walk-through" in the subject stairwell. (T. 167). Hosty testified **Petitioner did not specifically allege any issues with the lighting of the subject stairwell or any defect in the stairwell**. (T. 167). Hosty testified she asked Petitioner whether the lights were off or on, and he responded to her, "oh maybe the lights were off." (T. 187). There was no direct report to Hosty that the lights caused the fall. (T. 187).

Hosty testified Petitioner never requested to amend his report of alleged accident subsequent to the completion of the accident report or submission of his memorandum. (T. 168). Hosty testified she never received a complaint from Petitioner concerning the subject stairwell, or the lighting in the subject stairwell prior to the alleged accident. (T. 175-176).

The Arbitrator finds and concludes the trial testimony of Juan Ortiz was credible at trial. The Arbitrator further finds and concludes Juan Ortiz's testimony was persuasive as to the threshold issue of accident. Ortiz testified he followed his normal work schedule on August 2, 2016. (T. 195). Ortiz testified he arrived at the school on August 2, 2016 at approximately 6:00 A.M., about three hours prior to Petitioner's alleged accident. (T. 196). Ortiz testified when he arrived at 6:00 A.M., he entered into the Five South Stairwell. (T. 196). Ortiz testified his first task of the day was to turn on the lights in the subject school. (T. 197).

Juan Ortiz testified he first turns on the lights in the first hall of the Five South Stairwell, then the gym, which is adjacent to the subject stairwell, and also turns on the lights in the upper half of the subject stairwell. (T. 198-199). Ortiz testified the then goes around the building and turns on the remaining lights in the hallways, stairwells, and other open areas of the building. (T. 200). Ortiz testified the entire routine takes approximately twenty minutes to complete. (T. 200).

Ortiz testified he performed this routine on August 2, 2016, and within approximately twenty minutes of his arrival at the subject school he turned on all of the lights in the subject stairwell, or near the stairwell, which would light the stairwell. (T. 201). Ortiz testified while referencing photographs admitted as Respondent's Exhibit 6B and 6E, that the photos show the lights in the subject stairwell, including the bottom of the second stairwell, where Petitioner alleged the accident occurred. (T. 210). **Ortiz first testified these were turned on the morning of August 2, 2016. (T. 210). Specifically, Ortiz testified the lights were turned on within twenty minutes of his arrival at the Piper Elementary School.** (T. 210-211).

Ortiz testified regarding Respondent's Group Exhibit #6, which showed the subject stairwell at the Piper Elementary School. Ortiz testified he was present when all of the photographs were taken, and he testified the photographs were taken on either June 21, 2017 or August 2, 2017. (T. 217-218). Ortiz testified the photographs taken on August 2, 2017 were taken at 9:00A.M. (T. 218). Ortiz testified the Respondent's Exhibit 6E, as well as 6B through 6G, depicted the subject stairwell as it appeared, in terms of lighting, on August 2, 2016 prior to Petitioner's alleged accident. (T. 211; 224).

Juan Ortiz testified it was sunny on the morning of August 2, 2016. (T. 197). Ortiz testified in the morning hours, the sun shines through the window [in the door] in the Five South Stairwell. (T. 202). The window faces in the southeastern direction. (T. 202-204).

Regarding lighting in the subject stairwell, Ortiz testified that at the bottom of the subject stairwell's second set of stairs, where Petitioner alleges the accident occurred, there is an exit sign overhead. (T. 214-215). **Ortiz testified the exit sign is always on and cannot be turned off.** (T. 215). Ortiz reviewed Petitioner's Exhibits 3 and #4 and testified the photographs did not depict the subject stairwell correctly. (T. 241). Specifically, Ortiz testified he believed "somebody covered the window and took the rest of the lights off." (T. 241). Ortiz testified the exit sign cannot be seen in the picture and looked blocked. (T. 260).

Applicable Law and Precedent:

It is well established that the petitioner bears the burden of proof that an incident arose out of and in the course of a risk connected to his employment. *Union Stark v. Industrial Commission*, 56 Ill.2d 272, 277, 307 N.E.2d 119 (1974); *Dodson v. Industrial Commission*, 308 Ill.App.3d 572, 720 N.E.2d 275 (1999).

Moreover, Illinois Courts have consistently rejected positional risk as a theory of compensability under the Illinois Workers' Compensation Act. *Brady vs. Louis Ruffolo & Sons Construction Company,* 143 Ill.2d 542, 578 N.E.2d 921 (1991). The mere presence of a claimant on his employer's property is insufficient to create liability under the Act. *Id.*

An injury arises out of one's employment when the injury has its origin in some risk connected with or incidental to the employment so as to create a causal connection between the employment and the accidental injury. *Sisbro, supra* 207 Ill.2d at 203, 797 N.E.2d at 672. A risk is "incidental" to the employment where it belongs to or is connected with what an Employee must do in fulfilling his employment duties. *Sisbro, supra,* 207 Ill.2d 204, 797 N.E.2d 672. In assessing the relationship between the risk and the employment, the Courts of Illinois have identified three categories of risk to which an Employee may be exposed: (1) risk distinctly associated with her employment; (2) personal risks; and (3) neutral risks which have no particular employment or personal characteristics. *Springfield Urban League v. Illinois Workers' Compensation Commission,* 2013 Ill.App.(4th) 1202 19WC27, 990 N.E.284.

Risks distinctly associated with the employment are generally compensable as they are inherently connected to an incidental to the employment. By contrast, "personal risks" are generally not compensable as they are associated with the individual or personal characteristics of the Employee. "Neutral risks" are those which have no specific relationship to either the employment or the claimant. "Neutral risks" are compensable only where the employee is exposed to that risk to a greater degree than the general public because of the demands and terms of his employment. *Don Young v. Illinois Workers' Compensation Commission,* 2013 Ill.App.(4th) 130392WC, 13 N.E.3d 1252.

Illinois Courts have held that a claim is compensable under the Act when the injury results from a risk "appreciably and substantially beyond the ordinary risk so that there is extra danger to which employees in ordinary occupations or places of employment are not subject...the burden of proof is on the applicant to show that the position of the injured person was more hazardous than that of others in the same community or that by reason of the employment the risk was greater." *Alzina Construction Co. v. Industrial Com.*, 309 Ill. 395, 398, 141 N.E.2d 191 (1923). A claimant must show the "by reason of his employment, [he] is exposed to a risk greater than the risk to which the public in the vicinity is subjected, or if his employment..." *American Freight Forwarding Corp. v. Industrial Com.*, 31 Ill.2d 293, 294, 201 N.E.2d 399 (1964) (emphasis added).

In the current case, in evaluating whether Petitioner was exposed to a risk greater than that of the general public, the Arbitrator finds Petitioner's alleged accident was not a "personal risk", as Petitioner was technically at his place of employment for Respondent and apparently performing his job duties. However, the Arbitrator further finds Petitioner's alleged accident also was not an "employment risk", as Petitioner failed to ***credibly prove*** any defect, hazard or condition (whether an increase either due to quantity or quality) was present that caused or contributed to his alleged fall or "misstep." At best, Petitioner was merely walking down a staircase and allegedly "missed a step." The Arbitrator therefore finds and concludes that Petitioner's alleged accident is considered a "neutral risk" under the Act. *Metropolitan Water Reclamation District v. Ill. Workers' Comp. Comm'n*, 407 Ill. App. 3d 1010 (2011).

In a neutral risk setting, Petitioner must establish that a "quantitative" or "qualitative" increase in risk occurred in order for a claim to be compensable. A "quantitative" risk assessment addresses whether a Petitioner engages in an activity so frequently as to increase the level of risk associated with a normally neutral task. A "qualitative" risk assessment addresses whether an

activity specific to the employment increased a normally neutral task. *Noonan v. Ill. Workers' Compensation Comm'n*, 2016 IL App (1st) 152300WC.

Additionally, in situations involving a "fall" the Illinois Appellate Court has held defects which are employment related and not neutral occur when there exists a "risk of tripping on a defect in the employer's premises, failing on uneven or slippery ground..., or performing some work related task which contribute to the risk of falling." *First Cash Financial Services v. Indus. Comm'n,* 367 Ill. App. 3d 102, 106 (2006). The Arbitrator finds that in this case, there was no credibly proven "defect" and nothing was credibly proven that would have increased Petitioner's risk of "tripping" or "missing a step." To the contrary, Petitioner agreed there were no defects present on the staircase. The Arbitrator discounts Petitioner's assertion that the stairs were "dark" and further finds that he was not engaged in any employment activity which contributed to his risk of falling; although Petitioner alleged that he was carrying a small clipboard and keys when descending the stairs where he allegedly fell, Petitioner's actual claim is his assertion that he fell and missed the steps because the stairs were "dark" (or thought he was in another building), a claim the Arbitrator finds lacks credibility, was rebutted by the witness testimony and other evidence, and which is accordingly rejected.

Two other consistent types of cases where a neutral risk is increased to an employment risk from a qualitative assessment are situations where an employee carrying objects directly contributes to the increased risk, or where an employee is forced to rush through an otherwise neural task. *See Nabisco Brands, Inc. v. Indus. Comm'n,* 266 Ill. App. 3d 1103 (1994) and *Knox County YMCA v. Indus. Comm'n,* 311 Ill. App. 3d 880 (2000). The Arbitrator likewise finds this scenario also was not present. **Petitioner did not offer any testimony to indicate that the clipboard and keys he was allegedly holding were a "hazard" or "increased risk" or caused or contributed to his fall; again, Petitioner's actual claim is his assertion that he fell because the stairs were "dark". Further, there was no credible evidence Petitioner was forced to rush or traverse the stairs in anything other than a normal manner, as would the general public when traversing stairs anywhere.**

Issue of Credibility:

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

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

The Arbitrator must judge the credibility of the witnesses, including Petitioner, who testified at trial. The Arbitrator has significant concerns with the credibility of Petitioner's testimony – especially in relation to the sum total of the other evidence admitted at trial. The Arbitrator finds the following contributed to his finding that Petitioner lacks credibility.

Most notably, the Arbitrator finds the photographs taken by Petitioner of the subject stairwell to lack credibility and not an accurate representation. The Arbitrator finds it is indisputable that natural light – and bright light at that - was entering thru the door window and shining down (directly or indirectly) into the subject stairwell on August 2, 2016. Moreover, all parties agreed an emergency running light is on at all times in the subject hallway. The Arbitrator infers that the emergency running light provided some light on the stairs (after all, that is the purpose of such a light). The Arbitrator further finds that the "exit sign" also was present at the bottom of the subject stairwell, which is seen in Respondent's Exhibit 6. Again, the Arbitrator infers that the "exit sign" light provided at least some additional light on the stairs (after all, that is the purpose of such a sign, to be seen). However, the Arbitrator finds the photographs submitted into evidence by Petitioner do not depict natural light, the emergency running light, or the exit sign at the bottom of the subject stairwell. The Arbitrator finds those photographs lacked credibility based upon the manifest weight of the testimony submitted, as has significant concerns as to the validity of the photographs themselves.

Application of Law/Precedent to Testimony and Evidence:

The Arbitrator holds Petitioner was traversing a staircase on August 2, 2016, which was a purely neutral risk and an act common to the general public. As such, Petitioner is required to prove by a preponderance of the evidence that there was either a quantitative or qualitative increase in the neutral risk caused by his employment. The Arbitrator finds Petitioner failed to do so; therefore, Petitioner did not sustain an accident that arose out of and in the course of his employment for Respondent and the Arbitrator therefore denies all claims for benefits.

Foremost, the Arbitrator finds no quantitative increase impacted Petitioner's alleged accidental injuries. Petitioner testified he only went to Piper Elementary School once per month for his duties as a safety coordinator. (T. 75). As such, Petitioner's job did not place him in a position to traverse the subject stairwell with a greater frequency than that to which the general public is exposed to create an increased risk.

Additionally, the Arbitrator finds no qualitative increase impacted Petitioner's alleged accidental injuries. In support of that position the Arbitrator cites to the following:

Petitioner made only two claims regarding the "cause" or "contribution" to his alleged accidental injury on August 2, 2016. First, prior to any attorney or legal involvement concerning his claim, Petitioner alleged he "missed a step," and fell down two to three stairs in the subject stairwell. At this time, Petitioner indicated the reason he "missed a step" was because his belief he was in a different school building. This was confirmed through his initial accident reporting to Respondent, in the form of his written accident report to Respondent on August 3, 2016, and in a clarification memorandum two days later on August 5, 2016. (Petitioner's Exhibit #2, Respondent's Exhibit #3, #4, and #5).

Second, Petitioner's sole allegation during his trial testimony was that a defect in the lighting of the stairwell ("dark") caused him to be unable to see the final few steps of the staircase.

Petitioner also specifically denied any cause or contribution from the following:

- Petitioner specifically denied any defect or hazard in the actual staircase;
- Petitioner specifically denied any defect or hazard in the handrails of the subject stairwell;
- Petitioner specifically denied he was rushing in any manner; and,
- Petitioner specifically denied any foreign object contributed to his alleged fall.

Petitioner's attorney inquired into additional facts surrounding Petitioner's alleged accident injuries, but Petitioner did not testify those in any way caused or contributed to his alleged accident.

Notably, Petitioner testified he was holding a clipboard and keys in his left hand, and may have held a pen in his right hand. However, the Arbitrator finds that Petitioner did not actually allege this activity caused or contributed to his alleged "missed step," or alleged fall down the stairs. Again, Petitioner only alleged he "missed a step," and fell due confusion with the building he was working in, and later attributed this fall to "dark" lighting issues. Petitioner never testified he was distracted by, unable to traverse, or placed into a dangerous situation due having to carry a clipboard and/or keys while walking down the subject stairwell. In addition, the Arbitrator finds Petitioner's testimony lacked credibility and allegations regarding him holding a clipboard and keys were unsubstantiated.

The Arbitrator finds the facts of this case inconsistent with the notable case law on "qualitative" risk claims:

- The Arbitrator finds Petitioner was not forced to rush, which could have created an increased risk. *Knox County YMCA v. Indus. Comm'n,* 311 Ill. App. 3d 880 (2000); *O'Fallon School District No. 90 v. Indus. Comm'n*, 313 Ill. App. 3d 413 (2000);
- The Arbitrator finds Petitioner was not alleging a defect in the stairwell or with the handrails, which could have created an increased risk. *First Cash Financial Services v. Indus. Comm'n,* 367 Ill. App. 3d 102, 106 (2006); and,
- The Arbitrator finds Petitioner was either not carrying any clipboard or pen, or if he were carrying a clipboard or pen, it did not cause or contribute to his alleged fall or cause a dangerous situation while traversing stairs. *Knox County YMCA v. Indus. Comm'n,* 311 Ill. App. 3d 880 (2000); *Nabisco Brands, Inc. v. Indus. Comm'n,* 266 Ill. App. 3d 1103 (1994).

In sum, the Arbitrator finds Petitioner's testimony lacked credibility. Moreover, Petitioner's alleged accidental injuries must be evaluated from a neutral risk perspective. The Arbitrator holds there was no quantitative or qualitative increased risk associated with Petitioner's alleged action of traversing the subject stairs on August 2, 2016. The Arbitrator also specifically finds that Petitioner's claim that the stairs were "dark" is not believable and was effectively rebutted at trial. As such, the Arbitrator finds and concludes Petitioner did not sustain accidental

injuries that arose out of his employment for Respondent. His claim for compensation is therefore denied.

E. Whether timely notice of an alleged accident was given to Respondent.

As the Arbitrator finds that Petitioner failed to prove accident, issue of "notice" is moot.

F. Whether Petitioner's condition of ill-being was causally connected to her injury.

As the Arbitrator finds Petitioner failed to prove accident, causation is moot.

J. Whether Petitioner's medical services were reasonable and necessary?

As the Arbitrator finds Petitioner failed to prove accident and causation, the issue of medical benefits is moot.

K. Whether Petitioner is due temporary total disability benefits?

As the Arbitrator finds Petitioner failed to prove accident and causation, the issue of temporary total disability benefits is moot.

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

As the Arbitrator finds Petitioner failed to prove accident and causation, the issue of permanent partial disability benefits is moot.

II. CONCLUSION

WHEREFORE, the Arbitrator finds Petitioner failed to prove he sustained accidental injuries arising out of and in the course of his employment with Respondent on August 2, 2016.

Petitioner's alleged trip and fall down the stairs was the result of a neutral risk, which was not qualitatively or quantitatively greater than the general public, and as a result, is not compensable. There was no hazard or increased risk present that caused or contributed to his alleged fall.

Therefore, his claims for compensation are denied.

Robert M. Harris

Arbitrator Robert M. Harris

Dated: May 2, 2018

STATE OF ILLINOIS)

)

COUNTY OF DUPAGE)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ROBERT MUSSELMAN,

Petitioner,

vs. No: 13 WC 7742

20 IWCC 396

SHELTER BUILDERS,

Respondent.

Dissent in Part & Concur in Part

I respectfully dissent in part from, and concur in part with, the Decision of the Majority. The Majority affirmed and adopted, with explanation, the Decision of the Arbitrator who found that Petitioner proved his condition of ill-being of his lumbar spine was causally related to a work-related accident on December 1, 2011 and awarded him $415,404.94 in medical expenses, 274&2/7 weeks of TTD benefits, 65&2/7 weeks of maintenance benefits, and total permanent disability benefits for life commencing on January 18, 2019. I concur with the Decision of the Majority on the issues of causation, the award of medical expenses, and the award of permanent total disability benefits. However, I dissent from the Decision of the Majority in its award of TTD/maintenance.

The Majority correctly cited the law that to be eligible for TTD/maintenance benefits, a claimant must prove not only that he did not work for a period of time, but also that he could not work for that period of time. In addition, a claimant has the burden of proving every aspect of his claim, including his/her entitlement to TTD/maintenance benefit.

Petitioner was self-employed and owned Respondent, a carpentry business, as a sole proprietorship. In December 2011, he fell on stairs and injured his lumbar spine. Petitioner testified that he continued to work after his accident and resulting injuries. He testified that he had difficulty working after the accident, but that he could do most things except measuring. He also testified that he basically worked the last six years his business was in operation until it closed in November of 2016. His testimony that he continued working was corroborated by the medical records which show that he reported to his medical providers that he worked throughout his treatment. While he may not have been able to do heavy manual labor associated with carpentry,

he continued to perform at least the management duties of the business. The Majority found that Petitioner was entitled to combined TTD/maintenance benefits totaling 339&4/7 weeks because he testified that he could not work for more than a few hours and that he did not pay himself a salary. In my opinion that in itself is not sufficient to prove Petitioner was entitled to the temporary benefits awarded.

Petitioner did not produce any business records showing how many hours he worked. If he had produced documentation that he worked a certain number of hours and was paid less because of the reduced hours of work, he would have been entitled to temporary partial disability benefits. The fact that Petitioner did not pay himself does not establish that he was entitled to TTD/maintenance. Petitioner affirmatively decided to not pay himself. That was a business decision he made as owner of the company. In my opinion, the reasoning behind the Majority opinion could open the door for possible abuse. Under the Majority's reasoning, an injured company owner could continue working in some form, not pay himself, and attempt to shift the burden of his salary from his sole proprietorship to its Workers' Compensation insurance carrier. Such an action would considerably increase the bottom line for the claimant's business.

In my opinion, Petitioner was not entitled to TTD/maintenance until his business closed in November of 2016. Petitioner proved that he was unable to work after his business closed, that he sought employment, but was unable to secure employment with the restrictions imposed because of his injuries. Thereafter, he was effectively precluded from working. At that point, he would be entitled to TTD if he had not reached MMI, maintenance if he reached MMI and could not work temporarily, or the commencement of permanent total disability benefits if he was at MMI and permanently unemployable. While these benefits represent different theories of compensation, practically they are interchangeable because the compensation rate for all three benefits are identical.

For the reasons stated above, I concur with the Decision of the Majority on the issues of causation, the award of medical expenses, and the award of permanent total disability benefits. However, I dissent from the Decision of the Majority in its award of TTD/maintenance. Therefore, I respectfully dissent from the Decision of the Majority in affirming the Arbitrator's TTD/maintenance award.

JUL 21 2020

O-5/21/20

DLS/dw

46

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Donna C. Mottley,
Petitioner,

20IWCC0415

vs.

No: 15 WC 27478

State of Illinois,
Department of Aging,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 2, 2019 is hereby affirmed and adopted.

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

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

20 IWCC0415

Pursuant to §19(f)(1) of the Act, claims against the State of Illinois are not subject to judicial review. Therefore, no appeal bond is set in this case.

DATED: JUL 2 1 2020

Marc Parker

Barbara N. Flores

mp/wj
06/04/20
68

Dissent in Part & Concur in Part

I respectfully dissent in part from, and concur in part with, the Decision of the Majority. The Majority affirmed and adopted the Decision of the Arbitrator who awarded Petitioner reimbursement of $200 in out-of-pocket expenses and 30 weeks of PPD benefits representing loss of 6% of the MAW. I agree with the award of reimbursement of Petitioner's out-of-pocket expenses which she established were related to her work injury. However, I would have modified the PPD award to reduce it from 30 weeks of benefits representing loss of 6% of the MAW, to 10 weeks of benefits representing loss of 2% of the MAW.

Petitioner sustained an injury to her right shoulder on July 22, 2015 when she pushed on a door of an overhead filing cabinet. Her entire treatment consisted of a visit to her Primary Care Physician, x-rays, an MRI, and two visits to an orthopedist, Dr. Romanelli. At the first visit on August 24, 2015, Dr. Romanelli administered a steroid injection in her right shoulder. In the second visit on September 16, 2015, he noted that Petitioner had excellent range of motion and excellent strength and released her from treatment with no restrictions. A few weeks after her release by Dr. Romanelli, Petitioner retired from her job with Respondent after 40 years of working for the State of Illinois.

In my opinion the award of 6% of the MAW is excessive in this case. Petitioner had a total of three doctor visits and a single injection. Upon her release she was found to have excellent range of motion and strength. She returned a few weeks after she completed that treatment showing that she did not have a long working life to have to deal with any possible ongoing complications from her injury. While she complained of ongoing pain, she provided no evidence to support that assertion. Under the circumstances of this case, I believe a PPD award of 10 weeks representing loss of 2% of the MAW is appropriate and I dissent from that part of the Commission decision affirming the Arbitrator's PPD award of loss of 6% of the MAW.

For the reasons stated above, I concur with the Decision of the Majority affirming the Arbitrator's award of $200 in reimbursement to Petitioner. However, I would have modified the

20IWCC0415

Arbitrator's PPD award and reduced it from 6% of the MAW to loss of 2% of the MAW. Therefore, I respectfully dissent from the Decision of the Majority in affirming the Arbitrator's PPD award.

Deborah L. Simpson

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

20 IWCC0415

MOTTLEY, DONNA C
Employee/Petitioner

Case# **15WC027478**

ILLINOIS DEPARTMENT OF AGING
Employer/Respondent

On 12/2/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.58% shall accrue from the date listed above to the day before the 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:

5703 SGRO HANRAHAN DURR RABIN ET AL
GREGORY P SGRO
1119 S 6TH ST
SPRINGFIELD, IL 62703

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

4993 ASSISTANT ATTORNEY GENERAL
CHELSEA T GRUBB
500 S SECOND ST
SPRINGFIELD, IL 62706

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

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

DEC 2 - 2019

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

20 IWCC0415

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

Donna C. Mottley
Employee/Petitioner

v.

Illinois Department of Aging
Employer/Respondent

Case # **15** WC **27478**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Seal**, Arbitrator of the Commission, in the city of **Springfield**, on **September 13, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **July 22, 2015**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**44,024.76**; the average weekly wage was $**846.63**.

On the date of accident, Petitioner was **64** years of age, ***married*** with **0** dependent children.

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

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

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

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $507.98 per week for a total of 30 weeks representing 6% loss of use of the person as a whole, as provided in Section 8(d)(2) of the Act.

Petitioner is awarded the medical bills set forth in PX7, and specifically that of Springfield MRI & Imaging Center, pursuant to the medical fee schedule in Section 8(a) and 8.2 of the Illinois Worker's Compensation Act. Respondent's dispute regarding the bills was based upon liability.

Respondent shall receive credit for all medical bills paid by its group medical plan for which credit is allowed under Section 8(j) of the Act, and further shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall further reimburse Petitioner for her co-payments as set forth in PX7 in the amount of $200.00.

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 29, 2019
Date

DEC 2 - 2019

Petitioner was opening the door to an overhead cabinet on July 22, 2015, above her desk at the Illinois Department of Aging. She described that she would have to stand, lift the door over her head and push it forward. She described that it was heavy and metal. In the process of pushing the door forward it rolled backwards and she felt a pop in her right shoulder. She experienced immediate pain of a type she had never previously experienced.

The Petitioner testified that she reported the occurrence to her Supervisor and then completed a Notice of Injury which is contained as Petitioner's Exhibit 8 and Respondent's Exhibit 3.

The Petitioner testified that she first sought medical treatment on July 28, 2015 from her Primary Care Physician, Dr. Michael Paul Bova. Dr. Bova's records were admitted as Petitioner's Exhibit 3. She provided an accurate history to Dr. Bova. He performed x-rays and asked her to return on August 03, 2015. At that time, he examined her, held her off work and ordered an MRI. He referred her to Dr. Ronald Romanelli.

Her MRI was performed on July 30, 2015 at Springfield MRI & Imaging Center. The report was admitted into evidence as Petitioner's Exhibit 5. She saw Dr. Romanelli on August 24, 2015. His records were admitted as Petitioner's Exhibit 6. She provided an accurate history of the accident to Dr. Romanelli. Dr. Romanelli discussed the MRI findings with her and that it showed some tears. She explained that she was right hand dominant and continuing to have achy pain rated as 7/10. The pain was radiating down her right arm. She had diminished strength and decreased range of motion. Her right shoulder impingement test was positive and she demonstrated weakness with forward flexion and with abduction. He diagnosed her with shoulder pain, rotator cuff tear and impingement syndrome. He described her tear as "partial." He believed she would benefit from a corticosteroid injection and he injected her right shoulder on that date. He gave her a physical therapy referral and told her to return to him in a few weeks. She did return to Dr. Romanelli on September 16th and reported improvement following the injection. She described she still had pain "especially when reaching overhead." She had not done any therapy. She was still was having pain at night, as well as popping and a decrease in strength.

He performed an impingement test which was now negative. He opined she was doing well and he was pleased. He gave her rubber bands for exercise, said she had "some mild impingement and partial rotator cuff tears," but thought she had a good prognosis without surgical intervention. He stated that "in the future she may need another cortisone injection. She will follow up prn." The Petitioner testified she has not returned to the doctor to treat for this condition following that visit.

The Petitioner testified that she continues through the present date to have aching pain in her right shoulder. She said she experiences that pain on a daily basis, particularly with usage. She described that she has diminished lifting, cannot lift overhead with her right arm and cannot reach behind her back. She described that she cannot undo her bra strap with her right hand. She also described that she cannot reach beneath her car seat with her right hand. She demonstrated the mobility of her right arm on the witness stand. She explained that the pain in her right arm

sometimes interrupts her sleep. The Petitioner testified that she retired from the State of Illinois on September 21, 2015. She indicated that she had worked for the State for forty years, with her first date of employment having been September 16, 2015. She admitted to being disciplined for having fallen asleep at her desk on one occasion. She stated that it was completely unrelated to her work injury. It is notable that her retirement date is less than one month after the time she was held off work for the injury she described.

Conclusions of Law

The Arbitrator finds as follows:

I The accident arose out of and in the course of Petitioner's employment with Respondent

The evidence proves that an accident arose out of Petitioner's employment. In order for an injury to arise out of employment it must have had its origin and some risk connected with or incidental to the employment so that there is a casual connection between the employment and the injury. *Technical Tape Corporation v. The Industrial Commission, 58 Ill.2d 226, 230 (IL. 1974)*. The Petitioner's uncontroverted testimony was that she was raising the door on a locked cabinet used to store work items above her desk. Her report of injury admitted as Petitioner's Exhibit 8 and Respondent's Exhibit 3 expressly states that "I was opening the door to my overhead file cabinet...I lifted open my overhead file cabinet door when something popped inside of my right shoulder." In the case of *Caterpillar Tractor Company v. The Industrial Commission*, 129 Ill.2d 52(1989), the Supreme Court wrote "typically an injury arises out of one's employment if, at the time of the occurrence, the employee was performing acts....which the employee might reasonably be expected to perform incident to assigned duties. A risk is incidental to the employment where it belongs to or is connected with what an employee has to do in fulfilling her duties." (Citations Omitted). Clearly the Petitioner was performing a function connected with or incidental to her duties when she was lifting a heavy metal door over her head and sliding it forward.

II. Petitioner's condition is causally related to the injury.

Petitioner testified that she is an Office Assistant with the State of Illinois Department of Aging and was performing administrative duties. On the date of the accident she lifted a heavy metal overhead door and rolled it forward when it rolled back causing her right shoulder to pop and she experienced immediate pain. The pain was a type she had never experienced before and the pain persisted from that date through the present. She provided an accurate and consistent history of the foregoing on her contemporaneous written report of injury, to Dr. Bova and to Dr. Romanelli. Her testimony at trial was similarly consistent.

The records show that she sustained a tear of supraspinatus tendon. The Petitioner sustained a shoulder injury which is causally connected to the work-related occurrence.

III. Petitioner's medical services are reasonable and necessary.

Section 8(a) of the Illinois Workers' Compensation Act requires the employer to pay for all medical services rendered by an employee that was injured during the course of employment. Petitioner has one unpaid medical bill arising from her injury; namely, Springfield MRI & Imaging Center, in the amount of $1,300.00. That invoice is contained within Petitioner's Exhibit A. In addition, Petitioner testified to the fact that the balance of her medical bills were paid by Group Health Insurance, but that she had paid a co-payment to Dr. Romanelli's office in the amount of $200.00.

IV. Nature and Extent

The Arbitrator concludes:

According to Section 8.1(b) of the Act, for injuries that occur after September 01, 2011, in determining the level of permanent partial disability, the Commission shall base its determination on the following factors:

i. The reported level of impairment pursuant to subsection 9(a) [AMA Guidelines];
ii. The occupation of the injured employee;
iii. The age of the employee at the time of the injury;
iv. The employee's future earning capacity; and
v. Evidence of disability corroborated by the treating medical records.

No single factor is to be the sole determinant of disability.

With respect to (i), the reported level of impairment – an AMA Impairment rating was not conducted. Petitioner's injection was successful, and she returned to work without restrictions. Petitioner testified she has diminished strength in her right arm. She has diminished mobility in her right arm. She specifically has difficulty with overhead lifting or with reaching behind her back. She is right hand dominant and is unable to operate her bra strap. She is unable to reach behind or below her car seat with her right arm. The Arbitrator therefore gives some weight to this factor.

With respect to (ii), Petitioner's occupation – Petitioner testified that she was employed as Administrative Assistant for forty years. Less than one month after returning to work she retired. Clearly her job duties involved overhead use of the filing cabinet. The Arbitrator therefore gives some weight to this factor.

With respect to (iii), Petitioner's age at the time of the injury – At the time of the work accident, Petitioner was 64 years old. As such, Petitioner may be considered of relatively advanced age. Given the foregoing, the Arbitrator gives great weight to this factor.

With respect to (iv), Petitioner's future earning capacity – There is inferential evidence that Petitioner's retirement was precipitated by the accident, as one of many factors associated with her advanced age. The Arbitrator gives some weight to this factor.

With respect to (v), Evidence of disability – Petitioner testified that she has diminished strength and mobility in the right arm. She experiences daily aching pain and some difficulty sleeping. Overhead lifting is no longer possible with her right arm and she cannot latch her bra strap or reach behind her car seat. The Arbitrator gives some weight to this factor.

Petitioner was a credible witness. Her testimony was unrebutted. The nature and extent of the injury is 6% loss of the person as a whole. Having considered the entirety of the evidence:

RESPONDENT SHALL PAY PETITIONER PERMANENT PARTIAL DISABILITY BENFITS OF $507.98 PER WEEK FOR A TOTAL OF 30 WEEKS REPRESENTING 6% LOSS OF THE PERSON AS A WHOLE AS PROVIDED IN SECTION 8(d)(2) OF THE ACT.

RESPONDENT SHALL PAY PETITIONER'S MEDICAL BILLS AS SET FORTH IN PETITIONER'S EXHIBIT 8. SPECIFICALLY, SPRINGFIELD MRI & IMAGING CENTER IN THE AMOUNT OF $1,300.00, ACCORDING TO THE MEDICAL FEE SCHEDULE IN SECTION 8(a) AND 8.2 OF THE ILLINOIS WORKER'S COMPENSATION ACT.

RESPONDENT SHALL FURTHER REIMBURSE PETITIONER HER OUT OF POCKET EXPENSES IN THE AMOUNT OF $200.00.

RESPONDENT SHALL RECEIVE CREDIT FOR ALL MEDICAL BILLS PAID BY ITS GROUP MEDICAL PLAN FOR WHICH CREDIT IS ALLOWED UNDER SECTION 8(j) OF THE ACT, AND FURTHER SHALL HOLD PETITIONER HARMLESS FROM ANY CLAIMS BY ANY PROVIDERS OF THE SERVICES FOR WHICH RESPONDENT IS RECEIVING THIS CREDIT, AS PROVIDED IN SECTION 8(j) OF THE ACT.

STATE OF ILLINOIS)
) SS.
COUNTY OF CHAMPAIGN)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jesus Anaya,

Petitioner,

20IWCC0416

vs. NO: 18 WC 3729

R G Construction Services, Inc.,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 15, 2019, is hereby affirmed and adopted.

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

20IWCC0416

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUL 21 2020
o7/9/20
MP/rm
046

Marc Parker

Barbara N. Flores

Deborah L. Simpson

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

ANAYA, JESUS J
Employee/Petitioner

Case# **18WC003729**

20IWCC0416

R G CONSTRUCTION SERVICES INC
Employer/Respondent

On 11/15/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.55% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1724 HASSAKIS & HASSAKIS PC
JAMES M RUPPERT
206 S 9TH ST SUITE 201 POB 706
MT VERNON, IL 62864

0481 MACIOROWSKI SACKMANN & ULRICH
ROBERT T NEWMAN
105 W ADAMS ST SUITE 2200
CHICAGO, IL 60603

20 IWCC0416

STATE OF ILLINOIS)
)SS.
COUNTY OF Champaign)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Jesus J. Anaya
Employee/Petitioner

v.

R. G. Construction Services, Inc
Employer/Respondent

Case # **18** WC **3729**

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 **Urbana**, on **December 13, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

20IWCC0416

FINDINGS

On the date of accident, **October 27, 2017**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**7,017.85**; the average weekly wage was $**1,403.57**.

On the date of accident, Petitioner was **55** years of age, ***married*** with **0** dependent children.

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

Respondent shall be given a credit of $**27,001.90** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**27,001.90**.

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 $57,290.26, as set forth in Petitioner's exhibit 11, as provided in Sections 8(a) and 8.2 of the Act.

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

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

Respondent shall pay Petitioner temporary total disability benefits of $935.17/week for 58 5/7 weeks, commencing 10/28/17 through 12/13/18, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $27,001.90 for temporary total disability benefits that have been paid.

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

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

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

Signature of Arbitrator

11/12/19
Date

ICArbDec19(b)

FINDINGS OF FACT

The parties stipulated that Petitioner was working for Respondent on October 27, 2017. The parties stipulated that Petitioner sustained an accidental injury on October 27, 2017 that arose out of and in the course of his employment for Respondent. The parties stipulated that Petitioner provided proper notice to Respondent of his work injury. Petitioner testified that his job title on October 27, 2017 was a carpenter (Tr. 13). Petitioner's job duty on October 27, 2017 was to install drywall (Tr. 13). The Petitioner was hired by Respondent approximately six (6) weeks prior to October 27, 2017 and worked 40 hours a week for Respondent during that time. (Tr. 13-14).

The Arbitrator notes for the record that Petitioner testified in this matter through an interpreter.

The Petitioner testified that on October 27, 2017 he stepped on a pipe and twisted his lower back and hurt his knee. (Tr. 14). The Petitioner testified that his supervisor on October 27, 2017 was "Don T." and that he immediately reported his injury to his supervisor (Tr. 15). Petitioner testified that his supervisor took him to a clinic, and he reported left knee complaints to the providers at Carle clinic (Tr. 15-16 and PX3). The Petitioner testified that he drove 2-1/2 hours home after being seen at the Carle clinic and that at that time he had "lots of pain" in his back (Tr. 16). The Petitioner testified that he asked his wife to come out of the house to help him get out of his car when he got home (Tr. 16). The Petitioner testified that October 27, 2017 was a Friday and that he tried to return to work on Monday, October 30, 2017 (Tr. 16-17). The Petitioner testified that when he showed up for work in Urbana on October 30, 2017 his supervisor noticed that he was not doing well and sent Petitioner home (Tr. 17). The Petitioner testified he returned to the doctor on October 30, 2017 after being sent home (Tr. 17). The Petitioner briefly testified as to his medical care (See Tr. 17-18).

From the medical records admitted into evidence, Petitioner presented to Carle Convenient Care on October 27, 2017 complaining of "pain to the medial aspect of his left knee after an injury at work today" when he stepped on a pipe (PX 3, p. 4). Ms. Jennifer J. Sapp, NP found tenderness to palpation over the medial joint line (PX 3, p. 5). Left knee x-rays showed mild enthesopathic spurring of the quadriceps and patellar insertions, medial joint line hypertrophy and mild medial compartment narrowing (PX 3, p. 7). Ms. Sapp diagnosed a left knee injury and noted that Petitioner will follow-up with a doctor near his home in Chicago (PX 3, p. 6). Ms. Sapp opined Petitioner could return to work on October 30, 2017 with restrictions of no climbing ladders or stairs, no kneeling or squatting and to mostly sit with standing only as needed (PX 3, p. 6).

On October 30, 2017 the Petitioner presented to Elmhurst Occupation Health (PX 4, p. 2). Dr. Phillip McAndrew noted left knee pain and right lower back pain (PX 4, p. 2). Dr. McAndrew recorded that Petitioner noticed "increase pain to right lower back after he left the ER on 10/27" and that Petitioner did "not report back pain while in the ER because his knee hurt the most" (PX 4, p. 2). Dr. McAndrew noted a mechanism of injury of "trip and fall over electric pipe" (PX 4, p. 2). The Petitioner rated his right back pain as 9/10 and left knee pain as 6/10 (PX 4, p. 2). Dr. McAndrew noted that Petitioner had no prior back injury or lower extremity symptoms (PX 4, p. 2). Dr. McAndrew noted a stent in Petitioner's gait secondary to his knee and back pain (PX 4, p. 3). Dr. McAndrew diagnosed a lumbar strain and left knee contusion and took Petitioner off of work (PX 4, p. 3). Dr. McAndrew prescribed Tylenol and physical therapy (PX 4, p. 3). Dr. Eric Pomazal, PA of Dupage Medical Group, Orthopaedics also examined Petitioner's left knee on October 30, 2017 (PX 5, p. 2).

Mr. Pomozal opined Petitioner was fine to return to work when released for his back injury and instructed Petitioner to return to his office for his left knee on an as needed basis (PX 4, p. 2).

The Petitioner returned to Elmhurst Occupational Health on November 3, 2017 (PX 4, p. 5). Dr. William Galassi noted that Petitioner's left knee pain had resolved but that his right lower back pain persisted (PX 4, p. 5). Dr. Galassi kept Petitioner off work and continued prescribing Tylenol and physical therapy (PX 4, p. 6). Dr. McAndrew reexamined the Petitioner on November 9, 2017 (PX 4, p. 11). Dr. McAndrew noted that Petitioner remained symptomatic in his right lower back and rated his pain as a 7 out of 10 (PX 4, p. 11). The Petitioner denied having any lower extremity symptoms of numbness, tingling or weakness (PX 4, p. 11). Dr. McAndrew noted pain with palpation across the right lower back and an antalgic gait (PX 4, p. 11). Dr. McAndrew maintained his diagnoses and prescriptions (PX 4, p. 11-12). Dr. McAndrew also allowed Petitioner to return to work on light duty (PX 4, p. 12).

Petitioner's medical records reflect that he completed five (5) physical therapy sessions from November 2 through November 15, 2017 (PX 4, p. 14-24). His therapist noted during his initial evaluation that Petitioner had difficulty rising from a chair and shifts his weight off of his right lower extremity (PX 4, p. 17). Petitioner's therapy reevaluation record indicates his back pain was not improved and therapy was discontinued for this reason (PX 4, p. 23). Dr. McAndew last examined Petitioner on November 16, 2017 (PX 4, p. 25). Dr. McAndrew noted that Petitioner's symptoms and examination concerning his right lower back were unchanged despite therapy, medication and rest (PX 4, p. 25). Dr. McAndrew also noted that Petitioner remained off of work because Respondent could not accommodate his light duty restrictions (PX 4, p. 25). Dr. McAndrew recommended a lumbar spine x-ray which showed chronic appearing compression deformities and spondylosis (PX 4, p. 25-26). Dr. McAndrew referred Petitioner to a physiatrist due to his ongoing symptoms (PX 4, p. 26).

On November 17, 2017 the Petitioner was evaluated by Dr. Lawrence Frank at Spine & Sports Physiatrists (PX 6, p. 8). Dr. Frank noted a consistent history of present illness and that Petitioner had some similar problems in 2011 but that he has not had any significant back pain since 2011 (PX 6, p. 8). Dr. Frank noted his back pain was constant with intermittent exacerbations (PX 6, p. 8). Dr. Frank's physical examination showed reproduction of back pain with right-sided bending, limited range of motion of back extension and tenderness to palpation over the right lumbosacral junction and mid parapsinals (PX 6, p. 9). Dr. Frank diagnosed a lower back strain and recommended lumbar facet injections on the right at L4-5 and L5-S1 (PX 6, p. 10). Dr. Frank prescribed Tramadol, Flexeril and six (6) additional physical therapy sessions and ordered Petitioner off of work (PX 6, p. 10-11).

The Arbitrator notes Petitioner's physical therapist began to document back pain that radiated into Petitioner's right leg beginning November 29, 2017 (PX 4, p. 59). Dr. Frank performed the facet injections on November 30, 2017 (PX 6, p. 13). There are also December 13, 2017 therapy notes stating "insidious onset of R thigh numbness that comes and goes" (PX 4, p. 88). The Petitioner followed up with Dr. Frank on December 15, 2017 (PX 6, p. 16). Dr. Frank noted Petitioner's symptoms were unchanged (PX 6, p. 16). At that time, Dr. Frank's examination showed reduced right great toe extension strength, reduced sensation in the right S1 and L5 nerve distributions, a positive straight leg raise on the right, reproduction of back pain with right-sided bending, limited range of motion of back extension and tenderness to palpation over the right lumbosacral junction and mid parapsinals (PX 6, p. 17). Based on his physical examination findings, Dr. Frank recommended a MRI of Petitioner's lumbar spine (PX 6, p. 18).

The January 3, 2018 MRI of Petitioner's lumbar spine showed epidural lipomatosis with ligamentum flavum redundancy, mild spinal canal stenosis and anterior osteophyte formation at L3-4; epidural lipomatosis with ligamentum flavum redundancy at L4-5 and a disc bulge with superimposed central disc protrusion, mild bilateral facet arthropathy and mild bilateral lateral recess and neural foraminal stenosis worse on the left at L5-S1 (PX 6, p. 22-23). Dr. Frank's January 8, 2018 notes indicate that he reviewed the MRI and opined there was no nerve root impingement (PX 6, p. 25-26). Dr. Frank thus recommended work conditioning and kept Petitioner off of work (PX 6, p. 26). From November 29, 2017 through January 8, 2018, the Petitioner completed twelve (12) additional physical therapy sessions (PX 4, p. 59-142). His therapist noted on January 8, 2018 that he had heightened back pain due to "overdoing" his home exercise program (PX 4, p. 136-142). His therapy records also include notations of intermittent right leg symptoms including pain and numbness (PX 4, p. 59-142).

The Petitioner returned to Dr. Frank for care on January 29, 2018 and February 14, 2018 (PX 6, p. 29-37). Dr. Frank's notes from these appointments reflect that the Petitioner was experiencing worsening pain due to work conditioning (PX 6, p. 31). Dr. Frank performed a right lumbar paraspinal trigger point injection on January 29, 2019 and ordered that Petitioner remain off of work (PX 6, p. 31). On February 14, 2018 Dr. Frank performed a second trigger point injection into Petitioner's lumbar spine and recommended a functional capacity evaluation (PX 6, p. 36). Dr. Frank also noted that Petitioner's work conditioning care had stopped (PX 6, p. 36).

Medical records from NovaCare Rehabilitation show that Petitioner attended ten (10) work conditioning sessions from January 22, 2018 through February 5, 2018 (PX 7). Petitioner's January 31, 2018 treatment note reflects that he completed 95 minutes of conditioning but left early (PX 7, p. 19). Petitioner's February 1, 2018 treatment note reflects that he completed 140 minutes of conditioning but left early (PX 7, p. 26). Petitioner's February 2, 2018 treatment note indicates that Petitioner was "demonstrating a number of game playing behaviors during work hardening. 1st client continues to leave early by not checking out. 2nd self limiting behavior noted with lifting. 3rd movements improve with distraction seated straight leg raise is negative, but supine SLR is strongly positive. FABQ and ODI indicate high level of perceived disability." (PX 7, p. 21). Petitioner showed no improvement in his symptoms from work conditioning (PX 7).

The Petitioner sought care from Dr. Kevin M. Koutsky at Elmhurst Orthopaedics on February 22, 2018 (PX 8, p. 14). Dr. Koutsky noted complaints of lower back pain radiating down into his right lower extremity with some numbness, tingling and occasional weakness (PX 8, p. 14). Dr. Koutsky reviewed Petitioner's care to date and performed a physical examination, finding deceased pinprick sensation along the lateral border and plantar aspect of his right foot when compared to the left foot, a positive right-sided straight leg raise test, paralumbar muscle tenderness and spasm to palpation with limited range of motion (PX 8, p. 15). Dr. Koutsky reviewed the MRI and opined that it showed some central disc herniation at L5-S1 causing central and foraminal stenosis (PX 8, p. 15). Dr. Koutsky diagnosed a right L5-S1 disc herniation and radiculopathy (PX 8, p. 15). Dr. Koutsky also opined that Petitioner's symptoms were consistent with axial back pain (PX 8, p. 15). Dr. Koutsky recommended conservative care consisting of physical therapy and a Pulsed Electro Magnetic Field device to help with pain and inflammation (PX 8, p. 15). Dr. Koutsky further recommended an EMG and kept Petitioner off of work (PX 8, p. 15). Dr. Koutsky ordered a drug screen before prescribing medication and noted a positive screen for THC and benzoylecgonine (PX 8, p. 22). Based on the drug screen, Dr. Koutsky would not prescribe any narcotic medication to Petitioner (PX 8, p. 22).

Respondent sent Petitioner for a Section 12 exam with Dr. T.S. Wright on February 28, 2018 (PX 6, p. 38). Dr. Wright authored an IME report dated February 28, 2018 (RX 3, p. 42 and Tr. 20). The Arbitrator notes that Petitioner attempted to introduce Dr. Wright's report into evidence and Respondent objected on the basis of hearsay (Tr. 7).

The Petitioner followed up with Dr. Koutsky on March 29, 2018 (PX 8, p. 30). Dr. Koutsky noted that Petitioner's care was not being authorized (PX 8, p. 30). Dr. Koutsky noted that Petitioner had a significant disk herniation with nerve root impingement (PX 8, p. 30). Dr. Koutsky's examination was unchanged (PX 8, p. 30). Dr. Koutsky commented that he would continue to request authorization for conservative care measures and kept Petitioner off of work (PX 8, p. 30). Dr. Koutsky's April 26, 2018 note reflects that Petitioner's therapy care but not his epidural injection was authorized and that Petitioner was completing therapy (PX 8, p. 35). Dr. Koutsky again recommended an EMG and epidural steroid injection while keeping Petitioner off of work (PX 8, p. 35). The records reflect that Petitioner completed fifteen (15) physical therapy sessions at Improved Functions Therapeutic Services, Inc. from April 10, 2018 through May 14, 2018 (PX 10).

Dr. Koutsky reexamined the Petitioner on July 16, 2018 and noted that Petitioner's back pain was worse than his leg pain (PX 8, p. 41). Dr. Koutsky commented that Petitioner had failed all conservative care and opined that Petitioner was a candidate for a decompression and stabilization with instrumentation procedure (PX 8, p. 41). Dr. Koutsky referred the Petitioner to a neurosurgeon, Dr. Geoffrey Dixon, for a neurosurgical opinion about whether Petitioner was a candidate for such procedure (PX 8, p. 41). Per Dr. Koutsky's July 25, 2018 notes, Dr. Dixon agreed that Petitioner was a reasonable candidate for a L5-S1 posterior lumbar interbody fusion surgery (PX 8, p. 43). Prior to trial, Dr. Koutsky last examined Petitioner on September 5, 2018 (PX 8, p. 56). Dr. Koutsky continued to recommended fusion surgery at L5-S1 given the Petitioner's lack of improvement from conservative care and opined Petitioner met the criteria for fusion surgery per the ODG guidelines (PX 8, p. 56). Dr. Koutsky kept the Petitioner off work as well (PX 8, p. 56).

The Respondent also sent Petitioner for a Section 12 medical evaluation by Dr. Morris Marc Soriano on May 9, 2018, and Dr. Soriano authored an IME report dated May 14, 2018 (RX 3).

The Respondent also admitted a number of utilization review reports into evidence (RX 6). The reports indicate that the fusion surgery at L5-S1 was not-certified and numerous medications and treatment modalities ordered by Dr. Koutsky were not-certified (RX 6). The only modalities ordered Dr. Koutsky that were certified by utilization review were the EMG and certain prescriptions for Gabapentin, Meloxicam and Ibuprofen (RX 6).

On November 26, 2018 Dr. Soriano testified via evidence deposition (RX 3). Dr. Soriano testified he is a board certified neurosurgeon (RX 3, p. 5). Dr. Soriano has experience performing lower back surgeries including lumbar fusion operations (RX 3, p. 6). Dr. Soriano testified that Petitioner told him he injured himself after stepping on a pipe, losing his balance and causing him to teeter (RX 3, p. 9). Dr. Soriano recounted Petitioner's medical care and testified that Petitioner felt he could return to work in a light duty capacity but not full duty because of his low back and right leg pain (RX 3, p. 9-11). Dr. Soriano testified that Petitioner advised him he first noticed his leg pain in April of 2018 (RX 3, p. 12). Dr. Soriano reviewed Petitioner's lumbar spine imaging, including the November 16, 2017 lumbar spine x-rays and the January 3, 2018 lumbar spine MRI (RX 3, p.12-13). Dr. Soriano testified that the x-rays and MRI were consistent with normal aging (RX 3, p. 13). Dr.

Soriano specifically opined that the lumbar MRI showed dehydration of the disc at L5-S1 with mild bulging at that level centrally and to the left as well as mild fact and ligamentum hypertrophy at L4-5 with mild central narrowing (RX 3, p. 13). Dr. Soriano opined there was no nerve root compression on the right side or traumatic findings based on the MRI (RX 3, p. 13). By way of clinical examination, Dr. Soriano found right lower back pain with pushing on Petitioner's back, a positive straight leg on the right while laying down, a negative straight leg raise on the right when sitting, right low back pain with lightly pushing down on Petitioner's head, decreased pin-prick sensation through his entire right chest, abdomen, thigh, calf and foot and pain with simulated truncal rotation. (RX 3, p. 14-15).

Dr. Soriano attributed Petitioner's reflex abnormality to his diabetes (RX 3, p. 15). Dr. Soriano felt atrophy in Petitioner's calf was within the normal range (RX 3, p. 15-16). Dr. Soriano felt Petitioner's normal gait and ability to stand on his heels and toes indicated Petitioner did not have radiculopathy (RX 3, p. 16). Dr. Soriano opined that Petitioner's straight leg raise findings was a Waddell's sign, meaning Petitioner is faking his illness (RX 3, p. 16). Dr. Soriano explained that a straight leg raise test is identical whether performed seated or in a supine position. (RX 3, p. 16). Dr. Soriano testified that Petitioner's lumbar spine condition could not explain Petitioner's sensory findings (RX 3, p. 17). Dr. Soriano also opined that pushing on one's head would not cause lower back pain, and therefore, Petitioner's response that he felt pain in his low back when Dr. Soriano pushed down on his head was indicative that the Petitioner was trying to "manufacture an illness" (RX 3, p. 17). Dr. Soriano also opined that Petitioner's response to truncal rotation was an "exaggeration of the normal human anatomy and physiology and consistent with a positive Waddell's sign (RX 3, p. 18). Dr. Soriano opined that Petitioner should not have been able to remove his socks and shoes if he was in as much pain as he related (RX 3, p. 18-19). Dr. Soriano noted Petitioner's positive drug screens for marijuana and cocaine and opined that he did not draw any specific conclusions with regards to this drug use (RX 3, p. 21-22). Dr. Soriano later testified that he felt Petitioner's drug use was "consistent with his Waddell's signs and that his ongoing subjective complaints don't have any foundation in real medical science or evidence-based medicine" (RX 3, p. 22).

Dr. Soriano testified that Petitioner's condition was "exaggerated symptoms after possibly a right lumbar strain and left knee strain" and that if Petitioner's ongoing complaints were valid that they were consistent with pre-existing mild degenerative changes at L3-4 and L4-5. (RX 3, p. 23). Dr. Soriano opined Petitioner's diagnosis was "consistent with symptom exaggeration, functional illness and malingering" (RX 3, p. 23). Dr. Soriano felt Petitioner's care was reasonable up to six weeks after the injury and that he could return to work within six weeks (RX 3, p. 24). Dr. Soriano also opined that there was no aggravation of a pre-existing condition caused by the October 27, 2017 incident (RX 3, p. 25). Dr. Soriano testified that sciatica and radiculopathy are different and that the only evidence of possible radiculopathy was the absent ankle jerk on the left (RX 3, p. 27). Dr. Soriano did not believe Petitioner required surgery or a functional capacity evaluation. (RX 3, p. 28-29). Dr. Soriano testified that Petitioner admitted to him he had back pain prior to his work injury (RX 3, p.32). Dr. Soriano opined Petitioner did not require an EMG or NCV (RX 3, p. 33). Dr. Soriano opined Petitioner reached MMI within six weeks of his injury (RX 3, p. 33-34).

On cross-examination, Dr. Soriano admitted that Petitioner had consistently complained of right-sided low back pain since his injury (RX 3, p. 37). Dr. Soriano admitted he was not aware of any prior injury that kept Petitioner from performing his job since 2005 (RX 3, p. 37-38). Dr. Soriano admitted he had not reviewed any medical records by Dr. Geoffrey Dixon, nor had he reviewed Dr. Koutsky's first treatment note of February 22,

2018, nor had he reviewed Dr. McAndrew's treatment note of October 30, 2017, nor had he reviewed Dr. Frank's treatment note of January 29, 2018 (RX 3, p. 38). Dr. Soriano also had not reviewed any medical records after April 28, 2018 (RX 3, p. 39). Dr. Soriano stated that he thought the current surgery being recommended was a two-level fusion and discectomy (RX 3, p. 39). Dr. Soriano testified that if he is missing important medical records he will request them and that he had not requested any medical records in this case (RX 3, p. 39-40). Dr. Soriano testified that he did not review any medical records prior to October 27, 2017 (RX 3, p. 37). Dr. Soriano admitted that twisting of the low back is known to cause low back injuries (RX 3, p. 41-42). Dr. Soriano testified that he reviewed the IME authored by Dr. Wright (RX 3, p. 42). Dr. Soriano admitted that Dr. Wright opined Petitioner's low back symptoms were causally related to his work injury but disagreed with Dr. Wright (RX 3, p. 42-43). Dr. Soriano also admitted that Dr. Wright thought all care was reasonable and necessary at the time of his examination and that Dr. Wright recommended the EMG and FCE (RX 3, p.43-44). Dr. Soriano testified that Dr. Wright did not document any Waddell's findings or signs and symptoms of malingering in his IME report (RX 3, p. 45-46). Dr. Soriano also admitted that Dr. Wright opined Petitioner should remain off of work until an FCE was performed and that Petitioner should continue to take his prescriptions (RX 3, p. 46-47).

On cross-examination, Dr. Soriano also admitted that he does not practice medicine anymore and is retired (RX 3, p. 47). Dr. Soriano can't admit patients or operate on them (RX 3, p. 47). Dr. Soriano admitted that he failed the neurology portion the first time he took his boards but passed the neurology portion a year later. Dr. Soriano admitted that he is not working as a neurosurgeon anymore and the only work he currently performs is serving as a "medicolegal expert" (RX 3, p. 49). Dr. Soriano admitted that if someone twisted and was nearly thrown to the ground it could cause an aggravation of a pre-existing lumbar spine condition (RX 3, p. 50). Dr. Soriano admitted that having all the medical records allows him to make the most informed opinion (RX 3, p.56).

On December 10, 2018 Dr. Koutsky testified via evidence deposition (PX 1). Dr. Koutsky is a board certified orthopedic spine surgeon that has been exclusively devoted to spine surgery since 2001 (PX 1, p. 5-7). Dr. Koutsky testified that he reviewed the Form 45 concerning Petitioner's injury as well as Petitioner's medical records from Carle Convenient Care, Elmhurst Occupational Health, Dupage County Medical Group and Dr. Lawrence Frank (PX 1, p. 9-11). Dr. Koutsky testified that he obtained a history from the Petitioner on January 22, 2018 and performed a physical examination (PX 1, p. 13). Dr. Koutsky also reviewed the Petitioner's lumbar spine MRI and opined it showed some desiccation at L5-S1 and a mild to moderate central disc herniation at L5-S1 that was causing some central and foraminal stenosis (PX 1, p. 14). Dr. Koutsky also believed the MRI showed some age related changes at the levels above L5-S1 (PX 1, p. 14). Dr. Koutsky opined that the Petitioner's objective findings during his physical examination were consistent with his findings on the MRI (PX 1, p. 14-15). Dr. Koutsky testified that his working diagnosis on February 22, 2018 was L5-S1 disc herniation and radiculopathy and that the Petitioner wanted to exhaust all conservative care before considering any surgery (PX 1, p. 15-16). Dr. Koutsky testified that he was aware the Petitioner had treated for some prior back issue in 2012 but had not reviewed any records indicating the Petitioner treated his back after 2012 (PX 1, p. 15-16).

Dr. Koutsky was questioned about Dr. Frank's physical examination findings on December 15, 2017, including decreased right greater toe extension strength, decreased sensation in right S1 distribution and right L5 distribution, a positive right straight leg raise on the right, reproduction of pain with extension and right-side

bending range of motion testing and tender to palpation over the right lumbosacral junction in the paraspinals (PX 1, p. 16-21). Dr. Koutsky testified that all of these physical exam findings are consistent with his diagnosis of L5-S1 disc herniation with radiculopathy (PX 1, p. 16-19). Dr. Koutsky testified the loss of extension strength is due to the L5 nerve root being responsible for the extensor halluces longus tendon which is the tendon that extends the great toe, meaning the weakness finding is consistent with an L5 nerve root injury which occurs at the level of the foramen at L5-S1 (PX 1, p. 17-18). Dr. Koutsky testified that the decreased sensation findings noted by Dr. Frank were in two particular nerve root distributions, both of which travel through the L5-S1 level where Petitioner's disc herniation is present (PX 1, p. 19). Dr. Koutsky testified that the straight leg raise test tests if there is any nerve root irritation (PX 1, p. 19). Dr. Koutsky testified the delay between Petitioner's injury and the onset of his back pain could be because Petitioner's knee was more bothersome than his back or it can takes days or weeks for inflammation to mature to the point it causes symptoms, such as back pain, leg pain or numbness/tingling (PX 1, p. 21).

Dr. Koutsky testified that Petitioner underwent the physical therapy he recommended but did not undergo the lumbar epidural injection at L5-S1 that he ordered (PX 1, p. 23-24). Dr. Koutsky opined that by July 16, 2018 he determined the Petitioner symptoms were not getting better and that Petitioner had failed conservative care (PX 1, p. 25). Dr. Koutsky testified that Petitioner's back pain was worse than his leg pain, and therefore, he and Petitioner began discussing a laminectomy and fusion at L5-S1 (PX 1, p. 25-26). For this reason, Dr. Koutsky referred Petitioner to Dr. Geoffrey Dixon, a neurosurgeron, for another opinion concerning the surgery (PX 1, p. 27). Dr. Dixon concurred that the Petitioner was a reasonable candidate for the procedure at L5-S1 (PX 8, p. 43 and PX 1, p. 27-28). Dr. Koutsky testified that as of his last examination of Petitioner on September 5, 2018 the Petitioner's complaints, his physical examination and treatment recommendations were unchanged (PX 1, p. 31). Dr. Koutsky testified that it is hard to assess what amount of symptoms are from the disc or facet but that the fusion of L5-S1 would address both of these pain generators (PX 1, p. 32). Dr. Koutsky opined he could significantly improve the Petitioner's symptoms with the surgery he is recommending (PX 1, p. 32). Dr. Koutsky further opined that whether someone had nerve root impingement at a certain level is not the sole factor to make a fusion reasonable and necessary care (PX 1, p. 33).

Dr. Koutsky opined that the October 27, 2017 work incident caused Petitioner back and lower extremity symptoms (PX 1, p. 33). Dr. Koutsky opined that all of Petitioner's care was reasonable and necessary due to the October 27, 2017 incident (PX 1, p. 33). Dr. Koutsky opined that all of Petitioner's care was causally related to the October 27, 2017 work injury (PX 1, p. 34). Dr. Koutsky opined that the fusion surgery was reasonable and necessary to treat the Petitioner's October 27, 2017 work injury (PX 1, p. 34). Dr. Koutsky also testified that the fusion surgery is casually related to the October 27, 2017 work injury (PX 1, p. 34-35). Dr. Koutsky opined that a twisting incident is one of the three most common mechanisms of injury for low back injuries and that twisting mechanism can cause a herniation (PX 1, p. 36). Dr. Koutsky opined that the Petitioner did not exhibit any somatization, malingering, Waddell's signs or symptom magnification during his examinations (PX 1, p. 37-38).

On cross-examaintion, Dr. Koutsky was handed a copy of the February 2, 2018 Novacare Rehabilitation physical therapy record (PX 1, p.41). Dr. Koutsky stated he had not considered this record, but that it did not change his opinion either (PX 1, p. 42). Dr. Koutsky testified that he did not disagree with the radiologist's interpretation of the MRI at the L5-S1 level (PX 1, p. 51). Dr. Koutsky opined that the MRI showed evidence of nerve root impingement in the form of stenosis (PX 1, p.52-53). Dr. Koutsky testified that he would have to

review the MRI images again to determine whether instability was present at the L5-S1 level (PX 1, p. 53). Dr. Koutsky testified that Petitioner was a smoker and that smoking causes a higher incidence of failure with lumbar fusion (PX 1, p. 54). Dr. Koutsky acknowledges that Dr. Frank's physical examination in February, 2018 showed Petitioner's extension strength and his neurologic findings were improved (PX 1, p. 56-58). Dr. Koutsky opined Petitioner was more subject to infection and more at risk for fusion failure because of his diabetic condition (PX 1, p. 59-60).

At the time of hearing, the Petitioner testified that his back still feels "very bad" and that he has "a lot of pain" (Tr. 18). The Petitioner testified that he never had pain into his right leg prior to October 27, 2017 (Tr. 18). The Petitioner testified that he has been off of work since his injury on October 27, 2017 and that he provided all of his off work notes to his employer (Tr. 19). The Petitioner testified that he had back pain before his October 27, 2017 work injury but last sought care for his back in 2012 (Tr. 19-20). The Petitioner testified that he did not have any back pain between 2012 and October 27, 2017 (Tr. 20). The Petitioner testified that he was examined by Dr. T.S. Wright on February 28, 2018 and had seen a report authored by Dr. Wright concerning his February 28, 2018 examination (Tr. 20). The Petitioner admitted that he used marijuana and cocaine in 2018 (Tr. 21). The Petitioner testified he used the drugs because he was in pain (Tr. 22). The Petitioner admitted that he smoked cigarettes but testified he would quit smoking to have the surgery (Tr. 22). The Petitioner testified that he wants to have his surgery as soon as possible because he wants to be able to work and he does not like being at home (Tr. 22).

On cross-examination, Petitioner testified that he had work construction for cash in 2018 in Chicago (Tr. 23-24). On further cross-examination, the Petitioner testified that he had not worked on any cars or trucks for cash in 2018 because he can't work (Tr. 25). The Petitioner testified that he had an x-ray of his back in 2011 because he had back pain then (Tr. 26). The Petitioner also testified that he was taking the medication that were prescribed by his doctors in 2018 (Tr. 32).

On re-direct examination, the Petitioner testified that he has worked construction since he was 10 years old (Tr. 33). The Petitioner testified that he had not worked construction in 2018 (Tr. 33). The Petitioner testified he has always worked in construction but not after he slipped in 2017 (Tr. 33-34). The Petitioner testified that prior to working for Respondent he was self-employed remodeling house and offices for four or five years and that he worked for cash while he was self-employed (Tr. 34).

CONCLUSIONS

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

As to the issue of causation, the evidence shows there is no true dispute whether Petitioner was injured on October 27, 2017 but only a dispute exists as to the nature of Petitioner's injury. Dr. Koutsky believed there was a L5-S1 herniation with right-sided radiculopathy while Dr. Soriano believed Petitioner only strained his back due to the work accident. There is no evidence in the record that Petitioner had right leg symptoms prior to October 27, 2017 and no evidence Petitioner had any back pain since 2012. The Arbitrator notes the Petitioner consistently worked 40 hours a week before the October 27, 2017 injury, suggesting he was without limiting back pain before October 27, 2017. The medical records show consistent complaints of right lower back pain with radiation into Petitioner's right lower extremity following slipping on a pipe at work. The symptoms in Petitioner's right leg were documented as early as November 29, 2017, or just one month after his injury. Dr.

Koutsky provided a reasonable explanation why there may be a delayed onset of symptoms as inflammation builds over a course of weeks. The Form 45 incident report is consistent with Petitioner's medical records and testimony. Further supporting causation here is Dr. Koutsky's testimony that twisting is one of the most common mechanisms of injury for a low back injury and Dr. Soriano acknowledge that sudden twisting can cause low back injuries. The record taken as a whole supports that Petitioner's current complaints of back and right leg symptoms are related to his work accident, and there has been no intervening incident or alternative cause to explain Petitioner's current symptoms. The Arbitrator also notes the objective signs of a L5-S1 disc herniation were documented by Dr. McAndrew, Dr. Frank and Dr. Koutsky during their examination and appeared on the January, 2018 lumbar spine MRI. The Arbitrator therefore concludes that the record taken as a whole supports Dr. Koutsky's diagnosis and opinion that Petitioner has a disc herniation at L5-S1 due to the October 27, 2017 work accident and which now causes Petitioner's back and leg symptoms.

The Arbitrator finds Dr. Koutsky's opinions to be more persuasive than those of Dr. Soriano for a number of reasons. First, Dr. Soriano did not review a number of medical records, including salient records such as the first treatment notes by Dr. McAndrew and Dr. Koutsky. Dr. Soriano readily admitted that he wanted to review all of Petitioner's medical records to make the most informed opinions. In other words, Dr. Soriano did not have the most informed opinions. Second, Respondent's stipulation that Petitioner was temporarily and totally disabled through May 17, 2018 contradicts Dr. Soriano's opinions regarding the nature of Petitioner's injury, the amount of time he should be off of work and when Petitioner reached maximum medical improvement. The Arbitrator finds it difficult to find Dr. Soriano more persuasive when Respondent has disregarded Dr. Soriano's opinions. Third, it is clear from Dr. Soriano's testimony that Respondent sent Petitioner to Dr. T.S. Wright for a Section 12 exam on February 28 2018, and Dr. Wright had opinions that were favorable to Petitioner regarding causation, the reasonableness and necessity of medical care and the Petitioner's need for future medical care. In accordance with Wasfi Alsaraj v. Taxi Affiliation Services, Inc., 14 I.W.C.C. 0217 (March 27, 2014), the Arbitrator draws an inference that Dr. Wright's IME report was favorable to Petitioner because the Respondent had access to the report and chose not to present it at trial, specifically objecting to its admission when it was offered into evidence by Petitioner. Although his report was not admitted into evidence, the Arbitrator can determine from the record that Dr. Wright's opinions align with those of Dr. Koutsky's. Lastly, Dr. Soriano admitted that he was no longer practicing medical and his sole occupation was as a medical-legal expert. The Arbitrator generally finds a practicing physician to be more persuasive than a non-practicing physician in this case.

Based on the record taken in its entirely and the reasons set forth hereinbefore, the Arbitrator concludes the October 27, 2017 work accident caused Petitioner's current back and right lower extremity symptoms.

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

Issue (K): Is Petitioner entitled to any prospective medical care?

Based on the testimony of Dr. Koutsky, the opinions of Dr. Wright, this Arbitrator's conclusions regarding causation and in light of Petitioner's symptoms, the Arbitrator concludes that the medical care Petitioner received through the date of hearing was reasonable and necessary for his injuries. The Arbitrator acknowledges the utilization review reports submitted into evidence by Respondent, but the Arbitrator finds the

treating providers' and Dr. Wright's recommendation and opinions to be more persuasive due to those doctors' direct communication and examination of the Petitioner.

The Arbitrator also finds significant the rather lengthy attempts at modalities of conservative treatment which were unsuccessful.

Based on the medical bills admitted at trial (see Petitioner's Exhibit 11), Respondent shall pay reasonable and necessary medical services of $57,290.26, as provided in Section 8(a) and Section 8.2 of the Act. Respondent shall be given a credit for medical benefits it has paid.

The Arbitrator concludes that Respondent shall pay for ongoing care concerning Petitioner's lower back, including, but not limited to, the recommended fusion surgery at L5-S1. The Arbitrator also finds that Petitioner's illicit drug use had no bearing on the issues in dispute.

In light of Dr. Koutsky's opinions, the likelihood Petitioner's symptoms will improve following the recommended surgery and the fact that the recommended surgery may allow Petitioner to return to work, the Arbitrator finds that the recommended fusion surgery at L5-S1 is reasonable and necessary care for Petitioner's current symptoms and Respondent shall authorize and pay for same as provided in Section 8(a) and Section 8.2 of the Act.

Issue (L): What temporary benefits are in dispute?

The Petitioner's testimony and his medical records support that Petitioner is due temporary total disability benefits from October 28, 2017 through the date of hearing, December 13, 2018 because he was either ordered to remain off of work or on light duty that his employer could not accommodate. The Arbitrator acknowledges Petitioner's testimony that he had worked for cash as a handyman during 2018. However, the Petitioner testified on redirect-examination that he has not worked at all since his October 27, 2017 injury. While this testimony is undoubtedly contradictory, the Arbitrator believes Petitioner was confused by Respondent's questioning due to his language barrier and use of the interpreter. The Arbitrators finds Petitioner was referencing his self-employment before his employment by Respondent when he testified he was working for cash. The Arbitrator found Petitioner to be a forthright and credible witness.

In light of the Arbitrator's above conclusions, the Arbitrator finds that Respondent shall pay Petitioner temporary total disability benefits of $935.71 for 58-5/7ths weeks, commencing October 28, 2017 through December 13, 2018, as provided in Section 8(b) of the Act and shall continue to pay temporary total disability benefits thereafter until such benefits are no longer due. Respondent is entitled to a credit of $27,001.90 for temporary total disability benefits previously paid.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

LEONARD EVANS,

Petitioner,

vs. NO: 17 WC 024895

CITY OF CHICAGO,

Respondent.

20IWCC0413

DECISION AND OPINION ON REVIEW

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

Petitioner sustained a work accident on May 11, 2017 when a backhoe he was operating slid into another truck and collided. He immediately sought medical treatment for complaints of back and neck pain. He underwent a course of treatment with Dr. Kevin Jackson at MidAmerica Orthopedics who took Petitioner off work and referred him to physical therapy.

On October 24, 2017 Petitioner underwent a Section 12 examination at the request of Respondent with Dr. Sepehr Sani. Dr. Sani diagnosed a mild cervical and lumbar sprain and opined that would have resolved by August 11, 2017 and that Petitioner had achieved MMI. The Commission agrees with the Arbitrator's finding that the opinion expressed by Dr. Sani is more persuasive than that expressed by Dr. Booker and better aligns with Petitioner's medical records.

Permanent Disability

20IWCC0413

The Commission views the evidence of disability differently with respect to the Section 8.1b(b) factors (iii) and (v).

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

Petitioner was age 48 years at the time of the work-injury. Petitioner's young age means that he will have to live with the issues caused by his cervical and lumbar injury for the remainder of his natural and working life. The Commission finds that more weight should have been given to this factor. This factor weighs heavily in favored of increased permanent disability.

(v) evidence of disability corroborated by the medical record

Petitioner testified at hearing that he continues to have low back pain which runs to his hip, buttocks and occasionally his feet. An MRI performed of the lumbar spine performed on December 4, 2017 demonstrated lumbar spondylosis and multilevel lower lumbar degenerative disc disease most severe at L4-5 and L5-S1. Additionally, posterior disc bulges were identified at L3-4 and L5-S1, and a left lateral disc protrusion/herniation at L4-5.

While these findings reflect pre-existing degenerative disc disease, the medical records reflect that the work-injury caused an exacerbation of symptoms. Having weighed the evidence and analyzed the Section 8.1b(b) factors, the Commission finds that Petitioner sustained a loss of the use of 10% of the person as whole under Section 8(d)2.

All else is affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $1,304.88 per week for a period of May 12, 2017 through August 11, 2017 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act. Respondent shall receive a credit of $35,420.07 for benefits that have been paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $775.18 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 medical expenses for services rendered by Mid America Orthopedics, if previously unpaid and not written off, in accordance with the fee schedule from May 11, 2017 through August 11, 2017 under §8(a) of the Act.

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

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

20 IWCC0413

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

DATED: JUL 2 0 2020
SM/msb
o-6/17/2020
44

Stephen Mathis

Douglas McCarthy

L.Elizabeth.Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

EVANS, LEONARD
Employee/Petitioner

Case# **17WC024895**

14WC038036

CITY OF CHICAGO
Employer/Respondent

20IWCC0413

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

If the Commission reviews this award, interest of 2.45% 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:

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CHICAGO, IL 60602

20 IWCC0413

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
CORRECTED

Leonard Evans
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **17** WC **24895**

Consolidated cases: **14 WC 38036**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Thomas L. Ciecko**, Arbitrator of the Commission, in the city of **Chicago**, on **November 21, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **May 11, 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 $**101,780.38**; the average weekly wage was $**1957.32**.

On the date of accident, Petitioner was **48** years of age, ***single*** with **0** dependent children.

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

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

Respondent shall be given a credit of $**35,420.07** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**35,420.07**.

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

ORDER

Respondent shall pay, if previously unpaid and not written off, in accordance with the fee schedule, charges for medical services to Mid America Orthopedics from May 11, 2017 through August 11, 2017.

Respondent shall pay Petitioner temporary total disability benefits of $1304.88 per week from May 12, 2017 through August 11, 2017. Respondent shall be given a credit of $35,420.07 for benefits that have been paid.

Respondent shall pay Petitioner permanent partial disability benefits of 2.5% (12.5 weeks) at $775.18 a week for loss of a person as a whole.

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

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

Signature of Arbitrator

February 4, 2019
Date

FEB 4 - 2019

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

LEONARD EVANS,

Petitioner,

vs. NO: 14WC038036

CITY OF CHICAGO,

20IWCC0414

Respondent.

DECISION AND OPINION ON REVIEW

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

Permanent Disability

The Commission views the evidence of disability differently with respect to the Section 8.1b(b) factors (iii), and (v).

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

Petitioner was age 46 at the time he suffered his work-injury. Petitioner's young age means that he will have to live with the issues caused by his left knee injury for the remainder of his natural and working life. The Commission finds that more weight should have been given to this factor. This factor weighs heavily in favor of increased permanent disability.

(v) evidence of disability corroborated by the treating medical record

20IWCC0414

The Arbitrator inexplicably gave no weight to this factor. An MRI of the left knee revealed a partial extrusion of the medial meniscus with an underlying tear of the root and an ACL tear. Petitioner testified that he continues to suffer left knee pain and that the knee often pops. Petitioner takes over-the-counter pain relievers once or twice a week to manage his symptoms.

Having weighed the evidence and analyzed the Section 8.1b(b) factors, the Commission finds that Petitioner sustained a 6% loss of use of the left leg under Section 8(d)2.

All else is affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $735.37 per week for a period of 12.9 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the loss of the use of 6% of the left leg.

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

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

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

DATED: JUL 20 2020

Stephen Mathis

SM/msb
o-6/17/2020
44

Douglas McCarthy

L.Elizabeth.Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

EVANS, LEONARD
Employee/Petitioner

Case# **14WC038036**

17WC024895

CITY OF CHICAGO
Employer/Respondent

20IWCC0414

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

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

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

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CHICAGO, IL 60602

0010 CITY OF CHICAGO
DANIEL KALLIO
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

20 IWCC0414

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

Leonard Evans
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **14** WC **38036**

Consolidated cases: **17 WC 24895**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Thomas L. Ciecko**, Arbitrator of the Commission, in the city of **Chicago**, on **November 21, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **October 31, 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 **$96,497.75**; the average weekly wage was **$1855.73**.

On the date of accident, Petitioner was **46** years of age, ***single*** with **0** dependent children.

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

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

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

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of 1% (2.15 weeks) loss of left leg at $ 735.37 per week.

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

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

Thomas L Ciesla

Signature of Arbitrator

1-16-19

Date

JAN 16 2019

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

William Marsellos,

Petitioner,

20IWCC0417

vs. No. 16 WC 2044

State of Illinois, Dept. of Transportation,

Respondent.

DECISION AND OPINION ON REVIEW

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

Petitioner, a 50-year-old truck driver, injured his neck and right shoulder on January 3, 2015 when he slipped while grabbing the handle of his truck cab. The Arbitrator found Petitioner's current condition of ill-being was related to his accident, and awarded Petitioner 8-4/7 weeks of temporary total disability and his medical expenses consisting of an $8,166.59 lien from Hines Veteran's Administration. The Arbitrator also awarded Petitioner 5% body as a whole for his right shoulder injury and 2% body as a whole for his cervical injury, under §8(d)2 of the Act. The Arbitrator found that Petitioner's current condition of ill-being was causally related based upon Petitioner's testimony, medical records and Petitioner's accident histories, which the Arbitrator found were consistent with his testimony.

The Commission agrees with the Arbitrator that Petitioner did sustain injuries to his right shoulder and neck as a result of his accident, and that the permanent partial disability award of 7% body as a whole was appropriate. However, the Commission views the evidence differently

20IWCC0417

than the Arbitrator as to when Petitioner reached maximum medical improvement for his work related injuries.

During the eight months following Petitioner's accident, he treated primarily with Dr. Steven Anderson and Dr. William Heller. Both doctors released Petitioner to full, unrestricted duties on March 15, 2015. Petitioner received some treatment after that; his last visit with Dr. Anderson was on July 15, 2015. At that time, Petitioner still had some complaints of right shoulder pain and neck tenderness, but Dr. Anderson found he was able to work full duty without restrictions, and he scheduled Petitioner for a follow-up visit on September 9, 2015.

Petitioner missed his September 9, 2015 appointment. He called Dr. Anderson's office on September 14, 2015, but declined an offer for a referral to an orthopedic doctor and agreed to close the case. Petitioner was discharged from the clinic at that date. After that, Petitioner received no further treatment to his neck or shoulder for over 14 months.

On November 23, 2016, Petitioner went to the orthopedic clinic at Hines VA with complaints of right shoulder pain, which he attributed to his work injury. He was subsequently diagnosed with tendinosis of the biceps, infraspinatus, supraspinatus and subscapularis. On January 14, 2017, Petitioner received an injection to his right biceps tendon. On February 22, 1017, Dr. Tomas Kuprys of the VA Hospital noted Petitioner's report of marked improvement, and released Petitioner from care.

The Commission finds that Petitioner did not prove his condition of ill-being after September 14, 2015 was related to his January 3, 2015 injury. Not only was there a significant gap in Petitioner's treatment after September 14, 2015, but Petitioner presented no medical opinion that any treatment he received after that date was causally related to his work accident. Dr. Kuprys reported that Petitioner might experience recurrent right shoulder pain which may improve; however, neither he, nor any other physician, provided an opinion that Petitioner's treatment between November 2016 and February 2017 was causally related to his January 3, 2015 accident.

Accordingly, the Commission vacates the Arbitrator's award to Petitioner of the $8,166.59 lien from the VA, and finds that the treatment rendered after September 14, 2015, was not related to the work injuries sustained on January 3, 2015. The Commission finds that Respondent is not responsible for any medical bills incurred after September 14, 2015. The Commission affirms and adopts all other parts of the Arbitrator's decision.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 30, 2018, is hereby modified as stated herein and otherwise affirmed and adopted.

20IWCC0417

IT IS FURTHER ORDERED BY THE COMMISSION that the Arbitrator's award of $8,166.59 for medical bills paid by the Department of Veteran's Affairs is reversed. Respondent is not responsible for any medical bills incurred after September 14, 2015.

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

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

Pursuant to §19(f)(1) of the Act, claims against the State of Illinois are not subject to judicial review. Therefore, no appeal bond is set in this case.

JUL 23 2020

DATED:
o-06/18/2020
MP/mcp
68

Marc Parker

Deborah L. Simpson

Barbara N. Flores

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

20IWCC0417

MARSELLOS, WILLIAM Case# **16WC002044**

Employee/Petitioner

ST OF IL/DEPT OF TRANSPORTATION

Employer/Respondent

On 7/30/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.14% 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:

0320 LANNON LANNON & BARR LTD
MICHAEL S ROLENC
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CHICAGO, IL 60601

5204 ASSISTANT ATTORNEY GENERAL
KRISTIN KEASIA
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CHICAGO, IL 60601

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

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

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

JUL 30 2018

Brandon J. Rascia, Acting Secretary
Illinois Workers' Compensation Commission

20 IWCC0417

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

William Marsellos,
Employee/Petitioner

v.

State of Illinois/Dept. of Transportation,
Employer/Respondent

Case # 16 WC 2044

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Paul-EricSeal, Arbitrator of the Commission, in the city of Chicago, on 6/20/2018. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

20IWCC0417

FINDINGS

On January 3, 2015, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $59,159.36; the average weekly wage was $1,137.68.

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

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

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

Respondent shall be given a credit of $5417.86 for TTD, $0 for TPD, $0 for maintenance, and $0 for other benefits, for a total credit of $5417.86.

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

ORDER

The respondent shall pay the petitioner temporary total disability benefits of $758.46/week for 8/4/7 weeks, commencing January 5, 2015 through March 5, 2015, as provided in Section 8(b) of the Act.

The respondent shall be given a credit of $5,417.86 for temporary total disability benefits paid.

The respondent shall pay to the petitioner $8,166.59 for medical bills related to his injury which were paid by the Department of Veterans Affairs.

The respondent shall pay the petitioner permanent partial disability benefits of $682.61 per week for 10 weeks for his cervical injury, because the injuries sustained caused 2% loss of the person as a whole, as provided in Section 8(d) (2) of the Act.

The respondent shall pay the petitioner permanent partial disability benefits of $682.61 per week for 25 weeks for his shoulder injury because the injuries sustained caused 5% loss of the person as a whole, as provided in Section 8(d) (2) of the Act.

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

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

Signature of Arbitrator
Paul-Eric Seal

JUL 30 2018

July 30, 2018
Date

FINDINGS OF FACT

The parties stipulate that the petitioner and the respondent were operating under the Act, and that there was an employee and employer relationship. (AX1) The parties further stipulate that on January 3, 2015, the petitioner sustained accidental injuries arising out of and in the course of his employment with the respondent.

The petitioner testified that on January 3, 2015, he worked for the State of Illinois Department of Transportation as a minuteman since April 2013. His job duties included emergency traffic and accident response on the expressways.

On January 3, 2015, the petitioner reported to a vehicle accident scene at I-80 and I-94. There was sleet, water and antifreeze on the road. As the petitioner was getting back into his truck, he grabbed the handle on the door with his right hand. As he pulled himself up to the cab, his left foot slipped on the liquid and sleet and he started to fall. He hit his left hand on the step of the cab and his right hand was yanked down from the door handle. That movement in turn pulled the petitioner's right shoulder. The petitioner testified that he finished working that day. When he went home, his neck and right shoulder began to hurt.

The petitioner returned to work January 5, 2015, and he informed his supervisor who drove him to Mercy Hospital where he complained of numbness and tingling to his fingertips. (PX1) He reported moderate sharp pain in his right shoulder and upper back. Cervical radiculopathy and muscle spasm were diagnosed. He was prescribed Flexeril, Ibuprofen and Norco and was advised to follow-up with MercyWorks. (PX2)

On January 7, 2015, the petitioner saw Dr. Steven Anderson at MercyWorks. Examination revealed tenderness midline at C5-7 and on the right C7-T3. Active range of motion was limited with extension, right rotation, and right-side bending. Right shoulder examination revealed tenderness of the bicipital tendon. The petitioner was diagnosed with a right brachial strain and referred for a cervical MRI. He was authorized off work. (PX2)

On January 13, 2015, the petitioner underwent the cervical MRI at Chicago Ridge Radiology. There were diffuse degenerative changes, disc desiccation and multi-level osteophyte formation at C3-4. There was mild spinal canal stenosis and moderate right and mild left forminal stenosis due to a mild central disc bulge and osteophyte formation. There were similar findings at levels C4-5, C5-6 and C6-7; although, at C6-7, a left lateral disc protrusion was noted. (PX2)

The petitioner returned to MercyWorks January 14, 2015, still complaining of neck and right upper arm pain, and numbness and tingling into his right hand. Dr. Anderson referred him for physical therapy and recommended that he continue with his medications. He also started him on a Medrol dose pack. (PX2) On January 19, 2015, the petitioner began his physical therapy at Accelerated Rehabilitation Centers.

On January 28, 2015, he returned to MercyWorks, advising that he had some improvement with the physical therapy but still had numbness and tingling to his right hand and pain in front of his shoulder. The petitioner was diagnosed with right cervical brachial sprain and multi-level degenerative disc disease. (PX2)

In his February 3, 2015, physical therapy progress report, the petitioner was reporting constant right suprascapular pain running distally into the posterolateral right shoulder. He also complained of intermittent decreased tingling in his right upper extremity. He reported decreased pain and improved mobility with right cervical rotation and extension. (PX2)

The petitioner returned to MercyWorks February 4, 2015, advising that physical therapy was helping but that he still had right shoulder and neck pain along with tingling into his right ring and little fingers. Dr. Anderson advised that he continue with his physical therapy and consider an EMG.

On February 12, 2015, the petitioner returned to MercyWorks advising that his right shoulder had gotten worse – but that the tingling and pain were not as frequent or intense. Dr. Anderson recommended right shoulder MRI and continued to authorize him off work. (PX2) On February 25, 2015, the petitioner underwent right shoulder MRI at Chicago Ridge Radiology. It revealed arthropathy and an inferior bone spur at the AC joint – likely causing impingement and tendinopathy, as well as a partial thickness tear of the supraspinatus tendon. (PX2)

The petitioner returned to MercyWorks February 27, 2015, still complaining of neck pain on his right side and right shoulder pain. Dr. Anderson reviewed the MRI and diagnosed cervical degenerative disc disease and right shoulder tendinopathy with a partial rotator cuff tear. The petitioner then was referred to Dr. William Heller of Midland Orthopedics. (PX2)

On March 3, 2015, the petitioner saw Dr. Heller, who reviewed MRI studies. Dr. Heller opined that the petitioner suffered an injury to his right arm and diagnosed him with right shoulder subacromial impingement syndrome and rotator cuff tendinosis. He administered a cortisone injection and advised that the petitioner could return to regular work March 6, 2015. (PX2)

On March 5, 2015, the petitioner returned to MercyWorks still complaining of neck pain with numbness down his right arm. He was advised to continue with his Aleve and to return to work March 6, 2015. The petitioner returned to MercyWorks April 2, 2015, advising that he had been working without problems but that he still had soreness. He still complained of pain in his neck with occasional numbness in his fourth and fifth digits. Dr. Anderson refilled the petitioner's prescriptions for Ibuprofen and Norco. (PX2)

On May 14, 2015, the petitioner returned to MercyWorks advising that he still was experiencing neck pain and occasional numbness in his fourth and fifth digits. The neck was positive for tenderness on the right at T1-2. The petitioner did have full range of motion. His medication was refilled, and he was advised that he could continue working full duty. (PX2)

On June 17, 2015, he returned to MercyWorks and reported that he had tweaked his right shoulder on June 10, 2015, taking down a spare tire on a minivan – but that his neck was okay. He still was complaining of tingling into his right ring and little fingers, and he had positive tenderness at the AC joint and biceps. His Norco was refilled, and he again was advised that he could continue working full duty.

On June 25, 2015, the petitioner was seen by Dr. Mangistu at the VA. He testified that Dr. Mangistu is his primary care physician. He told Dr. Mangistu about his work accident in January. The petitioner testified that he treated at the VA for numerous medical conditions which are not related to this instant January 3, 2015, work accident. (PX3)

The petitioner's last visit to MercyWorks was on July 15, 2015. He advised Dr. Anderson that he was working twelve-hour shifts somedays and still had significant pain in his right shoulder. He still was taking Ibuprofen but was trying to wean off the Norco. There was positive tenderness on the right at T1-3 with palpitation, right rotation, and on right-side bend. With respect to the right shoulder, there was positive tenderness at the biceps tendon and rotator cuff with stress. There was a positive impingement test. Dr. Anderson continued the petitioner's diagnosis as a right cervical-brachial strain, cervical degenerative disc disease, and right shoulder tendinopathy with a partial rotator cuff tear. (PX2)

The petitioner testified that he returned to the VA on November 23, 2016, with a history that he initially sustained a work-related injury in January 2015 after falling. He related having physical therapy and a cortisone injection that was ineffective in controlling his right shoulder symptoms. He had repeated injury to the right shoulder since and complaints of intermittent right shoulder pain with worsening limitations and decreased mobility of the right shoulder. He still was complaining of occasional numbness and tingling on the right hand and fingers. He also noted a history of neck problems. Petitioner was diagnosed with right shoulder pain due to right shoulder arthropathy and he was advised to obtain a new right shoulder MRI. (PX3)

On December 17, 2016, the petitioner underwent right shoulder MRI at the VA. The MRI revealed severe infraspinatus tendinosis with mild intrasubstance tearing but no full thickness component. There was also supraspinatus and subscapularis tendinosis without a tear and mild subacromial-subdeltoid bursitis. (PX3)

The petitioner returned to the VA January 4, 2017, and he was seen by Dr. Bryan Smith in the orthopedic department. Dr. Smith reviewed MRIs with the petitioner and recommended a cortisone injection which he administered. He also discussed with the petitioner the possibility of surgery. Dr. Smith noted that the petitioner had made no improvement with the earlier injection that he received from Dr. Heller. (PX3)

The petitioner returned to the VA February 23, 2017, and he was seen by Dr. Tomas Kuprys. Dr. Kuprys noted marked improvement from the cortisone injection and opined that the petitioner was not in need of any surgery. Dr. Kuprys also opined that the petitioner had plateaued and was not in need of any follow-up medical treatment – but, he indicated that his right shoulder pain might recur. (PX3)

On April 16, 2018, Dr. Kathleen Weber examined the petitioner at the respondent's request pursuant to section 12 of the Act. Dr. Weber diagnosed the petitioner with bicipital tendinitis and tenderness over the bicipital groove. She noted no abnormal behaviors during the examination. Dr. Weber also noted pre-existing degenerative disc disease which did not appear to be aggravated; although, she opined that it might have been temporarily aggravated following the accident. She further opined that, based on the mechanism of injury, the petitioner likely irritated his rotator cuff and biceps. Dr. Weber stated that the petitioner's treatment to date was reasonable and necessary. She was unclear whether the biceps treatment in 2016 was due to the

petitioner being symptomatic or if the treatment was related to the 2015 injury, and she requested additional records to address causal connection. (RX1)

The petitioner testified that he last worked for the Respondent in approximately July 2016. He then began working for Dependable Billing Services. He worked in the warehouse earning $10.00 per hour plus an additional $4.00 per hour for fieldwork. He then left that job and began working at Brackenbox as a truck driver. He earned $20.00 an hour at that job but was laid off in February.

The petitioner testified that his right shoulder remains painful. He still experiences tingling in his shoulder and fingers. He testified that he sometimes has to move his arm away from his body when he feels the pain. He also testified that his right arm becomes irritated when he sleeps on it. Regarding his neck, the petitioner testified that he still has some occasional pain which he described as a type of twinge. He testified that he never injured his neck or right shoulder prior to January 3, 2015.

On cross-examination, the petitioner agreed that there were three or four VA visits between July 2015 and May 2016 that had nothing to do with his work-related injuries. He also concurred that there were some visits between November 2016 and February 2017 that were due to his work-related injury. The petitioner also testified that he used to work out before the accident but does not do so now as he does not want to push it. He testified that he favors his right side.

In support of the Arbitrator's decision as to whether or not the petitioner's current condition of ill-being is causally related to the injury (F), the Arbitrator finds as follows:

The petitioner's testimony that prior to January 3, 2015, he had never injured his neck or right shoulder or received medical treatment is unrebutted. His accident histories to all medical professionals in this instant case are consistent with his testimony.

The respondent's section 12 examiner, Dr. Weber, opined that, based on the mechanism of injury, the petitioner likely irritated his rotator cuff and possibly his biceps. She further opined that at a minimum he sustained a temporary aggravation of his cervical degenerative disc disease that resolved.

Therefore, based on all of the above testimony and medical evidence, the Arbitrator finds that petitioner met his burden of proving by the preponderance or greater weight of the evidence that his current condition of ill-being involving his neck and right shoulder is causally related to the accident.

In support of the Arbitrator's decision as to whether or not Respondent has paid all appropriate charges for all reasonable and necessary medical services (J), the Arbitrator finds as follows:

Petitioner's exhibit #4 from Hines VA concerns its lien in the amount of $8,166.59 for medical treatment starting November 2016. Four additional pages submitted with the letter also contain the treatment dates, physician name(s), procedure(s) performed, primary diagnosis, CPT codes and the charge(s) for each visit to substantiate the lien of $8,166.59. Additional charges on the itemization show as unrelated by the VA, and the petitioner also testified to this.

The medical records of the VA support this treatment that was rendered to the petitioner for his neck and right shoulder. No evidence was offered to rebut Petitioner's exhibit #4 or his testimony and the records of the VA. Even the respondent's section 12 examiner, Dr. Weber, could not opine regarding causal connection concerning these treatments and bills, suggesting review of additional records. No subsequent addendum from Dr. Weber is in evidence.

The Arbitrator, therefore, finds that the respondent is liable for the VA lien of $8,166.59, as it was incurred for services rendered for the petitioner's neck and right shoulder injuries.

In support of the Arbitrator's decision as to the Nature and Extent of the injury (L), the Arbitrator finds as follows:

As a result of his injury, the petitioner sustained a neck injury that was diagnosed as an aggravation of degenerative disc disease at multiple levels with a defined disc protrusion on the left at C6-7.

He also was diagnosed with right shoulder tendinopathy with a partial rotator cuff tear as well as bicipital tendinitis. The petitioner received two cortisone injections to his shoulder as a result of this injury.

He further testified to complaints that he presently has involving his neck and right shoulder.

Pursuant to Section 8.1(b) of the Act, the following factors are to be considered in determining the level of permanent disability for accidental injuries occurring on or after September 1, 2011:

(i) The reported level of impairment;

(ii) The occupation of the injured employee;

(iii) Age of employee at the time of injury;

(iv) The employee's future earning capacity;

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

With regard to subsection (i) of §8.1b(b) of the Act, the Arbitrator notes that no impairment rating, report or opinion was submitted into evidence. The Arbitrator gives no weight to this factor.

With regard to subsection (ii) of Section 8.1b(b) of the Act, the occupation of the employee, the Arbitrator notes that the record reveals that petitioner was employed as a minuteman with the Department of Transportation at the time of this accident and that he left that job in July 2016. He took a job in a warehouse for six to eight months and then obtained a job driving a truck before being laid off in February 2018. The Arbitrator gives some weight to this factor.

With regard to subsection (iii) of Section 8.1b(b) of the Act, the Arbitrator notes that the petitioner was 50 years old at the time of the accident. Due to his age, he will have to spend a longer period of time in the work force dealing with his injuries. The Arbitrator gives some weight to this factor.

With regard to subsection (iv) of Section 8.1b(b) of the Act, the petitioner's future earnings capacity, the Arbitrator notes that after leaving the respondent's employ, the petitioner obtained a job in a warehouse earning $10.00 before leaving that job to become a driver for another company earning $20.00 an hour. This is less than what he earned with the respondent. The Arbitrator gives some weight to this factor.

With regard to subsection (v) of Section 8.1b(b) of the Act, the evidence of disability corroborated by the treating medical records, the Arbitrator notes that in his final visit with Dr. Kuprys at the VA, the nursing notes indicate that on a scale of 0 to 4, the petitioner rated his pain as a 3. The Arbitrator also gives some weight to this factor.

Based on all of the above, the Arbitrator finds that the petitioner sustained a 2% loss of use of a person pursuant to Section 8(d) (2) of the Act for his cervical injury and 5% loss of use of a person pursuant to Section 8(d) (2) of the Act for his right shoulder injury.

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

Melissa Causey,

Petitioner,

vs.

NO: 18 WC 9605
20 IWCC 333

Amazon,

Respondent.

CORRECTED DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 1, 2019, is hereby affirmed and adopted.

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

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

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: JUL 24 2020
TJT:yl
o 6/9/20
51

Thomas J. Tyrrell

Deborah L. Simpson

Maria E. Portela

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

CAUSEY, MELISSA
Employee/Petitioner

Case# **18WC009605**

AMAZON
Employer/Respondent

20IWCC0333

On 8/1/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

4463 GALANTI LAW OFFICE
GIAMBATTISTA PATTI
115 S BELLWOOD DR
E ALTON, IL 62024

0000 WIEDNER & McAULIFFE LTD
JULIE M TENUTO
8000 MARYLAND AVE SUITE 550
ST LOUIS, MO 63105

20IWCC0333

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)

Melissa Causey
Employee/Petitioner

v.

Amazon
Employer/Respondent

Case # 18 WC 09605

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 6, 2019. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ 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 _____

20IWCC0333

FINDINGS

On the date of accident, February 15, 2018, Respondent was operating under and subject to the provisions of the Act.

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

On this date, Petitioner did 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 $380.96.

On the date of accident, Petitioner was 35 years of age, married with 3 dependent child(ren).

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

Respondent shall be given a credit of $6,656.38 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $6,656.38.

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, Arbitrator
ICArbDec19(b)

July 30, 2019
Date

AUG 1 - 2019

Petitioner filed an Application for Adjustment of Claim which alleged she sustained an accidental injury arising out of and in the course of her employment by Respondent on March 21, 2018. The Application alleged Petitioner "Hurt back packing" and sustained an injury to the "MAW" (Arbitrator's Exhibit 2). At trial, counsel for Petitioner made an oral motion to amend the Application to change the date of accident to February 15, 2018. Counsel for Respondent had no objection, the Arbitrator granted the motion and changed the date of accident on the Application to February 15, 2018.

This case was tried in a 19(b) proceeding and Petitioner sought an order for payment of medical bills and temporary total disability benefits as well as prospective medical treatment. In regard to temporary total disability benefits, Petitioner alleged she was entitled to temporary total disability benefits of 62 4/7 weeks, commencing March 25, 2018, through June 6, 2019 (the date of trial). The prospective medical treatment sought by Petitioner was a two level disc replacement surgery recommended by Dr. Matthew Gornet, an orthopedic surgeon. Respondent disputed liability on the basis of accident and causal relationship (Arbitrator's Exhibit 1).

Petitioner became employed by Respondent in August, 2017, and worked as both a "picker" and a "packer." Most of the time, Petitioner worked as a picker, but there were occasions in which Petitioner was directed to work as a packer.

Petitioner testified that when she worked as a picker, she was told where a product was located, she proceeded to the location where the product was, and scanned both the location and product. The product was then picked and placed in a cage. Petitioner stated she was at the same level as the cage so she could walk into and place the product in its appropriate place. While picking, Petitioner used a lift to raise her to the level of the product on the shelf that it was to be picked from. Once the cage was full of products, Petitioner would take it to a packing station and then resume her duties as a picker.

When Petitioner worked as a packer, she would pack various products into boxes. Packing involved getting an empty box, putting the box on a table, getting the product out of the cage and packing the product inside the box. Petitioner stated she was directed to work as a packer on a regular basis, especially when Respondent had large orders. While packing, Petitioner stated she would pack approximately 60 items per hour for a 10 hour shift with two 15 minute breaks and an hour for lunch.

When Petitioner was initially questioned about the accident of February 15, 2018, she testified she had been at work all day, was at her residence, sat down to take a break and when she got up she felt as though she was "...going to snap in half" and compared it to when she had kidney stones approximately 15 years prior.

Petitioner subsequently testified she experienced the onset of pain at work on February 15, 2018, when she lifted a bag of dog food from the bottom of the cage. Petitioner estimated the bag of dog food weighed approximately 45 pounds. Petitioner testified she reported that she sustained the injury while lifting the bag of dog food to her treating medical providers, Dr. Eavenson and Dr. Gornet as well as to Respondent's Section 12 examiner, Dr. deGrange.

Petitioner initially sought medical treatment at the ER of Anderson Hospital on February 15, 2018. According to the ER record, Petitioner complained of left sided flank pain that had been present for two or three days. Petitioner indicated it began that day while going to work and nothing she did brought the pain on, worsened it, or lessened it. The record did not contain any reference to Petitioner having sustained an injury at work or that she injured her back while lifting a bag of dog food. Further, the record noted that Petitioner "denies injury" (Petitioner's Exhibit 1).

On cross-examination, Petitioner acknowledged she did not know she injured her back at work, but experienced pain while working as a packer. Petitioner agreed there was not a specific incident of bending or twisting which caused her to experience low back pain, but it appeared over time while she was working in packing.

Following the ER visit of February 15, 2018, Petitioner returned to work for Respondent as a picker. Petitioner worked as a picker for several weeks and did not experience any back pain. On March 21, 2018, Petitioner was directed to work in the packing department. During that day, Petitioner requested to be moved back to the picking department, but her request was denied. Petitioner was informed that there was no one else trained for packing. Later in the day, Petitioner said she saw two or three other pickers who were trained to pack, so she renewed her request to move back to the picking department, but it was again denied.

On March 21, 2018, Petitioner went to the HR department to complain about her request being denied. At that time, Petitioner reported she sustained a work-related injury. Petitioner completed and signed a form captioned "Associate First Report of Injury." The form listed the incident date as "2/15/ER Visit" and Petitioner started feeling pain in the back before lunch, asked if she could pick or if someone could alternate, was informed no one else was trained, saw four pickers that were trained and talked to individuals named Christian, Thomas and Steve. There was no mention in this report of Petitioner having injured herself while lifting a bag of dog food (Respondent's Exhibit 3).

On March 21, 2018, Petitioner sought treatment at Multicare Specialists and was evaluated by Michelle Lemp, a Nurse Practitioner. Petitioner informed NP Lemp that she experienced low back pain while at work while working as a packer. NP Lemp diagnosed Petitioner with low back pain, prescribed medication and authorized Petitioner to be off work. There was no mention in the record of Petitioner sustaining an injury while lifting a bag of dog food (Petitioner's Exhibit 2).

The following day, March 22, 2018, Petitioner was seen by Dr. Mark Eavenson, a chiropractor. Petitioner complained of low back pain and related it to working as a packer and the picking job was much easier. Dr. Eavenson ordered x-rays of the lumbar spine which revealed degenerative disc disease at multiple levels. He opined Petitioner had a lumbar disc protrusion and imposed work/activity restrictions. Dr. Eavenson ordered physical therapy, chiropractic treatment, cupping and an MRI scan. Again, there was no reference to Petitioner sustaining an injury while lifting a bag of dog food (Petitioner's Exhibit 2).

The MRI was performed on March 22, 2018. According to the radiologist, the MRI revealed annular tears at L4-L5 and L5-S1 (Petitioner's Exhibit 7).

Dr. Eavenson referred Petitioner to Dr. Matthew Gornet, an orthopedic surgeon. Dr. Gornet evaluated Petitioner on March 30, 2018. In a form completed and signed by Petitioner on that date, Petitioner noted that the date of accident was March 21, 2018, at about 3:15 PM. According to Dr. Gornet's record of that date, Petitioner informed him her problem began one to two months prior when she was switched from picking to packing. He noted that when Petitioner was packing she was required to bend and lift packages from a cage and place them on a table and this aggravated her condition, but picking did not. Dr. Gornet reviewed the MRI and opined it revealed annular tears and disc protrusions at L4-L5 and L5-S1. Dr. Gornet recommended three more weeks of physical therapy. There was no reference in Dr. Gornet's records, including the form completed by Petitioner, of Petitioner having injured her back while picking up a bag of dog food (Petitioner's Exhibit 3).

At the direction of Respondent, Petitioner was examined by Dr. Donald deGrange, an orthopedic surgeon, on June 7, 2018. In connection with his examination of Petitioner, Dr. deGrange reviewed medical records provided to him by Respondent. Petitioner complained of low back pain, but without any lower extremity pain, numbness or weakness. Petitioner advised Dr. deGrange that on February 15, 2018, she was working as a packer and develop symptoms similar to those she previously had when she had kidney stones 10 years prior. Petitioner described the pain as being insidious and did not recall any specific incident (including lifting a bag of dog food), but only that she began to experience discomfort.

Dr. deGrange reviewed the MRI and opined it revealed annular fissures at L4-L5 and L5-S1. Dr. deGrange opined Petitioner's work activities of February 15, 2018, were consistent with a lumbar strain which aggravated a pre-existing degenerative condition. He also opined that further physical therapy was not indicated, but that Petitioner might benefit from epidural steroid injections, but a maximum of two. He noted Petitioner could return to work with a 25 pound lifting limit and limited bending and twisting (Respondent's Exhibit 5).

Dr. Gornet saw Petitioner on August 6, 2018, and reviewed Dr. deGrange's report noting he had recommended epidural steroid injections. Dr. Gornet agreed there was no significant neurologic compression, but referred Petitioner to Dr. Helen Blake for the epidural steroid injections (Petitioner's Exhibit 5).

Dr. Blake saw Petitioner on August 7, and August 21, 2018. On those occasions, she administered an epidural steroid injection on the right at L5-S1 and on the right at L4-L5, respectively (Petitioner's Exhibit 8).

Dr. Gornet subsequently saw Petitioner on October 1, 2018, and noted the epidural steroid injections did not provide Petitioner with any significant relief. Dr. Gornet ordered additional diagnostic tests including a discogram, CT scan and MRI spectroscopy. Dr. Gornet has recommended Petitioner undergo a two level disc replacement surgery at L4-L5 and L5-S1. Dr. Gornet last saw Petitioner on March 28, 2019 (Petitioner's Exhibit 5).

At the direction of Respondent, Petitioner was again examined by Dr. deGrange on February 6, 2019. At that time, Dr. deGrange reviewed additional medical records and diagnostic studies provided to him by Respondent. Petitioner complained of low back and right hip pain with occasional numbness in the right calf; however, Dr. deGrange's findings on examination were consistent with what they were previously. Dr. deGrange noted Petitioner had received extensive

medical treatment since the last time he saw her, which included 10 to 11 months of physiotherapy, chiropractic care and cupping. Dr. deGrange again questioned Petitioner whether she could recall any specific event such as lifting or slipping/falling. Petitioner could not recall any such incidents and again stated the bending and twisting while packing aggravated her low back pain (Respondent's Exhibit 6).

Dr. deGrange now opined that the bending and twisting previously described by Petitioner was no more likely to cause pain than bending and twisting at home. He also opined that the continuous therapy and chiropractic treatment Petitioner had received was excessive and a two level disc replacement surgery was not indicated due, in part, to the fact Petitioner was morbidly obese. Dr. deGrange now opined Petitioner had chronic low back pain which was not related to the work-related activities of February 15, 2018 (Respondent's Exhibit 6).

Dr. Gornet was deposed on April 29, 2019, 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 related the annular tears at L4-L5 and L5-S1 to Petitioner's activities as a packer because that was when her symptoms began. He reaffirmed his recommendation Petitioner undergo a two level disc replacement surgery at those levels (Petitioner's Exhibit 5; pp 9, 14-15).

On cross-examination, Dr. Gornet agreed he had not reviewed job descriptions for either the picking or packing job. Dr. Gornet also agreed he had not reviewed a job analysis report or video job analysis of either position. When cross-examined about degenerative findings being present before the work injury, Dr. Gornet replied, in part "...something occurred with this mechanical activity, and doing that, I believe that's when she sustained disc injury." (Petitioner's Exhibit 5; pp 17, 23).

Dr. deGrange was deposed on May 7, 2019, and his deposition testimony was received into evidence at trial. On direct examination, Dr. deGrange's testimony was consistent with his medical reports and he reaffirmed the opinions contained therein. In regard to his first examination of June 7, 2018, Dr. deGrange testified Petitioner did not inform him that she had sustained a specific injury on February 15, 2018. Based upon Petitioner's description of her work activities, Dr. deGrange opined she sustained a lumbar strain which was a temporary exacerbation of her underlying degenerative disc disease at L4-L5 and L5-S1 (Respondent's Exhibit 4; pp 7, 13-14).

Dr. deGrange testified Petitioner could not recall any specific incident, but that she attributed her symptoms to bending and twisting while working as a packer. Dr. deGrange considered bending and twisting as a normal daily activity and while Petitioner attributed it to her work, Dr. deGrange noted that one should "...not confuse association with causation." (Respondent's Exhibit 4; pp 28-29.

When cross-examined, Dr. deGrange explained he changed his opinion regarding causation based upon Petitioner's persistence of symptoms and that Petitioner could not recall anything that might have caused it. He stated "I no longer believed that her ongoing symptoms were a consequence of anything she might have done in February of 2018." (Respondent's Exhibit 4; pp 47-48).

At trial, Petitioner testified her current symptoms prevent her from doing anything involving any stress for longer than five minutes or so. Petitioner stated she is willing and able to return to work as a picker, but not as a packer. Petitioner has continued to seek chiropractic care and wants to proceed with the surgery as recommended by Dr. Gornet.

On cross-examination, Petitioner conceded she was still able to take family vacations and recently made a trip to Florida which included a two and one-half hour plane ride. Further, Petitioner also traveled to Utah by car to visit her sister and estimated this took about 18 hours. While there, Petitioner also engaged in some hiking on trails.

Conclusions of Law

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

The Arbitrator concludes Petitioner did not sustain an accidental injury arising out of and in the course of her employment by Respondent on February 15, 2018.

In support of this conclusion the Arbitrator notes the following:

It was not clear from Petitioner's testimony whether she was claiming to have sustained a specific accident on February 15, 2018, or whether she was claiming to have sustained a repetitive trauma injury which manifested itself on February 15, 2018.

Petitioner testified she experienced pain in her low back while working as a packer, but also testified she experienced the onset of pain on February 15, 2018, when she lifted a bag of dog food that weighed 45 pounds.

Petitioner testified she informed Dr. Eavenson, Dr. Gornet and Dr. deGrange of having injured her back while lifting a bag of dog food; however, such a history was not contained in any of their records/reports. Further, such a history was not included in the First Report prepared by Petitioner.

Petitioner also testified she experienced the onset of pain on February 15, 2018, when she got up from taking a break at home.

When seen at Anderson Hospital on February 15, 2018, Petitioner complained of left sided flank pain that had been present for two or three days and that she had experienced the onset of pain while going to work. Further, there was nothing in the record of that date that referenced any work-related injury and Petitioner denied injury.

When Petitioner was seen by Dr. Gornet on March 30, 2018, she completed a form which noted the date of accident was March 21, 2018, at 3:15 PM; however, Dr. Gornet's record indicated Petitioner experienced the onset of pain while working as a packer.

Petitioner apparently did have to engage in bending and twisting while working as a packer and Dr. deGrange initially opined this may have caused Petitioner to have sustained a lumbar strain. However, given the long periods of physical therapy, chiropractic care, cupping and epidural steroid injections, and the persistence of her symptoms, Dr. deGrange subsequently opined Petitioner had a chronic low back condition that was not related to her work activities of February 15, 2018.

Dr. Gornet's opinion that Petitioner's low back condition was related to her work was based, in large part, on his belief that "something occurred" with Petitioner's activities at work to cause the disc injury. This is not a sufficient basis to find a medical causal relationship.

Based upon all of the preceding, the Arbitrator concludes Petitioner did not sustain either a specific injury or a repetitive trauma injury on February 15, 2018.

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

William R. Gallagher, Arbitrator

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

LORI LAIDLAW,

Petitioner,

20IWCC0419

vs. No: 12 WC 33795

STATE OF ILLINOIS – DEPARTMENT OF CORRECTIONS,

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, occupational disease, medical expenses, temporary total disability, and permanent partial disability, and being advised of the facts and law, reverses the Decision of the Arbitrator, finds that Petitioner sustained her burden of proving she suffered a repetitive trauma accident which caused current conditions of ill-being of her right arm and right hand and awards benefits.

I. FINDINGS OF FACT

A. Background and Accident

Petitioner testified that on July 23, 2012 she worked for Respondent as supervisor of the bureau of identification. She was initially hired by Respondent in 1984 as a correctional officer ("CO"). She moved to the bureau of identification in 1993 full time. While a CO, Petitioner was assigned to the bureau often to fill in. Petitioner described the office in which she worked in Dixon to be a long office with a counter measuring about chest high. Inmates are on the other side of the counter and she fingerprinted them. It was determined that the counter was about four and a half feet high. All individuals coming into the facility were fingerprinted.

Petitioner explained that fingerprinting required that she first cut down the fingerprint sheet to fit into a card using a large paper cutter fitted with a large blade. She also used the paper cutter to cut up old IDs. After cutting down the fingerprint page, she explained that one would "have to roll the thumb in the ink, and then [] roll the thumb on the fingerprint card and [] go on each fingers [*sic*], all 10

fingers, roll in the ink and then roll on the card." Then Petitioner explained that one would place full handprints at the bottom.

Petitioner testified that there are 14 total motions in the process of fingerprinting, but that number must be doubled because it is done in the ink and then on the card. She estimated that she fingerprinted 40 individuals a day on average. Petitioner also had to use hole punchers for mug shots of each inmate to be transferred. She explained that individuals being fingerprinted tended to try to force their fingers down in the ink and on the paper, so she had to lift their fingers up to get a good print. Sometimes inmates were uncooperative, which also made fingerprinting more difficult. In addition, Petitioner made IDs, issued reports, assembled and "disassembled" files, and took DNA samples.

On July 23, 2012, Petitioner began getting "electric shocks" in her wrists and hands and experienced pain while rolling fingerprints. Besides fingerprinting, as the supervisor, she had additional paperwork in terms of evaluations, training, approving time off, etc. Petitioner testified that there was also paperwork associated with every incoming inmate.

On cross examination, Petitioner testified that maybe in 1995 she was elected president of her union local. In 2010 she took several months of leave for union business and, while she did not know how long she was off, she was back at work fingerprinting inmates and making ID cards every day in 2012. Petitioner also testified that she had an assistant at that time, Barry Ogden[1], who would assist her in the fingerprinting and ID processes.

B. Medical Treatment

As her condition worsened, she sought medical attention with Dr. Risha Raven. The medical records reflect that Petitioner presented to Dr. Raven, her primary care physician, on August 1, 2012 reporting three weeks of right-elbow pain radiating to her lower arm and hand. She reported no known injury but "repetitive stress of fingerprinting at work, better on weekends." Petitioner smoked a pack of cigarettes a day and was counseled on smoking cessation.

Petitioner saw Dr. Raven on August 3, 2012. She authored a letter relating to Petitioner's treatment and work status addressed to Respondent. Therein, Dr. Raven noted that Petitioner was to be off work until August 6, 2012 and that she might need to take some time off work for physical therapy. Notably, she stated that Petitioner "has carpal tunnel and tennis elbow due to repetitive motion of fingerprinting and it is causing numbness of hand and pain."

The August 6, 2012 "Initial Workers' Compensation Medical Report" from Dr. Raven notes that Petitioner experienced "3 weeks of right elbow pain Radiating to lower arm and hand. stiffness As well. On July 23rd pt was fingerprinting And Felt sharp pain from elbow to [right] thumb." She also reported pain opening doors and lifting or stapling, with improvement on the weekends. Dr. Raven recommended physical therapy, use of support, and limited activity in the short term. Dr. Raven stated that repetitive use may increase Petitioner's problem and therapy may allow improvement. Dr. Raven estimated that Petitioner may return to work without restrictions on September 14, 2012. Until then Dr. Raven imposed restrictions to arm twisting if Petitioner felt pain.

[1] Respondent did not call Mr. Ogden as a witness.

On September 14, 2012, Petitioner returned to Dr. Raven for seasonal affective disorder and follow up for right-arm pain from repetitive use injury. Dr. Raven diagnosed "tennis + golfer's elbow" and "fingerprinter's arm." Petitioner was instructed to use NSAISDs as needed, use braces, and apply ice.

The medical records reflect that Petitioner underwent physical therapy from August 24, 2012 through September 12, 2012 and from March 13, 2013 through June 7, 2013. During that time, she reported a consistent mechanism of injury with an onset of symptoms at work. Specifically, she reported first noticing pain in her right elbow and wrists in mid July of 2012 and that, when rolling fingerprints, she felt the most pain. Petitioner's treatment was limited to her right hand, and she is right-hand dominant.

On March 4, 2013, Petitioner presented to KSB Hospital's Prompt Care department for right elbow/forearm pain for at least six months. She had been using a "TE band" without much benefit. Dr. Lyman Tieman, diagnosed right epicondylitis and prescribed Norco, Prednisone and Ibuprofen.

Four days later, on March 8, 2013, Petitioner followed up with Dr. Raven reporting that her right tennis elbow was worsening which seemed to increase with work. Petitioner also informed Dr. Raven that she had gone to KSB's prompt care department a few days earlier and that she had been prescribed Norco and Prednisone, but she did not want to take such medications. Dr. Raven advised her to take Aleve, to use a brace, and prescribed physical therapy. Petitioner reported her pain was better after a couple of weeks of physical therapy but then she went back to work and her pain returned.

On March 27, 2013, Petitioner presented to Dr. Thomas Hernandez, a KSB Hospital orthopedic surgeon, reporting seven months of right-elbow pain. She also reported that she worked "at a prison and does a lot of repetitive wrist extension activities involving fingerprinting and computer work." On her questionnaire, Petitioner reported that pain went from her elbow to fingertips while rolling fingerprints. X-rays of the right elbow were normal. However, on physical examination Dr. Hernandez noted positive point tenderness to palpation about the right lateral epicondyle and reproduction of pain with wrist extension that was more pronounced with elbow extension than elbow flexion. Dr. Hernandez diagnosed right lateral epicondylitis and recommended an injection, which Petitioner declined, and Dr. Hernandez thought was a reasonable decision. He provided a brace and prescribed physical therapy.

On April 26, 2013, Petitioner returned to Dr. Raven reporting that her pain was less on Fridays after physical therapy. Before Friday physical therapy she reported that her pain was 4/10, it was 1-2/10 after therapy with TENS, and 6-7/10 on Monday when she returned to work. Dr. Raven imposed work restrictions taking Petitioner off work unless she could do filing only. In a letter directed to Respondent, Dr. Raven noted that Petitioner was to be off work from April 26, 2013 to May 10, 2013 due to her repetitive use injury.

On May 13, 2013, Petitioner returned to Dr. Raven and reported her pain was much better with TENS, physical therapy, and two weeks off work. She continued to have right lower arm tenderness. Dr. Raven recommended she take NSAIDS as needed, wear her brace and use ice. Petitioner was again placed off work by Dr. Raven on May 13, 2013 due to her repetitive use injury. Dr. Raven allowed Petitioner to return to work effective May 14, 2013 with limitations as Petitioner was able.

The following year, on November 17, 2014, Petitioner presented to Dr. Christopher Rhyne at KSB Hospital for follow up for an unrelated condition and he also noted she was being treated for hypothyroidism. Petitioner asked questions about treatment for chronic wrist and forearm pain secondary to repetitive use injury from rolling fingerprints. She had physical therapy previously and took two weeks off work, both of which resulted in improvement. Petitioner did not want any additional physical therapy for her bilateral CTS at that time and was advised to continue using her braces.

C. Respondent's Section 12 Examination Reports and Deposition Testimony of Dr. Fernandez

On September 2, 2016, Respondent sent Petition to a Section 12 medical examination with Dr. Fernandez. Petitioner reported the sudden onset of pain at the right elbow laterally while fingerprinting at work. She felt a "sharp stabbing pain" at the lateral epicondyle extending down into the hand and wrist. Petitioner reported that she felt her symptoms would get better but actually got worse. Squeezing a stapler and writing were causing her pain. She further reported she developed numbness and tingling in the hand and fingers. Dr. Fernandez noted that an incident report and a witness report contained the same history he received from Petitioner. She was treated conservatively with splinting and physical therapy, but she did not have injections, an EMG, or MRI. Petitioner demonstrated how she took fingerprints, which she did for 30 years. It "appeared to involve multiple digits in both hands including palm prints, in which she would be palm down, 'rolling the finger' back and forth with pressure." She reported she performed these functions repeatedly throughout the day. Her duties also included assembling and reassembling files. She would also staple and un-staple papers on a fairly repeated basis. Petitioner reported overall her pain has improved since "she had to retire" and hasn't performed her work activities in the last sixteen months. Currently, she reported 2/10 pain at rest and 8/10 pain with heavy activity. She had thyroid disease.

Dr. Fernandez concluded that Petitioner exhibited symptoms consistent with epicondylitis and CTS. Her subjective complaints were consistent with his objective findings. He opined that Petitioner's 30 years of work was a contributory cause of her conditions based on her description of her work activities due to their frequency and duration. He noted that he did not have an official job description, and his opinion held unless he received a "better contradictory description regarding her work activities." If Petitioner did not receive any additional treatment, Dr. Fernandez believed that Petitioner would be at maximum medical improvement (MMI). However, he thought injections in both the carpal tunnel and elbow would be reasonable, along with stretching exercises. If Petitioner did not improve with these additional conservative treatments, surgery could be considered.

At Respondent's request, Dr. Fernandez issued an addendum report on March 28, 2017. He noted that he was provided "what appeared to be timesheets[2] related to approximately three years." Dr. Fernandez noted he wasn't sure "of the exact timeline in terms of years those were reflecting." He was also informed after his examination of Petitioner the positions she held during her career. Respondent also provided information that for three years union activities constituted a substantial part of Petitioner's work, and a description of Petitioner's job activities as fingerprint technician supervisor. Dr. Fernandez noted that in retrospect it was "somewhat surprising" that at the time of his examination

[2] The timesheets provided to Dr. Fernandez were not submitted into evidence.

Petitioner "still had these residual symptoms and complaints" after retiring nearly a year and a half earlier. With the benefit of additional information, Dr. Fernandez answered queries.

Dr. Fernandez's diagnosis remained the same: epicondylitis and CTS, but he noted again that it was "somewhat surprising" that Petitioner's symptoms did not improve after retirement. He also indicated that the lack of significant improvement would militate against work activities causing the conditions. He particularly cited the epicondylitis which is not permanent. Also, on the issue of causation, Dr. Fernandez indicated that the job description[3] he was provided showed more varied activities and his initial impression that she was spending all her time fingerprinting and assembling/de-assembling files was inaccurate. He no longer believed the nature of Petitioner's work was sufficient to constitute an aggravating factor in her conditions. He noted her co-morbid factors as well. Dr. Fernandez believed that prospective treatment could include an EMG and MRI and injections. Any current restrictions from her ability to work would be based on her subjective complaints. The MRI and EMG could determine whether there is any objective basis to limit Petitioner's work activities.

Respondent called Dr. Fernandez as a witness and he gave testimony at an evidence deposition taken on October 20, 2017. Dr. Fernandez testified that he is a board-certified orthopedic surgeon. He examined Petitioner in August 2016 and issued a report. He also discussed her job activities with her. Dr. Fernandez testified that he understood that, essentially, Petitioner was a technician for DOC. She had various activities, but they concentrated on fingerprinting and processing files, which she did for about 30 years. She demonstrated the fingerprinting process. It was his impression that she was doing that activity "fairly constantly." She also engaged in "assembling" and "unassembling" files and "stapling" and "un-stapling, "also on a fairly constant or repeated basis." Later, he got a job description which included the job activities Petitioner described but on a less frequent basis than Petitioner asserted. According to the job description, she did less fingerprinting and more paperwork. After he received this information, Dr. Fernandez issued an addendum report.

Dr. Fernandez acknowledged that Petitioner had lateral epicondylitis and CTS, and his opinion did not change with the new information. However, he changed his opinion that there was sufficient "intensity or frequency" of the allegedly offensive activity to either cause or aggravate epicondylitis or CTS. He opined that there has to be "an element of force" to aggravate those conditions. "And if there's not as much of an element of force, there has to be an element of repetition" or use of vibratory tools or work on an assembly line.

Dr. Fernandez noted that there should be at least a half day, or four hours, of exposure to aggravate those conditions. He also noted that female sufferers of CTS outnumber male sufferers by 6 to 1. In addition, the "sweet spot" for developing the disease is between the ages of the late thirties to early sixties (Petitioner was 47 at the time of the accident). Smoking and obesity are risk factors for developing CTS and Petitioner smoked and was on the verge of being overweight, and she had thyroid disease.

On cross examination, Dr. Fernandez agreed that Petitioner was right-handed, and her right arm was being treated. However, 80% of CTS is seen bilaterally. At the time of his examination, Dr. Fernandez took Petitioner at her word about her work activities and opined that her activities were

[3] The job description provided to Dr. Fernandez was not submitted into evidence.

sufficient to cause or aggravate her neuropathic conditions. He did not believe the height of the counter was relevant but using paper-cutting and hole-punching machines could aggravate the conditions if of sufficient duration and frequency. However, moving between activities and interspersing non-offending activities would lessen the deleterious effects of those activities. Handling file folders could be offensive if they were very heavy.

On the issue of fingerprinting, Dr. Fernandez noted that it was not pinching that could be offensive, but rather the "palm-down awkwardness" of the position. The actions would also be more difficult and require more force if an inmate was uncooperative. Dr Fernandez indicated Petitioner's job activities could cause or aggravate CTS and lateral epicondylitis if done for at least 4 to 5 hours every day. Finally, in response to Respondent's counsel's question of how many months, years or days on the job would be relevant in making a causal connection for carpal tunnel and lateral epicondylitis he replied a "minimum of six to eight weeks."

D. Additional Information

Petitioner testified that she retired on March 31, 2015 because she could no longer do her job. Her condition improved after her retirement, and she continued doing work for the union intermittently. She used to paint walls when needed. She also painted furniture and did some furniture restoration.

Regarding her current condition of ill-being, Petitioner testified that currently she was a lot better, but it was still "not perfect." She cannot do things like shampoo carpets, paint walls, or paint pictures. It starts aching whenever she does repetitive activities, even things like using a screwdriver.

II. CONCLUSIONS OF LAW

A. Accident & Causal Connection

In finding that Petitioner did not sustain her burden of proving that her conditions of ill-being were causally related to her work activities, the Arbitrator stressed that Petitioner testified to performing a variety of workplace activities. He also noted that Petitioner had an assistant who could perform many of the activities about which she testified, and that Petitioner was away from the prison for a period of several months. Finally, the Arbitrator found the causation opinion of Dr. Fernandez more persuasive that that of Dr. Raven. He stressed that Dr. Raven did not have a detailed understanding of Petitioner's work activities, in contrast to Dr. Fernandez, who had the official job description. Based on a review of the totality of the record, the Commission views the evidence differently and concludes that Petitioner has established that her activities at work contributed to her development of carpal tunnel syndrome and lateral epicondylitis.

The facts must be closely examined in repetitive-injury cases to ensure a fair result for both the faithful employee and the employer. *Durand v. Industrial Comm'n*, 224 Ill. 2d 53, 71 (2006). Compensation is allowable where an injury is not sudden, but gradual so long as it is linked to the claimant's work. *Durand*, 224 Ill. 2d at 66 (citing *Peoria County Belwood Nursing Home v. Industrial Comm'n*, 115 Ill. 2d 524, 529 (1987)). The Illinois Supreme Court went on to highlight that "[t]o deny an employee benefits for a work-related injury that is not the result of a sudden mishap *** penalizes an employee who faithfully performs job duties despite bodily discomfort and damage." *Durand*, 224 Ill.

2d at 66 (citing *Peoria County*, 115 Ill. 2d at 529-30). It is also well-settled that there is no legal requirement that a certain percentage of the workday be spent on repetitive tasks in order to establish the repetitive nature of a claimant's job duties. *Edward Hines Precision Components v. Industrial Comm'n*, 356 Ill. App. 3d 186, 194 (2005).

In this case, Petitioner's description of her repetitive work activities over a 30 year period, and the force and flexion necessary to execute those activities, was consistent in her testimony at the hearing, to all of her treating physicians throughout the medical records, in her incident report and Mr. Ogden's witness statement and to Respondent's own Section 12 examiner, Dr. Fernandez. Petitioner consistently reported that the increase in her symptoms coincided with her work activities, particularly fingerprinting. Her treating doctors' records support Petitioner's testimony that her repetitive work activities caused her conditions of ill-being. Indeed, in an August 3, 2012 treatment and work status letter directed to Respondent, Dr. Raven opined that Petitioner "has carpal tunnel and tennis elbow due to repetitive motion of fingerprinting and it is causing numbness of hand and pain." Dr. Raven also completed an initial workers' compensation report three days later in which she noted that Petitioner had three weeks of right elbow pain radiating to her lower arm and hand as well as stiffness culminating on July 23, 2012 when Petitioner "was fingerprinting And Felt sharp pain from elbow to [right] thumb." Petitioner also reported pain with activities including opening doors and lifting or stapling, with improvement on the weekends. Dr. Raven believed that repetitive use may increase Petitioner's problem, and she maintained the opinion that Petitioner's need to be off work, in physical therapy, and under her medical treatment due to her repetitive use injury through May of 2013.

Moreover, Respondent's Section 12 medical examiner, Dr. Fernandez, opined that Petitioner's job duties contributed to the development of her condition of ill-being. In his initial report, which was issued after an examination held years after Petitioner's symptom onset and after undergoing treatment, Dr. Fernandez noted no malingering and specifically found that Petitioner's subjective reports were consistent with his objective findings. Seven months later, Dr. Fernandez authored an addendum report at Respondent's request. Therein, he changed his opinion that Petitioner's job duties caused her condition based on his review of a job description and timesheets provided to him by Respondent. Dr. Fernandez apparently understood based on the supplemental documents that Petitioner was not fairly constantly fingerprinting, assembling and disassembling files, or stapling and un-stapling. These documents are noticeably absent from the evidence submitted by Respondent at the hearing.

Notwithstanding the omissions by Respondent, Dr. Fernandez's explanations for his change in opinion, and the bases on which he retracted his causal connection opinion, are unpersuasive in this case. Without the benefit of reviewing such documents, the Commission views his reference to the timesheets as vague and conclusory. Also, Dr. Fernandez expresses surprise that Petitioner still had residual complaints and he attributes much of his new opinion to the surprising information. However, Dr. Fernandez's first report reflects that Petitioner had told him, very clearly, that she had been retired for 16 months and had improved, but still had residual complaints.

Dr. Fernandez also conceded at his deposition that the awkwardness of the positing of Petitioner's wrist during fingerprinting could be an offensive activity. He believed the flexion of Petitioner's palm to be significant at the time that he originally opined that her job duties contributed to her conditions. Dr. Fernandez also admitted that performing those duties 4 to 5 hours a day would be sufficient to cause or aggravate carpal tunnel syndrome and lateral epicondylitis. Also, performing the

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job for 6 to 8 weeks could be a cause. Petitioner had been performing the repetitive duties involving force and flexion for significantly longer. In light of the foregoing, the Commission does not find Dr. Fernandez's changed opinion to be persuasive.

Petitioner testified in detail about the motions that she had to make to execute particular activities at work, and the amount of times that she did so, at the hearing, to her treating physicians, and to Dr. Fernandez. That Petitioner conceded that she took several months of leave for union business in 2010, but was back at work in 2012 and made ID cards every day does not undermine the repetitive nature of her work or the force and flexion admittedly required to execute her work activities for the years before and thereafter. Petitioner also testified that she had an assistant, but no information was provided about the work this individual may have performed or whether it diminished Petitioner's repetitive activities in any way. Indeed, Respondent offered no witnesses at the hearing and makes no arguments related to the foregoing.

To the extent that Respondent relies on Petitioner's utilization of an assistant for a period of time to undercut the amount of time that Petitioner spent on the repetitive, awkwardly positioned, and forceful activities with her hand, the Commission is not persuaded. Respondent offered no evidence to controvert Petitioner's testimony that she engaged in the aforementioned activities to the extent that she did. While Respondent asked Petitioner on cross examination about this assistant, it did not introduce evidence undercutting the extent of Petitioner's work as she explained. Indeed, Petitioner acknowledged that she had an assistant for a time further enhancing her credibility. The Commission declines to infer, without evidence, that Petitioner ceased to perform the offending physical activities to some undefined extent giving rise to her occupationally developed repetitive trauma injury as she testified, as opined by Dr. Raven, or as opined initially by Respondent's Section 12 examiner, Dr. Fernandez.

Based on the entire record before us, the Commission finds that Petitioner sustained her burden of proving she suffered injuries to her right arm and right hand as a result of repetitive trauma and has established a causal connection based on the opinions and treating records of Dr. Raven and the initial opinion of Dr. Fernandez. Therefore, we reverse the Decision of the Arbitrator.

B. Temporary Total Disability

On the issue of temporary total disability, in her brief, Petitioner asserts the record established that Petitioner was taken off work from August 1, 2012 through August 6, 2012 and from April 26, 2013 through May 14, 2013. Respondent has not found it necessary to file a brief. Nevertheless, the only note in 2012 taking Petitioner off work was written on August 3, 2012 indicating that Petitioner would be off work through August 6, 2012. Petitioner was also taken off work in 2013 from April 26, 2013 to May 10, 2013 and on May 13, 2013. The medical records reflect Petitioner's report that she improved with two weeks of being off work. This is broadly consistent with the total period of time that she was placed off work by her treating physician. Thus, the Commission awards Petitioner temporary total disability benefits for these periods of time.

C. Permanent Partial Disability

Regarding permanent disability, section 8.1b of the Act requires permanent partial disability to be determined following consideration of five factors: (i) the reported level of impairment pursuant to

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subsection (a); (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability. 820 ILCS 305/8.1b(b).

With regard to factor (i), no AMA impairment rating was submitted into evidence. The Commission gives no weight to this factor.

With regard to factor (ii), Petitioner was employed as a correctional officer for Respondent. Petitioner was able to return to her prior job for a period of time, but ultimately retired. The Commission gives significant weight to this factor.

With regard to factor (iii), Petitioner was 47 years old at the time of the accident. The Commission gives moderate weight to this factor.

With regard to factor (iv), no evidence was submitted indicating an adverse impact on Petitioner's future earning capacity. The Commission gives some weight to this factor.

With regard to factor (v), Petitioner developed right epicondylitis and carpal tunnel syndrome as a result of repetitive activities at work requiring conservative treatment. The record reflects that Petitioner has reached maximum medical improvement but is not symptom-free despite her retirement. The Commission gives significant weight to this factor.

Based on the above, the Commission finds Petitioner sustained a 7.5% loss of use of her right arm and 2.5% loss of use of her right hand pursuant to Section 8(e) of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator dated September 5, 2019 denying Petitioner all benefits is reversed. The Commission finds Petitioner sustained her burden of proving a repetitive trauma accident that arose out of and in the course of her employment on July 23, 2012, and Petitioner proved by a preponderance of the evidence that her current condition of ill-being is causally related to that accident.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay Petitioner temporary total disability of $925.53 for a period of 2 & 4/7ths weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay medical expenses totaling $11,880.00, pursuant to §8(a), subject to the applicable medical fee schedule in §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner $605.50 as reimbursement for out-of-pocket medical expenses she incurred.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $735.37 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 the use of 7.5% of the right arm, and the sum of $735.37 per

week for a period of 4.75 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the loss of the use of 2.5% of the right hand.

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

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

Pursuant to §19(f)(1) of the Act, claims against the State of Illinois are not subject to judicial review. Therefore, no appeal bond is set in this case.

DATED: JUL 24 2020

Marc Parker

Barbara N. Flores

BNF-MP/dw
O-6/4/20
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DISSENT

I respectfully dissent from the Decision of the Majority. The Majority reversed the Decision of the Arbitrator who found that Petitioner neither sustained her burden of proving she sustained a repetitive trauma accident nor that her condition of ill-being was causally related to her work activities, and denied compensation. I would have affirmed and adopted the well-reasoned Decision of the Arbitrator.

I agree with the Arbitrator that Petitioner did not sustain her burden of proving a repetitive trauma accident. As the Arbitrator noted, Petitioner testified to performing various job activities besides the fingerprinting which she indicated was the most offensive activity. I also agree with the Arbitrator that the causation opinion of Dr. Fernandez was more persuasive than that of Dr. Raven. First, Dr. Raven is a primary care physician while Dr. Fernandez is a board-certified orthopedic surgeon specializing in upper extremities. Therefore, he has a better understanding than Dr. Raven of Petitioner's condition of ill-being and the causation of such a condition. Second, Dr. Raven simply recited Petitioner's statement about causation without offering any independent explanation of how her activities specifically caused her condition. It is interesting that she diagnosed Petitioner with "fingerprinter's arm," a diagnosis I have not encountered previously. In contrast, Dr. Fernandez went into detail about the causes of the Petitioner's condition of ill-being. In addition, Dr. Fernandez correctly noted that Petitioner still complained of symptoms relating to her condition a year and a half after she retired. Such ongoing complaints would clearly militate against the condition being related to her work activities, especially in light of the fact that she had no definitive treatment for her condition, *i.e.* no surgery and not even any injections.

The Majority discounts the opinions of Dr. Fernandez because Respondent did not offer its official job description into evidence. In my opinion, the fact that the job description was not submitted does not completely undermine Dr. Fernandez' persuasiveness. He explained why the activities that were noted in the job description did not support the allegation that the condition was work related and he cited Petitioner's co-morbidities, of gender, history of smoking, and thyroid disease. The Majority basically reversed the Decision of the Arbitrator because Respondent failed to submit its job description into evidence. In my opinion, in so doing the Majority has effectively shifted the burden of proof in this case. Under the Act, claimants specifically bear the burden of proving every aspect of their claim, including accident and causation. Here in my opinion, the Majority has reversed the Decision of the Arbitrator and awarded benefits because Respondent had not successfully proved that Petitioner's condition was unrelated to her work activities. I do not believe that is appropriate. Therefore, I dissent from the Decision of the Majority.

I would have found that Petitioner did not sustain her burden of proving she suffered a repetitive trauma accident or that her condition of ill-being was causally related to her work activities, affirmed and adopted the well-reasoned Decision of the Arbitrator, and denied compensation. Therefore, I respectfully dissent from the Decision of the Majority.

DLS/dw
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Deborah L. Simpson

Deborah L. Simpson

STATE OF ILLINOIS)
) SS.
COUNTY OF 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

MIGUEL MORALES,

Petitioner,

vs. NO: 15 WC 030757

EL CHISME,

20IWCC0420

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 29, 2019 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's claim for prospective medical is denied.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay reasonable and necessary medical services of $42,402.87, as provided in Sections 8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $286.00 per week for a period of 21-2/7 weeks, representing August 14, 2015 through

January 10, 2016, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b), 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 the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

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

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of 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 $48,500.00. 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: JUL 27 2020

LEC/cak

O: 7.8.2020

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Stephen Mathis

D. Douglas McCarthy

L. Elizabeth Coppoletti

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

MORALES, MIGUEL
Employee/Petitioner

Case# **15WC030757**

EL CHISME
Employer/Respondent

20IWCC0420

On 4/29/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.40% shall accrue from the date listed above to the day before the 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:

0226 GOLDSTEIN BENDER & ROMANOFF
JUNIRA A CASTILLO
ONE N LASALLE ST SUITE 1000
CHICAGO, IL 60602

1120 BRADY CONNOLLY & MASUDA PC
JEFFREY R GIBELLINA
10 S LASALLE ST SUITE 900
CHICAGO, IL 60603

M. Morales v. El Chisme, 15 WC 030757

20 IWCC0420

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)

MIGUEL MORALES
Employee/Petitioner
v.
EL CHISME
Employer/Respondent

Case # 15 WC 030757

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jeffrey Huebsch**, Arbitrator of the Commission, in the city of **Chicago**, on **December 10, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **8/11/15**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**19,646.28**; the average weekly wage was $**375.89**.

On the date of accident, Petitioner was **61** years of age, ***married*** with **1** 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

Respondent shall pay reasonable and necessary medical services of $42,402.87, as provided in Sections 8(a) and 8.2 of the Act and as is explained below.

Petitioner's claim for prospective medical care is denied.

Respondent shall pay Petitioner temporary total disability benefits of $286.00/week for 21-2/7 weeks, commencing August 14, 2015 through January 10, 2016, 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.

Signature of Arbitrator

April 29, 2019
Date

ICArbDec19(b)

APR 29 2019

20 IWCC0420

INTRODUCTION

This case was tried pursuant to §§19(b) and 8(a) of the Act, with the disputed issues being causation, medical expenses, prospective medical treatment, TTD and TPD. The transcript states that nature and extent was in issue, but that is not the Arbitrator's recollection and does not comport with the Request for Hearing form that was admitted. (ArbX 1)

Petitioner's testimony was elicited via Spanish/English interpreters.

FINDINGS OF FACT

The Parties stipulated that Petitioner sustained accidental injuries which arose out of and in the course of his employment by Respondent on August 11, 2015 and that correct notice was given.

Witness testimony and non-medical documents:

Petitioner testified that he felt something pop in his back when he lifted boxes of chicken to put them on a dolly. Petitioner said that there were 4 boxes of frozen chicken, weighing 40 pounds each.

Petitioner testified that he had low back problems in the past that had resolved prior to August of 2015. He was feeling perfectly well before the accident and was able to work full time, 40 hours per week, full duty, and never had any "issues". He had undergone back surgery in October of 2013 and by the end of 2013, 2014 had no back problems and did not see a doctor for his back between then and the August 11, 2015 injury.

Petitioner testified that he was helped a lot by the treatment that was given to him by his doctors after the August 11, 2015 injury. He has been doing PT "for quite a long time." He received 3 injections and x-rays and MRIs. He continues to have low back pain. Petitioner's doctors (Drs. Koutsky, Dixon, Jain and Zaragoza) agree that Petitioner needs surgery. He has not improved and he is in constant pain and they advised that surgery is the only thing that would improve his situation. Petitioner testified that the need for surgery is directly connected to the August 11, 2015 accident according to his doctors. Petitioner attended 2 IME examinations and he thought that the IME physicians were not sympathetic or sensitive to his situation.

Petitioner testified that he is suffering because of constant pain in his low back. The pain radiates down his right hip and leg to his right foot. He has difficulty standing, walking and difficulty sleeping.

Petitioner testified that after the 2013 injury, he had pain on the left side. He did not have pain on the right side after the 2013 injury. After the 2015 injury, he had right sided pain. He currently has pain on both sides.

Petitioner has not received any indemnity benefits from Respondent regarding this claim.

As of the last visit with Dr. Koutsky, on November 12, 2018, surgery was recommended and Petitioner was instructed not to work. Petitioner is receiving SSDI benefits with a date of disability of August 11, 2015. The SSDI award was made in March of 2017 and the monthly benefit is $910.00. (PX 19)

On cross-examination, Petitioner denied that he presented to Chiropractor Barnabas on August 11, 2013 with back pain of 8 going down his right leg, saying the pain was just down his left leg. The Arbitrator observed that when cross-examination began and Petitioner was being asked questions about the 4/3/2013 injury, he answered "Yes" to a question before it had been interpreted. Petitioner had been instructed by the Arbitrator that all questions and answers are to go through the interpreter when he was sworn in.

Petitioner did not recall many of the details of treatment for the 2013 injury. He did not recall exactly when he felt "perfectly fine" after the 2013 surgery. He did file a Workers' Compensation case for the 2013 injury (No. 13 WC 12179), which settled in February of 2015 for $26,000.00. Petitioner was represented by his current attorneys in the 13 WC 12179 case. (RX 13) No doctor had recommended further back surgery before the August 11, 2015 injury.

Respondent presented the testimony of two private investigators, Brian Sotir and Chris Sabal, to provide the foundation for surveillance video discs, which were admitted as Respondent's Exhibits 16 and 17.

RX 16 shows activities of Petitioner on July 19, 2016 and September 24, 2016. He is seen walking with no problems and is able to get up into a Ford Expedition SUV without difficulty. He then walks with a 4-way wrench in his right hand, with a slight limp. Petitioner is next seen at a junk yard leaning into a Dodge Durango which is up on blocks. He bends into the Durango several times, climbs in and crawls across the SUV. He bends into the back seat of a compact car. These activities occurred on July 19th. Petitioner is seen to walk fast and stand for a long period of time at O'Hare Airport on September 24th. He leans on his right leg and jokingly kicks a kid with his left leg. These activities are inconsistent with severe back pain and radiculopathy.

RX 17 shows activities of Petitioner on July 15, 2016, November 6, 2018 and November 10, 2018. On July 15, Petitioner gets into a car smoothly, with no limitations, twice. He walks fine across the street. He then is seen to do yard work for at least 25 minutes, involving bending, reaching, stooping, squatting (and arising with no limitations), trimming and pruning plants. An acquaintance approaches Petitioner from behind and nudges him with no apparent effect (one would not expect such an action if Petitioner was as disabled and in pain as he claims). Petitioner appears to be a little stiff and slow at the end of the video of July 15th, but that is consistent with his age, habitus and prior back surgery. Petitioner is then seen on November 6, 2018 walking with no problems at a quick pace. He buys produce, leaning over a display with all of his weight on his right leg and later walking, carrying a bag of produce over his left shoulder to his car. On November 10, 2018, Petitioner walks a dog and trots along at various times without limitations. These activities are not consistent with a symptomatic low back condition with radiculopathy such that spinal fusion surgery would be appropriate.

Petitioner never returned to work for Respondent. He did work at Pulaski Pizza from January 11, 2016 to February 21, 2016, working 131.08 hours and making $10.00 per hour. (RX 14) Petitioner testified that he had to go back to therapy because the soles of his feet were hurting and he could not walk or stand. When he started at Pulaski, he had 3/10 pain. When he went back to therapy, his pain was 7/10.

Petitioner's Exhibit No. 2 was the Application for Adjustment of Claim in this case, filed on September 23, 2015. It was signed by Petitioner on August 29, 2015 and the response to: "If a prior application was filed for this employee, list the case number and its status" on the form is null.

Medical Records and testimony:

Respondent submitted several exhibits regarding prior medical treatment for Petitioner's low back related to the 2013 injury. The records of Herron Medical Center and Dr. Ravi Barnabas show that Petitioner was first seen

on August 11, 2013. The history was that he felt lower back pain, which he rated at an 8/10, going down his right leg after lifting garbage at work. Upon physical examination, the doctor noted positive straight leg raise test on the right at 30 degrees and negative on the left. The sitting straight leg raise test was also positive on the right at about 45 degrees and negative on the left. The diagnosis was lumbar sprain, lumbago, thoracic or lumbosacral neuritis/radiculitis, and displacement of lumbar intervertebral disc without myelopathy. Due to the weakness on the right side, an MRI was ordered. (RX 10)

Petitioner continued with treatment by Dr. Barnabas and continued right side complaints were noted. On April 23, 2013, Petitioner returned for chiropractic treatment at Herron Medical Center Practice. The straight leg raise test was positive now "in back and leg right greater than left." On May 14, 2013, the straight leg raise test on the right was positive (without reference to test on the left leg). On June 4, 2013, Petitioner complained of worsening left leg symptoms with worsening radiculopathy. (RX 10)

On June 21, 2013, Petitioner was seen by Dr. Sean Salehi at Neurological Surgery & Spine Surgery for an initial consultation for low back pain that radiates to his left leg. Petitioner's complaints were of pain in the low back that shoot down the left posterior leg to the heel. He rated his pain at a 7/10. *Id.* He added that it feels like "someone is cutting his calf with a knife." He also reported numbness in his calf. Dr. Salehi recommended, given the ineffectiveness of physical therapy, that he undergo 1 to 2 transforaminal epidural steroid injections at left L4-5 and L5-S1. (RX 10)

After failed epidural injections and additional chiropractic treatment, on October 7, 2013, Petitioner underwent low back surgery: 1.) left inferior L4 to S1 hemilaminectomy and decompression of lateral recess, 2.) left L4-5, L5-S1 foraminotomy, 3.) with use of intraoperative fluoroscopy, performed by Dr. Salehi. The pre- and post-operative diagnosis was left lumbar radiculopathy and lateral recess stenosis at L4-5 and L5-S1. (RX 9)

Petitioner had a long course of follow-up care with Dr. Salehi. Petitioner's left leg pain had resolved, but he still had back pain. Petitioner underwent therapy, work conditioning and work hardening. On February 14, 2014, the Petitioner underwent a job-specific functional capacity evaluation at Accelerated Rehabilitation Centers. His position prior to the April 3, 2013 accident was a maintenance "dishwasher" for AC Fox Inc. Petitioner did not demonstrate the physical capabilities and tolerances to perform all the essential job functions of a dishwasher. The lifting restrictions per the functional capacity evaluation ranged from 10 pounds to 30 pounds. (RX 11)

Petitioner was last seen by Dr. Salehi on May 22, 2014. The history section related that after Petitioner was released per a functional capacity evaluation, he attended an IME and that doctor recommended additional work conditioning. He had completed 2 weeks of additional work conditioning and stated that he continues to have pain in his back with "any type of bending or twisting motion. He rates the pain at a 4-5/10 for which he is not taking any medication. Petitioner was released to work as a dishwasher at that time, as he was able to meet 100% of the job demands (under medium physical demand). The diagnosis was history of lumbar laminectomy, lumbosacral spondylosis, and lumbar degenerative disc disease. He was to return on an as-needed basis. (RX 9)

Petitioner's first medical treatment regarding the August 11, 2015 injury was with his PCP on August 14, 2015. He presented to Cavero Medical Group and stated that on August 11, 2015, while at work, he was helping a coworker lift some boxes of chicken and when trying to do so he felt pain on his right side. A pain drawing shows the affected area to be the right buttocks and right posterior thigh. Petitioner was taken off work through September 10, 2015. He was prescribed medications, CPM, PT and an x-ray. Petitioner self paid Cavero's $130.00 bill. (PX 13)

Petitioner next began treatment with La Clinica on September 2, 2015. A pain drawing dated September 1, 2015 depicts that he was experiencing pain in the low back, right buttock, right posterior thigh, top of right anterior thigh, right lateral thigh, right lateral shin, and right heel. (PX 17) The initial evaluation from La Clinica is dated September 2, 2015. The history was on a lifting injury working for Respondent on August 11, 2015. The complaints were of low back pain 7-8/10 that refers to the RLE. Petitioner advised that he had back surgery two years before and the lower extremity symptoms were on the left leg at that time. Dr. Aleksandr Goldvekht diagnosed Lumbar spine IVD syndrome, Lumbar spine sprain/strain and Lower extremity radiculitis. He recommended PT, Mobic, Prilosec, Flexeril and Terocin, an MRI and an EMG/NCV. (PX 16)

On September 2, 2015, petitioner started physical therapy treatment at La Clinica administered by "primary provider" Dr. Adrian Zaragoza in the form of unattended electrical muscle stimulation to the lumbar region. On September 3, 2015, the EMG/NCV study was positive for moderately active left S1 radiculopathy. (PX 17, PX 13)

Petitioner underwent physical therapy and chiropractic treatment at La Clnica from September 2015 to December 2017 with treatment comprised primarily of (1) joint mobilization of the lumbar region, (2) unattended electrical muscle stimulation to the lumbar region, and (3) cold or hot packs to the lumbar region. (PX 17)

The September 10, 2015 MRI of the lumbar spine, taken at Archer Open MRI, was said to show a 3-mm broad-based left paracentral protrusion at L4-5, left hemilaminectomy defects from L4-S1 (thecal sac partially extends into the laminectomy defects), and lumbar spondylosis with multilevel disc bulging. (PX 5)

On September 28, 2015, Petitioner presented to La Clinica for physical therapy, stating that he was doing "much better." (PX 17)

On October 12, 2015, Petitioner underwent a L3-4, L4-5 transforaminal epidural steroid injection performed by Dr. Neeraj Jain at APM Surgical Group for lumbar radiculopathy. On December 9, 2015, Petitioner underwent a lumbar epidural steroid injection for lumbar radiculitis at APM Surgical Group. (PX 15)

On December 11, 2015, Petitioner presented to La Clinica, stating that he underwent another injection that Wednesday. He added that he felt pain on the right side after the injection whereas he only felt pain on the left side prior to the same. (PX 17)

On January 14, 2016, Petitioner presented to La Clinica for examination by Dr. Zaragoza. He stated that his low back pain varies depending on his activity. He added that he found a new job which he started that week. He works 28-30 hours per week. He denied any numbness or tingling to his lower extremities and has not taken any medication for about 3 months. Straight leg raise was negative. He was discharged from Dr. Zaragoza's care during that appointment. Dr. Zaragoza opined that he was doing well and may continue with home exercises. He was to return to the clinic if his pain worsened. (PX 17)

On February 16, 2016, Petitioner returned to La Clinica for an examination by Dr. Zaragoza. He stated that his conditioned worsened with standing activities past 4 hours. He related that his pain increased to a 7/10, but had diminished to a 4/10 since he stopped working. Straight leg raise was positive bilaterally. Petitioner was to seek a second opinion from a surgeon. (PX 17)

On February 18, 2016, Petitioner presented to Elmhurst Orthopedics for an initial consultation with an orthopedic surgeon, Dr. Kevin Koutsky. He complained of low back pain radiating down the right lower extremity including some numbness and tingling. Petitioner stated that he underwent a lumbar decompression back in 2013, but was doing well up until August 11, 2015. During his neurological exam, Dr. Koutsky noted decreased pinprick sensation at the plantar aspect of left foot. He also had some decreased pinprick sensation in the dorsolateral border of his right foot. Petitioner also had weakness in his left ankle dorsiflexors and plantar flexors when compared to the right lower extremity. There was a positive left sided straight leg raise test. He also had right-sided paralumbar muscle trigger point with spasm, tenderness and swelling. Dr. Koutsky reviewed an MRI of the lumbar spine taken at Archer Open MRI which showed evidence of generalized protrusions at multiple levels; left-sided laminotomy defects noted at L4-5 and L5-S1 from previous surgery; moderate foraminal stenosis noted both levels; moderate foraminal stenosis and disc protrusion noted at both levels; no evidence of any abnormal enhancement. The EMG/NCV study conducted on September 3, 2015 revealed evidence of acute left S1 radiculopathy. A lumbar discogram revealed evidence of concordant pain after injection at L3-4, L4-5, and L5-S1. The assessment was bilateral L4-5 and L5-S1 radiculopathy, status post decompression, and discogenic pain. Dr. Koutsky noted that the discogram was positive at L3-4, although the disc looked "very good" on the MRI scan. Dr. Koutsky recommended re-exploration, decompression and stabilization with instrumentation at both L4-5 and L5-S1. Dr. Koutsky restricted Petitioner from working. He recommended that the patient see Dr. Geoffrey Dixon for a neurosurgical evaluation prior to surgery. Dr. Koutsky performed a trigger point injection that day comprised of 40 mg of Kenalog into the right paralumbar muscle trigger point, without complication. (PX 7)

On February 23, 2016, Petitioner was seen by Dr. Kenneth Candido for an Independent Medical Examination. (RX 1) Dr. Candido diagnosed Petitioner with resolved lumbar strain, low back pain limited to right sacroiliac joint, and resolved lumbar radicular pain. Dr. Candido opined that the August 11, 2015 accident resulted in "transient exacerbation" of Petitioner's low back pain and his radicular pain conditions superimposed upon a pre-existing history of lumbar spondylosis and lumbar spine decompression surgery. There was no new lumbar disc herniation and no pathology on examination or seen on the contemporaneous MRI of the lumbar spine to indicate a requirement for additional surgery or for ongoing interventional pain management. Petitioner underwent a series of lumbar transforaminal steroid injections by Dr. Jain which resolved the lumbar radicular pain component. The only objective finding was pain in the area anatomically of the right sacroiliac joint. Per Dr. Candido, the FABER test was positive on the right for left-sided SI joint pain, which is atypical. The FABER test on the left was also positive for left sided SI joint pain; however, on examination, the palpation tenderness was right sided, and not left sided. Forward lumbar flexion caused right-sided, and not left-sided SI joint pain. According to Dr. Candido, the subjective complaints were not consistent with the objective findings, and the objective findings are minimal. Dr. Candido placed Petitioner at Maximum Medical Improvement given the contra-lateral FABER test finding for the right-sided sacroiliac joint pain. Petitioner was released to full duty work, as he only had some pain in the right SI joint. (RX 1)

A February 26, 2016 re-evaluation note from La Clinica related that Petitioner had low back pain that radiates to his left leg. There was also a positive straight leg raise test on the left side. (PX 17)

On March 23, 2016, Petitioner followed up with Dr. Koutsky at Elmhurst Orthopedics. He underwent 2 injections of the lumbar spine at La Clinica and was awaiting authorization for a third. Neurosurgeon Dr. Dixon agreed with Dr. Koutsky that Petitioner was a reasonable candidate for lumbar spinal fusion surgery at L4-5 and L5-S1. Petitioner was taking medication on an as-needed basis to control pain. He also stated that the trigger point injections administered during his last office visit with Dr. Koutsky helped to reduce his low back muscular spasms and pain. Dr. Koutsky notes that Petitioner was worked up for a lumbar discogram, as well as

EMG/NCV, which are consistent with the MRI pathology. Dr. Koutsky was seeking authorization for lumbar spinal fusion surgery at L4-5 and L5-S1 wth re-exploration, decompression and stabilization with instrumentation of the lumbar spine at L4-5 and L5-S1. (PX 7)

On March 24, 2016, Petitioner presented to La Clinica for physical therapy rating his low back pain at a 3/10, He added that "most days he has no pain at all." Subsequent visits to La Clinica document 3 or 4/10 pain complaints and complaints regarding left sided pain. (PX 17)

Petitioner also continued to follow up with Dr. Koutsky, intermittently, with largely unchanged complaints and findings and recommendations by the doctor. (PX 8, PX 9)

On July 21, 2016, Petitioner presented for an Independent Medical Evaluation by Dr. Avi Bernstein., an orthopedic surgeon. (RX 3) Upon examination, Dr. Bernstein noted that when Petitioner walked into the exam room he had a "marked antalgic gait." During the exam, when Dr. Bernstein asked Petitioner to walk, he had a "marked antalgic gait with severe pain guarding maneuvers." Petitioner protected his right leg "substantially" during the evaluation. With distraction maneuvers, his straight leg raise was completely negative. He had a normal motor strength and normal sensation in the lower extremities. After the examination, Dr. Bernstein reviewed video surveillance, which showed Petitioner "performing a variety of physical activities without any pain guarding whatsoever." Dr. Bernstein noted that Petitioner seemed to be walking normally without evidence of an antalgic gait. Dr. Bernstein noted that he was working in a yard on some plants in a stooped over position without any difficulty or pain guarding. He seemed to bend fully to the knees and bend fully at the waist again without any pain guarding per Dr. Bernstein. Dr. Bernstein thought that Petitioner was functioning normally. He added that Petitioner is seen entering and leaving a car, and driving, and later walking for prolonged distance without any evidence of pain guarding behaviors." Dr. Bernstein opined that Petitioner's objective findings do not support his subjective complaints. There was evidence of symptom magnification exaggeration. Dr. Bernstein went so far as to say that Petitioner was "exaggerating for the purposes of secondary gain." He opined that Petitioner is capable of working full duty work without restrictions. The MRI scan, per Dr. Bernstein, failed to identify any pathology that would explain severe right lower extremity radiculopathy. Furthermore, he noted that the EMG study identified only left-sided findings, likely related to the prior surgery he had years earlier. (RX 3)

On October 30, 2017, Dr. Nakul Mahajan from Prium (URAC accredited workers' compensation utilization management) issued a Utilization Review report addressing the reasonableness and necessity of physical therapy at La Clinica from August 21, 2015 through January 17, 2017. Dr. Mahajan found that 10 physical therapy visits and 6 chiropractic treatment visits were reasonable and necessary. (RX 5)

On November 8, 2017, Thomas Sato, DC, from Prium (URAC accredited workers' compensation utilization management) issued a Utilization Review report for physical therapy and chiropractic treatment at La Clinica from January 18, 2017 through September 18, 2017. He agreed with Dr. Mahajan's conclusion in certifying 10 physical therapy visits as well as 6 chiropractic treatment sessions, which had already been exhausted. (RX 7)

On December 8, 2017, Petitioner presented to La Clinica for consultation. Petitioner continued to experience persistent pain. At that time, Petitioner wished to hold off on treatment until he followed up with an orthopedic spine specialist. He continued to perform home exercise on a daily basis. (PX 17)

As of June 18, 2018, Dr. Koutsky charted that Petitioner was at MMI, in the absence of the fusion surgery. (PX 9) Petitioner was last seen by Dr. Koutsky on November 12, 2018. The patient was said to have been off work because of the disabling pain. He was neurologically unchanged. Dr. Koutsky continued to recommend re-

exploration, decompression and stabilization at L4-5 and L5-S1. Petitioner was authorized off work. No medications were refilled. They were awaiting the December 2018 hearing with the Arbitrator. (PX 23)

Respondent submitted the Evidence Depositions of Dr. Candido (RX 2), Dr. Bernstein (Rx 4), Dr. Mahajan (RX 6) and Dr. Sato, D.C. (RX 8).

Dr. Candido is Board Certified in Anesthesiology, with added qualifications in pain medicine. The physical exam ruled out radiculopathy. Petitioner was in no need of further treatment from a pain management standpoint. The MRI did not show any acute condition that would require surgery. Petitioner was at MMI and needed no further treatment. He could return to work at full duty. Dr. Candido agrees with Dr. Bernstein's report. The patient's subjective complaints were asynchronous to the objective findings (which were minimal). Dr. Candido disagreed with Dr. Koutsky's recommendation for a fusion and noted that the results of the neurologic exams by Dr. Koutsky and him were dramatically different. Dr. Candido had photographic evidence of the benign findings regarding his examination of Petitioner. As of 2/23/2016, there was no evidence of a lumbar strain, ergo, it has resolved. Dr. Candido thought that the treatment up to Dr. Jain's September, 2015 injection was reasonable and necessary. He could not comment on other treatment. He could not comment on work restrictions before 2/23/2016. The injury resulted in maybe a transient exacerbation of low back pain and radicular pain, but that had resolved, possibly due to the injection that Dr. Jain did. (RX 2)

Dr. Bernstein is a Board Certified Orthopedic Surgeon, fellowship trained in spinal surgery. Dr. Bernstein testified that there was no objective evidence to support Petitioner's complaints of right lower extremity pain or right lower extremity sciatica. There was nothing objective that would prevent Petitioner from doing his normal work activities. Petitioner's veracity was in question based on inconsistencies. He exhibited symptom magnification, which could be referred pain from the prior surgery, but Dr. Bernstein does not believe so. The videos that Dr. Bernstein saw were substantially different than the patient's physical presentation. They were distinctly and dramatically different. The video demonstrates a behavior and comfort level contrary to the patient's presentation at the exam. It is inconceivable to Dr. Bernstein that Petitioner has a real problem in his spine and needs surgery. Dr. Bernstein does think that Petitioner is a faker. (RX 4)

Dr. Mahajan testified in accordance with his report. He relied on ODG guidelines in certifying 10 PT visits and 6 chiropractic visits. He conceded that the treating doctor's opinion on diagnosis and prognosis may be closer to reality than that of an examining doctor. (RX 6)

Dr. Sato testified that he is a chiropractor, certified in many states. He is employed by Prium full time to review records. He would not certify any treatment for Petitioner for the time period of 1/18/2017 to 9/18/2017. It is not medically necessary and not reasonable and necessary. There should be some treatment for the acute phase and some treatment for chronic issues, but this treatment went on for years with no improvement for the patient. Continued treatment without improvement is a bad thing. It fosters physician dependency and illness behavior. (RX 8)

Petitioner's Exhibit 10 was a letter from Hartford UR, dated September 2, 2016, authorizing a total of 18 PT visits. Petitioner's Exhibit 21 was Petitioner's claimed medical bills, totaling $139, 725.73, said to include $95,200.00 in chiropractor bills for services from La Clinica.

20IWCC0420

CONCLUSIONS OF LAW

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

Section 1(b)3(d) of the Act provides that, in order to obtain compensation under the Act, the employee bears the burden of showing, by a preponderance of the evidence, that he or she has sustained accidental injuries arising out of and in the course of the employment. 820 ILCS 305/1(b)3(d).

To obtain compensation under the Act, Petitioner has the burden of proving, by a preponderance of the evidence, all of the elements of his claim (O'Dette v. Industrial Commission, 79 Ill, 2d 249, 253 (1980)), including that there is some causal relationship between his employment and the injury. Caterpillar Tractor Co. v. Industrial Commission, 129 Ill. 2d 52, 63 (1989)

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

Petitioner's testimony is found to be not credible. This finding is first based upon Petitioner's demeanor and testimony at trial. Second, his attempt to influence his case by saying he had only left sided problems after the 2013 injury and right sided problems after the 2015 injury is not supported by the medical exhibits (PX 7, 8, 9, 16, 17, RX 1, 2, 3, 4, 9). Petitioner's complaints to physicians and testimony regarding pain complaints and limitations is inconsistent and is fatally weakened by the video evidence, the medical records and the persuasive and credible testimony of Drs. Candido and Bernstein.

WITH RESPECT TO ISSUE (F), IS PETITIONER'S PRESENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS:

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

The Arbitrator finds that the injury of August 11, 2015 resulted in a transient exacerbation of low back pain and radicular pain that resolved by February 23, 2016. The causally related condition of ill-being is: 1.) Lumbar strain, resolved; 2.) Lumbar radicular pain-resolved; 3.) Low back pain limited to atypical right sacroiliac pain, at MMI as of 2/23/2016. The Arbitrator relies upon his finding above regarding Petitioner's credibility, the medical records, the video evidence, and the persuasive and credible opinions of Drs. Bernstein and Candido.

Petitioner relies upon Petitioner's testimony and the treating medical records to support causation on a chain of events theory. First, Petitioner's testimony is not credible. Second, the treating records do not support causation in this case, as they rely upon the subjective statements of disability and pain given by Petitioner, which are found to be not credible.

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

The Arbitrator relies upon the finding above regarding the credibility of Petitioner and the opinions of Dr. Candido in awarding medical expenses, along with the UR opinion of Dr. Mahajan and the letter from Hartford UR.

Dr. Candido found Petitioner to be at MMI as of February 23, 2016. Dr. Mahajan's retrospective UR opinion was that 6 chiropractic treatments and 6 PT visits were medically necessary. Hartford advised that they had approved 18 PT visits as on September 2, 2016.

The treatment rendered by Dr. Koutsky is found to be not causally related to the injury, given the dramatically different physical exam results between Koutsky's examination of Petitioner on 2/18/2016 and Candido's examination of Petitioner on 2/23/2016. The Arbitrator has found Dr. Candido's opinions to be credible and persuasive and, therefore, declines to endorse any treatment by Dr. Koutsky to be causally related to the injury and to be reasonable and necessary to cure or relieve the effects of the injury.

Accordingly, the following bills are awarded:

Archer Open MRI (Dos: 9/10/2015):	**$2,530.00**
Specialized Radiology Consit (Dos: 9/20/2015):	**55.00**
RM Anesthesia LLC (Dos: 10/12/2015 and 12/09/2015):	**2,290.00**
APM Surgical Group LTD (Dos: 10/12/2015 and 12/09/2015):	**9,200.00**
Radiology Imaging Specialists (Dos: 8/25/2015):	**145.00**
Little Company of Mary Hospital (Dos: 8/25/2015):	**327.87**
Cavero Medical Group (Dos: 8/14-8/21/2015):	**130.00**
Argus Medical Supply (Dos: 10/13/2015-12/19/2015):	**13,700.00**
La Clinica (Dos: 9/1/2015-10/18/2015 [EMG/NCV, 5 chiropractic visits, 18 PT sessions] and 10/27/2015 chiropractic follow-up):	**14,025.00**
TOTAL:	**$42,402.87**

The award of medical expenses is made pursuant to §§8(a) and 8.2 of the Act.

The following claimed bills are denied:

DOCRX - based upon the Arbitrator's finding regarding causation.

Consolidated Pathology – No supporting medical records, no showing that service is causally related.

Ashland Medical Specialist – No date of service, no explanation of service.

Elmhurst Orthopaedics SC – Based upon the finding regarding causation, and as is explained above.

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

Petitioner's claim for prospective medical care is denied, based upon the Arbitrator's finding above regarding causation.

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

Petitioner is entitled to TTD benefits from August 14, 2015 (when he was taken off work by his PCP on 8/14/2015) through January 10, 2016 (Petitioner began working at Pulaski Pizza on 1/11/2016), a period of 21-2/7 weeks.

Petitioner's claim for TPD is denied. There was a failure of proof as to whether TPD would be appropriate under §8(a) of the Act.

All claimed TTD after February 22, 2016 is denied based upon the Arbitrator's finding regarding causation and the opinions of Dr. Candido.

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

Darrin Barton,

Petitioner,

vs. NO: 17 WC 6447

SOI/Illinois Youth Center—Harrisburg, 20IWCC0418

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Petitioner and Respondent herein and notice given to all parties, the Commission, after considering the issue of nature and extent, and being advised of the facts and law, partially modifies the Section 8.1b analysis in the Decision of the Arbitrator and also corrects certain scrivener's errors. The Commission otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

In the interest of efficiency, the Commission relies on the Arbitrator's detailed recitation of facts. After carefully considering the evidence, the Commission agrees with the Arbitrator's conclusion that Petitioner sustained a 20% loss of use of the whole person pursuant to Section 8(d)2 of the Act. However, the Commission partially modifies the Section 8.1b analysis.

In his examination of the third factor of the Section 8.1b analysis, the Arbitrator wrote, "There is no evidence offered to indicate with any degree of likelihood how petitioner's age would impact his disability. Accordingly, the Arbitrator places no weight on this factor." The Commission hereby strikes those two sentences. Dr. Davis testified that age can affect healing. He further testified that he did not believe Petitioner's age precludes a good opportunity to heal. After considering the evidence, the Commission assigns some weight to this factor.

The Arbitrator did not include an examination of the fourth factor of the Section 8.1b analysis regarding Petitioner's future earning capacity. A review of the credible evidence shows Petitioner voluntarily retired from his employment effective December 31, 2017, prior to his doctor prescribing permanent work restrictions. As Petitioner voluntarily retired, the Commission assigns no weight to this factor.

20 IWCC0418

The Commission also corrects certain scrivener's errors. On the Arbitration Decision Form, the Arbitrator mistakenly wrote that Respondent shall pay permanent partial disability benefits for injuries to the **right shoulder**, as provided in Sections 8(d)2 of the Act. On page three (3) of the Decision, the Arbitrator mistakenly wrote that on August 22, 2017, Dr. Davis gave light duty restrictions of no **right** upper extremity work. On page eight (8) of the Decision, the Arbitrator references the fifth factor regarding the evidence of disability pursuant to Section 8.1(b) as **factor (iv)**. The Commission thus modifies the above-referenced sentences to read as follows:

> Respondent shall pay Petitioner permanent partial disability benefits of $790.64 for 100 weeks for 20% of a person as a whole, for injuries to the **left shoulder**, as provided in Sections 8(d)2 of the Act. (Decision Form)
>
> On August 22, 2017, Dr. Davis gave petitioner light duty restrictions of no **left** upper extremity work, and no inmate contact effective 8/23/17. (pg. 3 of the Decision)
>
> In regard to **factor (v)**, evidence of disability corroborated by treating medical records, the Arbitrator notes that petitioner sustained injuries predominantly to his left shoulder in the accident. (pg. 8 of the Decision)

Finally, on page four (4) of the Decision, the Arbitrator wrote, "**On December 31, 2019.** Petitioner voluntarily retired effective 12/31/2017 after respondent no longer accommodated his modified light duty restrictions. The Commission strikes the sentence fragment, "On December 31, 2019." from the Decision.

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 January 15, 2020, is modified as stated herein.

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

DATED: JUL 24 2020
d: 7/14/20
TJT/jds
51

Thomas J. Tyrrell

Maria E. Portela

Kathryn A. Doerries

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BARTON, DARRIN
Employee/Petitioner

Case# **17WC006447**

SOI/ILLINOIS YOUTH CENTER-HARRISBURG
Employer/Respondent

20IWCC0418

On 12/27/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 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:

0536 RON D COFFEL & ASSOC
502 W PUBLIC SQ
PO BOX 366
BENTON, IL 62812

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

0558 ASSISTANT ATTORNEY GENERAL
AARON WRIGHT
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

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

DEC 27 2019

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

20IWCC0418

STATE OF ILLINOIS)
)SS.
COUNTY OF WILLIAMSON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

Darrin Barton
Employee/Petitioner

v.

SOI/ Illinois Youth Center-Harrisburg
Employer/Respondent

Case # **17** WC **006447**

Consolidated cases: **N/A**

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Herrin**, on **November 20th, 2017.** By stipulation, the parties agree:

On the date of accident, **2/8/17**, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned **$95,712.00**, and the average weekly wage was **$1840.62.**

At the time of injury, Petitioner was **49** years of age, **married,** with **1** dependent children.

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

Respondent shall be given a credit for 0 Paid, $ for all paid extended benefits paid, 2/8/17-5/30/17, 8/10/17-8/22/17, 11/22/17-12/31/17. **$0** for TPD, **$0** for maintenance, and, for a total credit of **ANY PAID .**

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $790.64 for 100 weeks for 20% of a Person as a whole, for injuries to the Right shoulder, as provided in Sections 8(d)2 of the Act.

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

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

Carl Lee 12/18/19

Signature of Arbitrator Date

DEC 27 2019

FINDINGS OF FACT

A full hearing was held in this matter. The sole issue was nature and extent of the injuries to the Petitioner.

Mr. Merriman works at the Vienna Correctional Center. The Parties stipulated Petitioner suffered an accidental injury in the course of his employment. The Petitioner testified he had to break up a fight between two inmates in a walk in cooler. In the process he injured his right shoulder, back and right hand. At trial he testified his right hand was fine. He did state that he had a prior spinal fusion to the lower back in 2010.

Petitioner initially presented to Rural Health Clinic in Anna, Illinois with complaints of right shoulder pain, low middle back pain and intermittent numbness. An MRI of the lumbar spine was conducted on 6/10/15 indicating there might be finding suggestive of fracture of the S1 screws bilaterally but it could have been due to MR artifact. There was moderate foraminal narrowing at L3/L4 on the left and L4/L5 bilaterally. An MRI of the right shoulder was also conducted with findings of moderate supraspinatus and mild to moderate subscapularis tendinopathy, no tear. Additionally, there was mild to moderate osteoarthritis of the acromioclavicular joint.

Eventually Petitioner was seen by Dr. Mall of Regeneration Orthopedics. His initial consult was on 7/24/15 with for evaluation of his right shoulder and lumbar spine. Dr. Mall's assessment was of a right shoulder superior labral tear and AC joint sprain. He reviewed the MRI of the right shoulder and gave the opinion that while it was of poor quality, there was a superior labral tear. Dr. Mall performed diagnostic and therapeutic injections into the AC joint and glenohumeral joint which gave the Petitioner almost 100% relief in symptoms and pain. Mr. Merriman returned on 8/21/16 reporting the injection had given him almost 100% relief for approximately a week and then his pain had slowly returned. At that time Dr. Mall recommended shoulder arthroscopy.

Mr. Merriman returned on 10/16/15 with continued complaints of right shoulder pain with instability. Dr.Mall recommended physical therapy but continued to recommend right shoulder arthroscopy and superior labral debridement with biceps tenodesis. He returned on 11/20/15 with complaints at which time Dr. Mall referred him to Dr. Gornet for his lumbar spine issues.

Mr. Merriman presented to Dr. Gornet on 2/11/16 with chief complaints to his central low back, pain to the right buttocks, right hip and right leg to his foot with numbness and tingling. Petitioner readily admitted a history of low back pain with a previous fusion. Dr. Gornet recommended an MRI and performed a transforaminal injection at right L4-5. He returned on 3/24/16; Dr. Gornet's working diagnosis was annular tear at L4-5 with aggravation of his facet condition at L3-4, L4-5. He reported a good result from the previous injection. He returned a couple of more times and on 5/19/16 Dr. Gornet opined he may require further rhizotomies and or surgery. He then returned on 8/29/16 and was placed at MMI, full duty with no restrictions on 8/29/16.

Surgery to the right shoulder was conducted on 12/17/15 consisting of arthroscopic debridement of the superior labrum and anterior supraspinatus, subacromial decompression and acromioplasty. Additionally, an open AC joint resection and open biceps tenodesis was conducted.

The Petitioner returned on 12/29/16 for his first post-operative visit. Dr. Mall noted his incisions were healing nicely and that he was doing well with minimal complaints. He recommended physical therapy. On 3/8/16 Dr. Mall reported Mr. Merriman was doing extremely well, was basically pain free and doing most

activities. Moreover, he has full range of motion compared to his left shoulder. He releases him at MMI with no restrictions and he could return to work full duty with regard to his right shoulder.

At trial Mr. Merriman testified his surgery and therapy improved his condition. He testified he was able to return to work full duty. Furthermore; he stated none of his work duties are currently limited. He does have decreasing strength in his right arm but it is getting better with time. He also has a little bit of leg numbness and tingling with regard to his back. He is able to work overtime now. Additionally his range of motion in his right arm is good.

CONCLUSIONS OF LAW

Respondent shall pay Petitioner permanent partial disability benefits of $790.64 for 100 weeks for 20% of a Person as a whole, for injuries to the Right shoulder, as provided in Sections 8(d)2 of the Act.

In determining the level of permanent partial disability, the Commission shall base its determination on the following factors: (i) the reported level of impairment pursuant to subsection (a); (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability; corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order." 820 ILCS 305/8.1b(b).

(i) Impairment Rating: The Arbitrator notes that no AMA rating has been offered in this case. Therefore, the Arbitrator gives no weight to this factor.

(ii) Occupation: Petitioner continues to be employed as a Correctional Officer for Respondent. The Arbitrator notes the physical nature of Petitioner's job and the Arbitrator gives greater weight to this factor.

(iii) Age: At the time of accident Petitioner was 47 years old. Given the age of the Petitioner it is without doubt the healing process will progress well.

(iv) Earning Capacity: There is no evidence that Petitioner's future earning's capacity has been affected. The Petitioner is able to work full duty and perform his duties.

(v) Disability: As a result of his accidental injury, Petitioner sustained a tear to the right shoulder which was surgically repaired and an injury to his lower spine. He was able to return to work full duty.

Based on the five factors enumerated above, the Arbitrator finds that Petitioner suffered an injury resulting in the 20% loss Person as a whole for injuries to the right shoulder.

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

Tiana Shorter,

Petitioner,

vs. NO: 19 WC 3285

University of Illinois Extension,

Respondent.

20IWCC0421

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by both the Respondent and Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, temporary total disability, prospective medical care, and penalties and fees, and being advised of the facts and law, changes the Decision of the Arbitrator as stated below, but otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. 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 (1980).

The Commission adopts the findings of fact as presented in the Arbitrator's Decision. The Commission also affirms and adopts the conclusions of law in the underlying Decision as related to the issues of accident, causal connection, prospective medical care and penalties and fees. However, the Commission notes a typographical error in the award of temporary total disability benefits. The Arbitrator awarded temporary total disability benefits from February 1, 2019 through February 12, 2019, and again from February 13, 2019 through April 22, 2019, a period of 11 and 3/7ths weeks. The record reflects that Petitioner was taken off work from February 1, 2019 through February 12, 2019, but was released to restricted duty and worked on February 13, 2019. Subsequent to this date, Respondent no longer accommodated Petitioner's restrictions. As Petitioner did work on February 13, 2019, the Commission notes that the latter temporary disability period should begin on February 14, 2019 extending through April 22,

2019. The Commission hereby corrects this error accordingly, and all else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's Decision dated July 22, 2019 is affirmed with changes as stated herein.

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

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

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

Pursuant to section 19(f)(1) of the Act, claims against the State of Illinois are not subject to judicial review. Therefore, no appeal bond is set in this case.

DATED: JUL 28 2020
O: 6/18/20
BNF/wde
45

Barbara N. Flores

Deborah L. Simpson

Marc Parker

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

SHORTER, TIANA
Employee/Petitioner

Case# **19WC003285**

UNIVERSITY OF ILLINOIS EXTENSION
Employer/Respondent

20IWCC0421

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

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

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

0154 KROL BONGIORNO & GIVEN LTD
MIKE BRANDENBERG
20 S CLARK ST SUITE 1820
CHICAGO, IL 60603

6205 HEYL ROYSTER VOELKER & ALLEN
BRAD A ANTONACCI
33 N DEARBORN ST 7TH FL
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Tiana Shorter
Employee/Petitioner

v.

University of Illinois Extension
Employer/Respondent

Case # **19** WC **03285**

Consolidated cases: **N/A**

20IWCC0421

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Brian T. Cronin**, Arbitrator of the Commission, in the city of **Chicago**, on **4/22/19**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ 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 _____

20IWCC0421

FINDINGS

On the date of accident, **1/22/19**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**27,359.80**; the average weekly wage was $**526.15**.

On the date of accident, Petitioner was **34** years of age, ***single*** with **2** dependent children.

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.

By stipulation of the parties, the issue of unpaid medical bills is to be determined at a later hearing. AX 1.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $**350.77**/week from **2/1/19** through **2/12/19** and from **2/13/19** through **4/22/19**, which represents a total of **11-3/7** weeks, because Petitioner was temporarily totally disabled during these periods, in accordance with Section 8(b) of the Act.

Respondent shall authorize and pay for the prospective medical care recommended by Dr. Amir El Shami for Petitioner on 3/21/19, pursuant to Section 8(a) and subject to Section 8.2 of the Act.

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

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

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

Signature of Arbitrator

7/21/19
Date

ICArbDec19(b)

JUL 22 2019

STATE OF ILLINOIS)
)
COUNTY OF COOK)

20IWCC0421

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Tiana Shorter
Employee/Petitioner

v. Case No. 19 WC 03285

University of Illinois Extension
Employer/Respondent

ATTACHMENT TO ARBITRATION DECISION

Findings of Fact:

At the time of accident, Tiana Shorter ("Petitioner") was a 34-year-old work program participant for the University of Illinois Extension's ("Respondent's") nutrition education program. Her job duties included traveling to different locations in the City of Chicago to present food demonstrations and cooking education to communities. Depending on her schedule, she would go to two or three presentations per day each week.

On January 22, 2019, she was scheduled to make a presentation at a location in Union Park at 5:00 PM. Prior to that presentation, she went to the office at 1140 N Lamont Ave in Chicago where she worked for Respondent on the second floor. As she left that office to go to the appointment, she slipped on a patch of ice on the entryway directly outside of the front entrance to the building. The ice was located directly between the doorway and the car she was walking toward. At the time she fell, Petitioner was carrying a bag of groceries that weighed ten to thirty pounds. She takes groceries and a supply kit from that office with her to the demonstrations that she presents. She also keeps some supplies for the presentations in her vehicle.

At the time she fell, Petitioner was walking to her car in the only parking lot in front of the office building. She did not always park in the same spot, but she always parked in that parking lot when she went into work at the office. She always exited the office through that same

door and used that walkway to reach her car. She always took her own car to reach the different locations where she would make presentations.

When she fell, Petitioner landed on her right side, hip, and knee. She felt pain in her low back, right hip, right knee, and right ankle. After the fall, she continued to the Union Park site to give the presentation and noticed increasing pain and difficulty standing. She reported the accident to her secretary that same day. The following day she reported the accident to her supervisor and sought care at University of Illinois Urgent Care.

On January 23, 2019, Petitioner was examined at University of Illinois Chicago ("UIC") Urgent Care, where she reported a fall onto her right side the day before and injuries to her right ankle, right knee, and low back. The diagnosis was accidental fall with acute right hip and right knee pain. She was allowed to return to work. PX1.

On January 25, 2019, Petitioner was examined by Dr. Jessica Richardson at UIC Hospital. Petitioner reported that ice and medications were not helping her pain. She reported shooting pain in her lower back and needles in her right leg. Upon examination, Petitioner exhibited tenderness to palpation in the paraspinal muscles of the lumbar and thoracic spine. The diagnosis was intractable neuropathic pain of right leg. Dr. Richardson recommended a course of physical therapy. PX1.

On February 1, 2019, Petitioner followed up with UIC Urgent Care. She exhibited positive straight leg raise and tenderness in the lower back. She was advised to continue with physical therapy, was given an ace wrap for her right knee, and was instructed to remain off work. PX1.

On February 2, 2019, Petitioner began physical therapy at UIC. PX1.

On February 5, 2019, Petitioner was examined by Dr. Christine Neeb at UIC. The diagnoses were pain in the right side, lower back, right leg, and right hip after fall. Dr. Neeb recommended that Petitioner continue physical therapy and remain off of work until February 13, 2019, at which time she could return to work with restrictions of taking frequent breaks due to neuropathic pain from the fall. PX1.

On February 8, 2019, Dr. Hector Robles of UIC examined her right knee. He found mild tenderness, restricted motion and pain. Dr. Robles referred her for an initial consultation with the pain clinic. PX1.

Petitioner testified that on February 13, 2019, she tried returning to work for one day but left early due to increased pain. She testified that she was already scheduled to leave early that day - at 2:00. After that date, Respondent no longer accommodated her restrictions.

On February 21, 2019, Petitioner followed up at UIC for pain in her right knee that she rated 10/10. She indicated that the right hip pain and low back pain had resolved. She was instructed to continue physical therapy and remain off of work until February 28, 2019, at which time she could return with restrictions of no standing over ten minutes, no lifting, and no pushing or pulling. She was referred to an orthopedic specialist. PX1.

On February 28, 2019, Petitioner was examined by Dr. Amir El Shami at UIC Sports Medicine. Her right knee exhibited some mild swelling and she had positive straight leg raise on the right and limited range of motion in the lower back. The diagnoses were right lower extremity strain with concern for possible lumbar radiculitis and meniscal pathology in the right knee. He recommended that she continue therapy and undergo an MRI of her right knee. He also recommended that have x-rays taken of her lumbar spine and pelvis. Dr. El Shami restricted her to limited walking and no lifting of heavy objects. PX2.

On March 14, 2019, Petitioner underwent an MRI of her right knee. PX2.

On March 21, 2019, Petitioner was reexamined by Dr. Amir El Shami. She reported having a lot of pain in her right lower back that radiates down her right lower extremity to her ankle. She also reported that she is pregnant. Her right knee exhibited some mild swelling and tenderness and she had positive straight leg raise on the right. The MRI of the right knee showed some mild soft tissue swelling anteriorly, but was otherwise unremarkable. The diagnoses were right knee strain with mild soft tissue edema and associated lumbar radiculitis. Dr. El Shami recommended that Petitioner continue therapy and restrictions of no lifting over ten pounds and no prolonged standing or walking. PX2.

On April 10, 2019, at the request of Respondent and pursuant to Section 12 of the Act, Petitioner presented to Dr. David Fetter. Upon examining Petitioner, he found that her lumbar spine exhibited reported tenderness of the right lower lumbar paravertebral and right buttocks area with no paravertebral muscle tightness to palpation of the lumbar spine. She reported low back pain at forty-five degrees on right straight leg raise in a supine position. Dr. Fetter considered that to be non-physiologic since she had a negative SLR on the right in a sitting position. Dr. Fetter found that she was positive for 4 out of 5 Waddell's signs. Her right leg exhibited tenderness at the medial joint line and infrapatellar, and she reported discomfort at the right medial heel. Dr. Fetter's diagnoses were right knee contusion and lumbar strain. He opined that she sustained those conditions from the accident but they had resolved and she was at MMI. He stated that she could return to her regular work without restrictions. He found that her subjective complaints exceeded the objective findings. Dr. Fetter opined Petitioner's treatment to that point had been reasonable. RX1.

Petitioner testified that she wants to undergo the treatment recommended by Dr. El Shami because she still has pain in her back and right knee. She has not been able to return to work since February 13, 2019. She has up and down days with her symptoms, but feels pain in her back most days. Her pain increases after standing in one spot for over ten minutes and walking for over twenty to thirty minutes. She does not have the stamina she used to and has to take sitting breaks. With increased activities, she gets increased, burning pain in her back, right buttock, and right leg. She is much more cautious with lifting anything. She has difficulty in a grocery store. Petitioner stood up from her seat during testimony due to discomfort.

On cross-examination, Petitioner agreed that the parking lot and office building were open to the public and other lessees in the building. After her post-accident cooking presentation on January 22, 2019, she did not have to load any items back into her car since they were all used at the presentation. Sometimes she would have items to load back into the car, but many times she did not because the items were either cooked or left at the location. Petitioner did not seek treatment until the following day because she thought she could work through the injury and just treat it with ice and Ibuprofen.

When shown clips of the video surveillance entered as Respondent's Exhibit 3, Petitioner testified that she did not hold onto a railing when she walked down the stairwell to her garden

apartment because there was no railing and the wall was too low for her to hold on to. If she were to lean on the wall, she would be putting a strain on her injury. She testified that the purse she carried in the video weighed about three pounds and held her keys, wallet, and prescription medication. With regard to another video clip, she agreed that she got her hair cut at Dynasties' Hair Creations but that she took breaks during the styling appointment.

Petitioner testified that she was about two months into a pregnancy. She did not become aware of her pregnancy until about the second week of March. She agreed that on February 13, 2019, she was mostly doing office work and not any field work. The sitting aggravated her back pain.

Respondent called Sherri Ambrose ("Ambrose") as its witness at the time of hearing. She has been employed for seven years by Respondent to oversee implementation of their nutrition education program. It is a federally-funded program to provide communities with demonstrations and classes regarding cooking and healthy foods. She identified Respondent's Exhibit 2 as an accurate description of Petitioner's job description, including the physical demands of lifting up to forty pounds. The lifting is needed for groceries, cooking utensils, and food models. Employees used carts to transport those materials to their cars from the office and from their cars to the presentation sites. The carts used were property of Respondent and were stored in employee's cars or at the office at 1140 Lamont Avenue. Ambrose testified that a work program participant spends 20% of her time in office versus out in the field. While in the office, a work program participant would perform sedentary work.

Ambrose testified that Petitioner made her aware that she was coming back to work on February 13, 2019, but that she also had an appointment for part of that day. When Petitioner returned to work on February 13, 2019, she was there for a couple of hours doing paperwork, then she informed the office secretary that she was in pain and left. Ambrose thought that Petitioner had been released to full-duty work on that date.

Ambrose agreed that Petitioner reported the accident. She testified that Petitioner had applied for reasonable accommodation with the Office of Equity and Access. Ambrose did not receive notice of the application until the beginning of April, but she did not have direct

knowledge of Petitioner's communications with that office. She agreed that Petitioner had applied for FMLA prior to April.

Ambrose testified that Respondent did not own or maintain the office building or parking lot. She indicated that the general public had access to the lot, walkway, and office building.

Conclusions of Law:

In support of his decision with regard to issue (C) "Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?", the Arbitrator finds as follows:

The Arbitrator finds that Petitioner's injury occurred in the course of her employment because she slipped and fell on the patch of ice while on the clock and en route to a presentation scheduled by Respondent. Petitioner further testified that she always used her car to travel to these presentations and that her car was always parked in the same lot.

Petitioner was leaving the office at 1140 Lamont Avenue where she worked for Respondent in order to make a presentation in Union Park. She was walking to her car with a bag of groceries in her hands for the presentation when she slipped on a patch of ice and fell onto her right side. She always took her own car to the presentations and would bring materials from that office, or store some of the presentation materials in that car. She always parked in that same parking lot and always exited the building through that same door and entryway. There was no dispute that the activity Petitioner was engaged in at the time of the accident was part of her job duties, including the carrying of groceries out of that office building. It was also not disputed that Respondent's employees would park in that lot and use the exit Petitioner described to reach their cars. Respondent's witness testified that she parked in that same lot herself.

The Arbitrator further finds that her injury arose out of her employment by Respondent as Petitioner was a traveling employee at the time of the accident.

The Illinois Supreme Court has stated that the test for determining whether an injury to a traveling employee arose out of and in the course of his employment is the reasonableness of the conduct in which he was engaged and whether it might normally be anticipated or foreseen by the employer. *Wexler & Co. v. Indus. Comm'n*, 52 Ill. 2d 506, 510, 288 N.E.2d 420 (1972)

Sherri Ambrose confirmed that at the time of the accident, Petitioner was engaged in an activity that was part of her job duties and was injured in a location that was regularly used by employees to park their cars, which they use to travel to work and carry materials for their presentations. There is no dispute that Petitioner's actions were reasonable and foreseeable. She was injured when she slipped on a patch of ice, which is a hazard on the property she had to traverse in order to complete her job duties. Therefore, her accident was incidental to her employment and arose out of and in the course of her employment.

In *Nee v. Illinois Workers' Comp. Comm'n*, 28 N.E.3d 961, 390 Ill. Dec. 308 (1st Dist. 2015), the Appellate Court concluded: "Having been exposed to the risk of traversing a curb to a greater degree than a member of the general public by virtue of his status as a traveling employee at the time of his accident, the injury which the claimant suffered when he tripped over the curb was sustained not only in the course of his employment, it also arose out of his employment with the City."

Petitioner and Sherri Ambrose both testified as to the frequency with which Petitioner was "out in the field."

Petitioner testified to the following:

Q: When you previously testified that as part of your job duties, you would have to go make these presentations at different locations. On a given week on average, about how many different times were you going out to these locations?

A: Anywhere between once or twice. I am sorry. Do you mean to particular places or any various places?

Q: To any of the locations that you were being sent as part of your job, about how many times each week?

A: It varied. It depends on the needs of the sites. But I generally will go out two to three times a day per week. (Trans. 23)

Sherri Ambrose testified to the following:

Q: Now, a work program participant works in the office as well; is that correct?

A: Yes. The record, there are recordkeeping duties. So all of the programs that are implemented out in the community, there are, you know, attendance sheets, surveys, paperwork that has to be completed to document those programs. So that type of work would be done in the office.

Q: Based on a percentage, how much time would you say a work program participant spends in the office versus out in the field?

A: So maybe in the office up to 20% of the time. That would be kind of a maximum. They also might be making phone calls or writing e-mails, confirming the times of their programs or doing outreach to new programs. That also could be happening in the office. (Trans. 56)

The Arbitrator finds that Petitioner was a traveling employee, and as such, she was exposed to the risk of slipping on a patch of ice and falling to a greater degree than a member of the general public.

In support of his decision with regard to issues (F) "Is Petitioner's current condition of ill-being causally related to the injury?" and (K) "Is Petitioner entitled to any prospective medical care?", the Arbitrator finds as follows:

Petitioner testified that, prior to the accident on January 22, 2019, she was not having any problems with her right leg or low back. After she fell onto her right side, she noticed increasing pain in her right ankle, right knee, right hip, and low back. The treating records support that history. She has undergone treatment at UIC from January 23, 2019 through the date of the hearing. PX1, PX2.

On March 21, 2019, Dr. El Shami diagnosed her with a right knee strain with mild soft tissue edema and associated lumbar radiculitis. He issued restrictions that include no lifting over ten pounds and no prolonged standing or walking. He recommended further treatment that would include continued physical therapy, some traction, and other modalities. PX2.

Petitioner testified that she wants to undergo the recommended treatment because she still has symptoms that affect her right leg and lower back and has difficulty with activities of daily living.

Respondent's Section 12 examining physician, Dr. David Fetter, agreed that Petitioner did sustain injuries to her right knee and low back from the accident and underwent reasonable treatment. Dr. Fetter's opinions differed from those of Dr. El Shami in that he believed her subjective symptoms were in excess of her physical findings, he thought that she does not need further treatment, and he opined she can return to full-duty work. RX1.

The Arbitrator finds the opinions of Dr. El Shami to be more persuasive than those of Dr. Fetter.

Even if one of the medical witnesses was equivocal on the question of causation, it is for the Commission to decide which medical view is to be accepted, and it may attach greater weight to the opinion of the treating physician. *International Vermiculite Co. v. Indus. Comm'n*, 77 Ill. 2d 1, 394 N.E.2d 1166 (1979)

Based on Petitioner's testimony, the chain of events, and the findings and opinions of Dr. El Shami, the Arbitrator finds that Petitioner's current condition of ill-being of her right leg and low back is causally related to the January 22, 2019 accident and further finds that she is entitled to the prospective medical care that Dr. El Shami has prescribed.

In support of his decision with regard to issue (L) "What temporary benefits are in dispute? TTD", the Arbitrator finds as follows:

Petitioner claims that she is entitled to TTD benefits for the period from February 1, 2019 through April 22, 2019, which represents a period of 11-4/7 weeks.

Respondent disputes liability for any TTD benefits.

On February 1, 2019, Petitioner was taken off of work by the physicians at UIC Urgent Care.

On February 5, 2019, Dr. Christine Neeb recommended that Petitioner remain off of work until February 13, 2019, at which time she could return to work if she is given frequent breaks. PX1.

Petitioner testified that she returned to work that day but had to leave due to increased pain. She also testified that worked in the office for as long as she was scheduled to work that day because she had an appointment.

After February 13, 2019, Respondent did not accommodate her restrictions.

On February 21, 2019, Petitioner was given restrictions of no standing over ten minutes, no lifting, no pushing and no pulling. PX1.

On March 21, 2019, Dr. El Shami recommended that Petitioner continue with restrictions of no lifting over ten pounds and no prolonged standing or walking. PX2.

The job description entered as Respondent's Exhibit 2 indicates that employees may be required to lift up to forty pounds occasionally and twenty pounds frequently. Respondent's witness, Sherri Ambrose, agreed that Petitioner would be required to lift up to forty pounds occasionally. Ambrose also agreed that Petitioner had to go through a separate office to apply for accommodation of her restrictions. She did not dispute that Petitioner's restrictions had not been accommodated by Respondent as of the date of hearing.

Respondent submitted video surveillance footage taken from March 3, 2019 through March 6, 2019 as its Exhibit 3. The Arbitrator notes that the footage does not show Petitioner engaged in any lifting beyond that of her purse, which she testified weighs approximately three pounds. Such weight does not exceed those weights required in her job description. RX3, p. 2.

The Arbitrator has reviewed the surveillance video and notes that it shows Petitioner walking slowly and deliberately.

During physical therapy on March 6, 2019, Petitioner reported that she had been experiencing some better days lately with less pain.

Following his examination of Petitioner on April 10, 2019, Dr. Fetter opined Petitioner sustained "a right knee contusion, and a lumbar strain, temporary conditions, resolved." However, he also opined: "The treatment to date has been reasonable." RX1.

The Arbitrator has reviewed the evidence and notes that Petitioner was able to work within her restrictions on February 13, 2019, but otherwise finds Petitioner is entitled to TTD

benefits for 11-3/7 weeks, which represents the period from February 1, 2019 through February 12, 2019 and the period from February 14, 2019 through April 22, 2019.

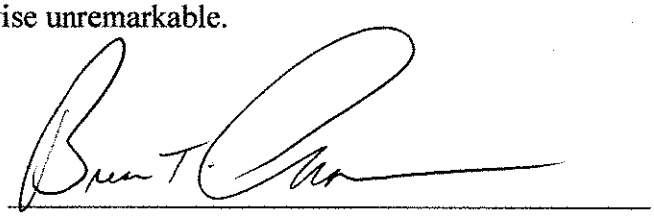
In support of his decision with regard to issue (M) "Should penalties or fees be imposed upon Respondent?", the Arbitrator finds as follows:

Section 19(k) of the Act requires an "... unreasonable or vexatious delay of payment or intentional underpayment of compensation, or proceedings have been instituted or carried on by the one liable to pay the compensation, which do not present a real controversy but are merely frivolous or for delay," in order for the Commission to award compensation pursuant to that section.

Section 19(l) requires a finding that the "... employer or his or her insurance carrier shall without good and just cause fail, neglect, refuse, or unreasonably delay the payment of benefits under Section 8(a) or 8(b)" in order for compensation to be awarded under that section.

Generally, an employer's reasonable and good faith challenge to liability does not warrant the imposition of penalties. When the employer acts in reliance upon reasonable medical opinion or when there are conflicting medical opinions, penalties ordinarily are not imposed. *Mechanical Devices v. Indus. Comm'n*, 344 Ill. App. 3d 752, at 763 (4th Dist. 2003).

The Arbitrator finds that penalties and attorney's fees are not warranted in this case. Respondent had a bona fide dispute with regard to the issue of causation. Respondent reasonably relied upon the opinions of Dr. Fetter. Moreover, on February 21, 2019, Petitioner indicated to her treating physician that her right hip pain and low back pain had resolved. Furthermore, the March 14, 2019 MRI of the right knee showed some mild soft tissue swelling anteriorly, but was otherwise unremarkable.



Brian T. Cronin, Arbitrator

7-21-19

Date

STATE OF ILLINOIS)
) SS.
COUNTY OF MCLEAN)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Terri Huber,

Petitioner,

vs. NO: 17 WC 28019

Illinois State University,

Respondent.

20IWCC0422

DECISION AND OPINION ON REVIEW

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

Regarding the issue of temporary disability, the Arbitrator awarded Petitioner temporary total disability (TTD) benefits for 35 and 1/7ths weeks, representing the periods from June 22, 2017 through October 22, 2017, and from February 1, 2018 through June 5, 2018. On appeal, Petitioner argues that the Arbitrator made a computational error. Petitioner also argues that the Arbitrator should have awarded her benefits for August 2, 2018, the date of her functional capacity evaluation (FCE).

Petitioner is correct regarding the computational error. The specified dates constitute 35 and 3/7ths weeks, not 35 and 1/7ths weeks. Accordingly, the Commission modifies the Decision of the Arbitrator to award the two additional days of TTD benefits.

Turning to the issue of whether the Arbitrator should have awarded benefits for the date of Petitioner's FCE, in general, "[t]o establish entitlement to TTD benefits, a claimant must demonstrate not only that he or she did not work, but also that the claimant was unable to work." *Mechanical Devices v. Industrial Comm'n*, 344 Ill. App. 3d 752, 759 (2003). The dispositive test is typically whether the claimant has reached maximum medical improvement (MMI). See *id.* "The factors to be considered in determining whether a claimant has reached maximum

20 IWCC0422

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." *Id.* at 760 (citing *Beuse v. Industrial Comm'n*, 299 Ill. App. 3d 180, 183 (1998)).

In this case, Petitioner seeks benefits for a date on which she had already returned to work. The Arbitrator ruled that Petitioner failed to establish that she did not work and was unable to work on this date because no work slip was issued by any physician taking Petitioner off work or placing her under work restrictions for this date. However, the therapist who conducted the FCE noted that Petitioner's wrist swelled by 1 cm by the end of the test, at which point Petitioner rated her pain at 8/10. The FCE report also recommended that Petitioner return to her physician for further assessment. The FCE report thus provides support for Petitioner's unrebutted testimony that she felt unable to work the shift after her evaluation. Moreover, Respondent's own Section 12 examiner, Dr. Williams, opined later that month that he did not believe Petitioner would be at MMI until after approximately four weeks of work hardening. After considering not only the lack of a doctor's note, but also the severity of Petitioner's condition and the fact Petitioner's condition had not stabilized, the Commission modifies the Decision of the Arbitrator to award Petitioner TTD benefits for August 2, 2018.

In all other respects, the Commission affirms and adopts the Decision of the Arbitrator.

IT IS FOUND BY THE COMMISSION that Petitioner proved she sustained an accident arising out of and in the course of her employment with Respondent on June 21, 2017.

IT IS FURTHER FOUND BY THE COMMISSION that Petitioner proved her current condition of ill-being is causally connected to the accident.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent is liable to pay Petitioner's outstanding reasonable and necessary medical expenses included in Petitioner's Exhibit 7 pursuant to the fee schedule and §§8(a) and 8.2 of the Act. Respondent is entitled to a credit for all medical benefits paid by its group medical carrier and is held harmless for any claims for which it receives credit, pursuant to §8(j) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $464.00 per week for the period from June 22, 2017 through October 22, 2017, from February 1, 2018 through June 5, 2018, and August 2, 2018, for a period of 35 and 4/7ths weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is awarded a credit of $15,853.19 for temporary total disability benefits already paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $417.60 per week for a period of 61.5 weeks, as provided in §8(e)(9) of the Act, for the reason that the injuries sustained caused a 30% loss of use of Petitioner's right hand.

20IWCC0422

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

Pursuant to §19(f)(1) of the Act, claims against the State of Illinois are not subject to judicial review. Therefore, no appeal bond is set in this case.

DATED: JUL 28 2020
d: 7/9/20
BNF/kcb
045

Barbara N. Flores

Deborah L. Simpson

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HUBER, TERRI
Employee/Petitioner

Case# **17WC028019**

ILLINOIS STATE UNIVERSITY
Employer/Respondent

20IWCC0422

On 11/27/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.58% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0293 KATZ FRIEDMAN EAGLE ET AL
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CHAMPAIGN, IL 61825

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

NOV 27 2019

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

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

Terri Huber
Employee/Petitioner

v.

Illinois State University
Employer/Respondent

Case # **17** WC **28019**

Consolidated cases: **N/A**

20IWCC0422

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Bloomington**, on **October 24, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

20 IWCC0422

FINDINGS

On **June 21, 2017,** Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

Per the stipulation of the parties, the average weekly wage was **$696.00**.

On the date of accident, Petitioner was **57** years of age, ***single*** with **0** dependent children.

Respondent shall be given a credit of **$15,853.19** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** in other benefits, for a total credit of **$15,853.19.**

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

ORDER

Respondent shall pay the reasonable and necessary medical services as included in **Petitioner's Exhibit 7** as provided in Sections 8(a) and 8.2 of the Act. Respondent is to hold Petitioner harmless for any claims for reimbursement from any health insurance provider and shall provide payment information to Petitioner relative to any credit due. Respondent is to pay unpaid balances with regard to said medical expenses directly to Petitioner. Respondent shall pay any unpaid, related medical expenses according to the fee schedule and shall provide documentation with regard to said fee schedule payment calculations to Petitioner. Respondent is entitled to a credit for all benefits paid under its group health plan under Section 8(j) of the Act.

Respondent shall pay Petitioner temporary total disability benefits of **$464.00**/week for **35 1/7** weeks, for the timeframes of **June 22, 2017 through October 22, 2017 and February 1, 2018 through June 5, 2018,** as provided in Section 8(b) of the Act.

Respondent shall be given a credit of **$15,853.19** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** in other benefits, for a total credit of **$15,853.19.**

Respondent shall pay Petitioner permanent partial disability benefits of **$417.60/week** for **61.5 weeks**, because the injuries sustained caused **30%** loss of use of the **left hand**, as provided in Section 8(e) of the Act.

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

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

Melinda M. Price-Sullivan
Signature of Arbitrator

11/25/19
Date

NOV 27 2019

ILLINOIS WORKERS' COMPENSATION COMMISSION
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Terri Huber
Employee/Petitioner

Case # **17** WC **28019**

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MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that she works for Respondent as a janitor/building service worker. She testified that she has held that job for about seven years and that she typically works second shift.

Petitioner testified that on or about June 21, 2017, she was performing summer cleaning which including the stripping and waxing floors. She testified that she placed the stripping solution on the floor and that it had to sit for a little while before proceeding with the stripping of the wax. She testified that she walked into the room where she had placed the stripping solution, that she felt her feet go out and that she then fell. She testified that her non-skid shoes did not prevent her from falling, and that the wax solvent caused her to slip. She testified that her foreman instructed her to strip floors that night.

Petitioner testified that after she slipped, she landed on the floor. She testified that her foreman came over and took her to the hospital, which was that of OSF St. Joseph's Medical Center. She testified that he injured her tailbone and her left wrist. She testified that she then sought treatment at McLean County Orthopedics. She testified that she did not really have any treatment for her tailbone and that she saw Dr. Armstrong for her wrist. She testified that while treating at McLean County Orthopedics she was placed under various restrictions, which Respondent was not able to accommodate.

Petitioner testified that she ultimately underwent surgery by Dr. Oakey on February 1, 2018, and that she was released to return to work on June 6, 2018. She testified that she also underwent an FCE, and that she was told by Respondent's workers' compensation carrier to undergo the testing. She testified that the FCE was performed on August 2, 2018 and that it was very strenuous. She testified that after she underwent the FCE, her wrist became swollen and she was unable to work that evening.

Petitioner testified that she returned to Dr. Oakey and discussed getting a second opinion, and that she was then seen by Dr. Bednar at Loyola. She testified that prior to seeing Dr. Bednar, she was seen by both Dr. Williams for her wrist and Dr. O'Leary for her tailbone. She testified that Dr. Bednar ordered another MRI and that he indicated that they could do surgery, but that he did not know if she would get more functionality or reduce her pain. She testified that she has not seen any doctors for her wrist since that time.

Petitioner testified that after had she had the FCE, Dr. Oakey gave her permanent restrictions. She testified that she was able to do her job with those restrictions and that if she needs help, she calls her foreman. She testified that she has difficulty lifting the 55-gallon drums garbage liners and that she also

has difficulty with the floor scrubbing machine. She testified that her wrist hurts to grip, twist, or pull anything. She testified that her left wrist aches all the time. She testified that she no longer has much strength in her left hand and that she believes that she can lift up to 10 pounds with her left hand. She testified that she does not have much range of motion in her left wrist. She testified that she uses mostly her right hand at work to mop and vacuum and that before her accident, she was ambidextrous for cleaning. She testified that she has difficulty cleaning the white boards in classrooms, as she is unable to use her left hand because it hurts with swiping back and forth. She testified that she is unable to open a jar with her left hand and that she has to hold it against her body and twist the lid off with her right hand.

On cross examination, Petitioner testified that her accident location was that of U-High in a small office. She testified that the office was not open to the public as it was a teacher's office.

On cross examination, Petitioner denied ever having had any wrist problems prior this fall.

On cross examination, Petitioner testified that she was able to complete her work tasks but that it takes longer to complete now because she has to be more careful with her wrist, and now has to think about tasks like twisting and grabbing items because her wrist hurts.

The IME Report of Dr. Patrick O'Leary dated August 30, 2018 was entered into evidence at the time of arbitration as Petitioner's Exhibit 1. The report reflects that Petitioner reported an incident which occurred on June 22, 2017 or thereabouts, that she was stripping a floor, that she walked into the room with non-skid work shoes on, and that she slipped and fell hard on the floor. It was noted that it appeared that Petitioner injured her left wrist and ended up needing wrist surgery, that it did not appear that there was a fracture, and that it was a surgery for degenerative findings in the injury. It was noted that Petitioner also sustained a tailbone injury and said that she had back pain, that she was seen in the emergency room and told that she had a tailbone fracture, and that she was working full duty. It was noted that on physical examination Petitioner had symptom magnification with minimal palpation to her lumbar spine, but really no tenderness over the sacrum or coccyx. (PX1).

The report reflects that Dr. O'Leary noted that Petitioner had x-rays which the radiologist did not call a fracture, but that the emergency room gave her a diagnosis of a coccygeal fracture. It was noted that Petitioner's subjective complaints included some back and buttock pain, and that it seemed to be improved since her fall over a year ago. It was noted that there were no objective findings on exam nor imaging, and that Petitioner had symptom magnification when palpating her lower back. When asked of his diagnosis of Petitioner's current condition, Dr. O'Leary indicated that she had non-specific low back pain and resolved coccydynia. It was noted that Dr. O'Leary opined that there was no causal relationship now for ongoing low back complaints, that they were not limiting Petitioner in any way, that he suspected that she had age-appropriate mild back pain and degenerative findings, and that he did not see the need for any further interventions. It was also noted that Dr. O'Leary opined that Petitioner likely had a temporary coccydynia as a result of a fall on her tailbone. (PX1).

The report reflects that Dr. O'Leary opined that Petitioner's medical treatment incurred to date had been reasonable and necessary, and that no additional medical treatment was necessary. It was noted that Dr. O'Leary opined that Petitioner's prognosis was good, that she could do work and life activities as tolerated, and that no restrictions were necessary. It was noted that Dr. O'Leary further opined that Petitioner had reached maximum medical improvement approximately six weeks after the fall with regard to the coccygeal injury, that she did not have a coccyx fracture, that she merely had coccydynia after a fall which would be a typical mechanism, and that no acute fractures were seen. (PX1).

The IME Report of Dr. James Williams dated August 30, 2018 was entered into evidence at the time of arbitration as Petitioner's Exhibit 2. The report reflects that Petitioner reported that on June 21, 2017 she was at work when she fell on the floor which had wax on it, that she was stripping the wax from

the floor, and that she was not sure if she fell on or hit something. It was noted that Petitioner was placed in a cast, went back to work, was in therapy from October 2017 to February 2018, and at first was at full duty. It was noted that an MRI was then done of the left wrist which revealed a TFCC tear as well as a partial scapholunate ligament tear, and that Petitioner underwent a left wrist arthroscopy with debridement of the partial scapholunate ligament tear as well as a wafer excision of the distal ulnar performed by Dr. Oakey and then went back to regular duty work on June 6, 2018. It was noted that Petitioner denied any previous injuries to the left wrist, and that she said that her pain in the right wrist at rest was 1-2/10 and with activity 1-7/10. It was noted that Petitioner stated that she had a ganglion cyst which showed up six weeks ago which was 1 x 1 cm over the CMC joint of the small finger, that she had pain over the dorsal palmar ulnar side of the wrist, that she had numbness and tingling in the right small finger which was constant for the past month, and that she complained of weakness. It was noted that on the left side Petitioner rated her pain at rest as 2-3/10 and with activity 3-9/10, that she had intermittent sharp pain over the ulna and top of the wrist and palmar pain over the side of the wrist and thumb, and that she had a nodule over the palmar aspect of the hand. It was also noted that Petitioner had numbness and tingling of the small finger, middle finger, and ring finger since surgery. (PX2).

The report reflects that Dr. Williams did not note any evidence of symptom magnification or malingering. It was noted that Dr. Williams' diagnosis was that of status post left wrist fracture with subsequent cast treatment and then left wrist arthroscopy with scapholunate ligament debridement, radial-sided TFCC debridement with ulnar wafer shortening osteotomy. It was noted that Dr. Williams believed that Petitioner had a left distal radius fracture which was directly related to her work injury and that the radial-sided TFCC tear was typically a degenerative-type tear, as well as with the wafer excision. It was noted that Dr. Williams believed that Petitioner's TFCC tear was most likely degenerative and that this was probably an aggravation of a pre-existing problem, that she may always have discomfort on this side of the wrist, and that he was not sure any further treatment was necessary. It was noted that Dr. Williams opined that Petitioner's medical treatment incurred to date had been reasonable and necessary, and that he did not think any additional medical treatment was necessary. It was noted that Dr. Williams believed that Petitioner would possibly benefit from further work hardening as was recommended by the FCE, and then see if any limitations in her work duties were present. It was noted that Dr. Williams believed that Petitioner could return to work with a 25-pound restriction on the left and full use of the right, and that he did not believe that she would be at maximum medical improvement until she underwent further work hardening for approximately four weeks' time. It was further noted that Dr. Williams at that point would place Petitioner at maximum medical improvement and determine if any work restrictions were necessary, based upon the work hardening results. (PX2).

The medical records of McLean County Orthopedics were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The records reflect that Petitioner underwent an Occupational Therapy Initial Evaluation on November 7, 2017, at which time it was noted that she reported that she had put stripper on the floor and slipped and fell, and that she reported that she broke her tailbone and her wrist on June 21, 2017. It was noted that Petitioner was initially casted and then placed in a pre-fabricated wrist brace on July 21, 2017, that she attended occupational therapy from July 26, 2017 to August 16, 2017 and then saw the doctor, and that she was instructed to stop therapy and have an MRI. It was noted that Petitioner was referred to Dr. Oakey and that she reported that she received an injection on October 23, 2017. It was noted that Petitioner reported that she could bend her wrist more and that the pain was a little better, that she presented in her wrist brace which she reported she was to wear for comfort, and that she reported that she took the brace off at home but the HR person at work told her to wear it all the time at work. It was noted that Petitioner was recommended to attend occupational therapy two times a week for up to 6-8 weeks pending her progress with treatment. At the time of the August 16, 2017 visit, it was noted that Petitioner reported that her arm was sore after her last session and that she reported that she had more pain that date, but had been using her hand more. It was noted that Petitioner's wrist flexion had decreased on that date, and that her thumb range of motion had improved. It was also noted that

Petitioner was having a lot of pain in her wrist but was forgetting and using her hand more at home, and that she felt she had irritated soft tissues causing increased pain. (PX3).

The records of McLean County Orthopedics reflect that Petitioner underwent an Occupational Therapy Initial Evaluation on July 26, 2017, at which time it was noted that she reported that she had put stripper on the floor and slipped and fell, and that she reported that she broke her tailbone and her wrist. It was noted that Petitioner was initially casted and then placed in a pre-fabricated wrist brace on July 21, 2017, and that she presented in her wrist brace on that date. It was noted that Petitioner was reporting a lot of pain in her wrist, and that edema was visible in the left wrist and hand. At the time of the October 23, 2017 visit with Dr. Oakey, it was noted that Petitioner presented with left wrist pain status post distal radius fracture on June 21, 2017. It was noted that Petitioner complained of continued pain over the radial and ulnar styloid, that aggravating factors included range of motion and use of the wrist, and that she had significantly decreased range of motion. It was noted that alleviating factors included Tramadol and immobilization with a cock-up brace, that Petitioner complained of numbness and tingling over the thenar eminence, and that she had undergone x-rays and an MRI in September. It was noted that Petitioner's x-rays on that date showed complete healing of the extraarticular distal radius fracture, and that she had substantial dorsal synovitis presumably at the radial carpal joint. It was noted that Petitioner also had some evidence of mechanical synovitis of the left middle finger flexor tendon sheath. It was noted that the fracture was healed and that the MRI which was performed almost two months ago did not suggest any ligamentous injuries. It was also noted that a discussion was held regarding the use of a steroid injection into the left radiocarpal joint and occupational therapy beginning in two weeks. The records reflect that Petitioner was given a lifting restriction that Dr. Oakey anticipated advancing when she returned in one month, and that he wanted her to wean out of the splint. (PX3).

The records of McLean County Orthopedics reflect that Petitioner was seen on August 18, 2017 by Dr. Armstrong, at which time it was noted that she was seen in follow-up for a left distal radius fracture. It was noted that Petitioner reported swelling and sharp pain in the left wrist and left thumb. It was noted that Petitioner continued to have significant disability in regard to her left distal radius fracture, that her pain was out of proportion to the current state of her injury, and that she was unable to return to work at that time. It was noted that Petitioner was to continue to wear the brace and to continue with a home exercise program, and that there was no need to continue formal occupational therapy. Petitioner was recommended to start Gabapentin and to undergo an MRI of the left wrist to evaluate the soft tissue. Petitioner was also recommended to follow-up with Dr. Armstrong after the MRI was completed, and if there was no pathology noted on the MRI she may benefit from pain management. At the time of the July 21, 2017 visit with Dr. Armstrong, it was noted that Petitioner still complained of pain at the dorsal aspect of the distal radius. It was noted that Petitioner was placed in a left Velcro wrist brace, that she was to wear it at all times with the exception of hygiene, and that left wrist range of motion exercises were demonstrated. It was also noted that in the near future Petitioner would start formal occupational therapy. It was further noted that Petitioner was to remain non-weightbearing of the left upper extremity, and that she was encouraged to take an oral supplemental calcium and vitamin D. Petitioner was recommended to return in four weeks for x-rays. (PX3).

The records of McLean County Orthopedics reflect that Petitioner was seen on June 23, 2017 by Dr. Armstrong, at which time it was noted that she reported left dorsal and radial wrist pain after a fall upon a slippery floor and had undergone x-rays at OSF on June 22, 2017. It was noted that Petitioner was a 57-year-old right-hand dominant female with a left distal radius fracture, possible left scaphoid fracture with a date of injury of June 21, 2017. Petitioner was recommended to proceed with conservative management and was placed in a left waterproof short-arm thumb spica cast. It was noted that Petitioner was to remain non-weightbearing in the left upper extremity, and that she was encouraged to take an oral supplemental calcium and vitamin D. Petitioner was recommended to return in four weeks with cast

removal and x-rays. It was noted that x-rays of the pelvis and right hip showed no fractures or dislocation. (PX3).

Included within the records of McLean County Orthopedics was an interpretive report for an MRI of the left wrist dated September 5, 2017, which was interpreted as revealing subacute non-displaced fracture of the left distal radial metaphysis. The records reflect that a work slip was issued on October 23, 2017, allowing Petitioner to return to work with restrictions of no lifting more than five pounds with the left arm and wear brace for comfort; that a work slip was issued on July 21, 2017, requiring Petitioner to remain non-weightbearing with the left upper extremity; and that a work slip was issued on June 23, 2017, requiring Petitioner to remain non-weightbearing with the left upper extremity until she was released. (PX3).

The records of McLean County Orthopedics reflect that Petitioner was seen for occupational therapy on November 14, 2017, at which time it was noted that she was able to drive for the first time using her left hand to help, that it went fine, that she was okay, and that no problems were voiced after her last occupational therapy session. It was noted that Petitioner picked up a mop bucket at work and that it hurt for a little while. At the time of the November 9, 2017 visit, it was noted that Petitioner hurt some after her first visit and was hurting right now at 4/10. It was noted that the fluidity/quality of motion and overall comfort levels seemed improved since last seen at Petitioner's previous round of therapy, and that there was expected discomfort at available end-ranges of motion but that nothing that limited the session. At the time of the August 14, 2017 visit, it was noted that Petitioner reported that she hurt after her last therapy session but that she always hurt, that the pain was 4/10 and with swelling, and that she reported that she may have overdone things over the weekend. At the time of the August 11, 2017 visit, it was noted that Petitioner reported that her arm was sore after the last session and that she felt her pain was improving. It was further noted that Petitioner continued to be very tender at the wrist, but that she felt it was a little better. At the time of the August 9, 2017 visit, it was noted that Petitioner was sore after the last session and was sore presently, that she did not feel like her soreness was improving, and that she wondered if some if it was how she was sleeping. It was noted that Petitioner was quite tender and symptomatic with gentle range of motion, and that she appeared independent with return-demonstration of initial home exercise program. (PX3).

Additional medical records of McLean County Orthopedics were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The records reflect that Petitioner underwent a Functional Capacity Evaluation on August 2, 2018, at which time it was noted that her patterns of movement and physiological responses were consistent with maximal effort. It was noted that Petitioner's main limitations were related to strength deficits and tolerance to pressure through the left wrist/hand, and that potential barriers to return to work were that of limited wrist and grip strength and reduced ability to grip and manipulate cleaning supplies and equipment for prolonged periods. It was noted that Petitioner was currently performing work duties on a 25# weight restriction and was typically wearing a wrist cock-up brace, as she reported that limiting wrist motion helped her hang onto things. It was noted that the therapist did not recommend increasing the weight restriction at that time and that, as able, Petitioner should rotate tasks and use tools that were lighter with a medium grip. It was also noted that Petitioner was recommended to return to the physician for further assessment as her limitations were not anticipated at this point, that her wrist also swelled 1 cm by the end of testing, and that her pain was rated up to 8/10. It was noted that if the physician found no problems with a surgical indication, Petitioner would benefit from additional rehab to build functional strength and abilities. (PX4).

The records of McLean County Orthopedics reflect that Petitioner underwent occupational therapy on July 3, 2018, at which time it was noted that no complaints were voiced after her last session and that she reported benefit from the ultrasound. It was noted that Petitioner had difficulty getting both arms behind her back bilaterally, that she reported pain and stiffness in the left shoulder but reported that

it had always been like this, and that she was now reporting more pain in the shoulder since performing heavier mopping/scrubbing last week. At the time of the June 11, 2018 visit, it was noted that Petitioner reported that she was now on a 25# restriction and started back at work on Wednesday and was to wear her brace, but may start to wean off of it. It was noted that Petitioner reported that she was in pain the entire time she was at work and after, and that the pain was not as bad in the morning after she had rested it. It was noted that the edema was decreased in the wrist, that range of motion was slightly improved, and that Petitioner's reports of pain were her biggest limiting factor. At the time of the April 27, 2018 visit, it was noted that Petitioner reported that she felt like she was not making any more gains and that she reported the more she tried to do, the more it hurt. It was noted that Petitioner continued to report a lot of pain in the arm and pointed to the ulnar wrist, that she reported pain was affecting her functional abilities, that wrist flexion and ulnar deviation was decreased 5 degrees each, and that wrist strength testing was limited by pain. (PX4).

The records of McLean County Orthopedics reflect that Petitioner underwent occupational therapy on March 8, 2018, at which time it was noted that she reported that her arm felt better after the last session and that she reported the machine (*i.e.*, Thermotherapy) really helped. It was noted that Petitioner's edema was decreased, that her range of motion was improving, and that her hypersensitivity was improving. It was noted that Petitioner reported pain with range of motion and fisting, and that they had not initiated strengthening yet. At the time of the Occupational Therapy Re-Evaluation on February 22, 2018, it was noted that Petitioner reported that she still could not use it (*i.e.*, her left wrist). It was noted that Petitioner's medical diagnosis was that of left wrist arthroscopy with TFCC debridement and ulnar wafer procedure, and debridement of scapholunate ligament. (PX4).

Included within the records of McLean County Orthopedics was the operative report from the Center for Outpatient Medicine dated February 1, 2018, which noted that Petitioner underwent left wrist arthroscopy with TFCC debridement and ulnar wafer procedure and debridement of scapholunate ligament by Dr. Oakey for a pre-operative diagnosis of left wrist pain and a post-operative diagnoses of left wrist central TFCC perforation with ulnar carpal abutment and partial scapholunate ligament tear. The records reflect that Petitioner underwent occupational therapy on December 7, 2017, at which time it was noted that she reported that she had to miss her last appointment because she went to Tennessee because her brother-in-law was dying and then passed away. It was noted that Petitioner was making good gains with range of motion, that she was reporting pain at the thumb and radial aspect of the wrist and forearm, and that there were questionable symptoms of De Quervain's. (PX4).

The records of McLean County Orthopedics reflect that Petitioner was seen by Dr. Newcomer on July 15, 2019, at which time it was noted that she was seen for follow-up of her left knee pain. It was noted that Petitioner had a history of medial meniscus tear and knee scope, that the date of surgery was that of June 30, 2016. It was noted that Petitioner presented three years since her last round of injections, that she was having pain on a daily basis, and that she specifically had pain that affected her at night and affected activities of daily living and recreational activity. It was noted that Petitioner complained of parethesias in the toes, radiating pain, hip pain, groin pain, and low back pain. Petitioner was given injections of cortisone and viscosupplementation, and was recommended to return the following week for a second injection. Included within the notes was a telephone note dated August 14, 2018, which noted that Petitioner wanted to go ahead with an appointment with Dr. Bednar at Loyola for a second opinion on her left wrist. (PX4).

The records of McLean County Orthopedics reflect that Petitioner was seen by Dr. Oakey on August 8, 2018, at which time it was noted that she was seen for her left wrist. It was noted that Petitioner stated that she had too much pain to work following the FCE, that she complained of mild, dull pain in the wrist, and that the pain was constant and worse with pronation and supination. It was noted that aggravating factors included work and use of the left wrist, that Petitioner could not identify any

alleviating factors, and that associated symptoms included swelling. It was noted that Petitioner had left wrist pain of uncertain etiology following a work injury. It was noted that it was Dr. Oakey's opinion that Petitioner was done with treatment, that they discussed options, and that while he thought it was reasonable for her to have restrictions at the U.S. Department of Labor Light level which he believed were permanent they discussed a second opinion, and that she was being referred to Dr. Bednar at Loyola to assume her care. It was noted that Petitioner was at work restrictions outlined in the FCE until she was able to establish with Dr. Bednar, and that she was to return as needed. At the time of the July 18, 2018 visit with Darren Sawyer, NP, it was noted that Petitioner was status post 5½ months left wrist arthroscopy. It was noted that Petitioner presented with continued limited active range of motion and weakness, that she noted recently after using a buffer she noted pain and swelling for several days, and that she had mild tingling in fingers 4-5 only at that time. It was noted that Petitioner stated that she continued to have difficulty performing her work duties, that she was tender to palpation on the ulnar aspect of her wrist, and that they would continue her with a 25# weight restriction. It was noted that Petitioner was to wear her brace for comfort at work, and that she would be sent for an FCE to be performed on or after August 1, 2018. (PX4).

The records of McLean County Orthopedics reflect that Petitioner was seen by Dr. Oakey on June 6, 2018, at which time it was noted that she complained of increased pain since her last appointment, that she was complaining of constant moderate pain in the dorsum and ulnar aspect of the left wrist, that aggravating factors included gripping and twisting, that she denied alleviating factors, and that she complained of associated numbness/tingling and burning in the dorsum of her left hand. It was noted that there was no evidence of further scapholunate ligament tearing and that Petitioner had dorsal scar tissue. It was noted that no further prescriptions would be issued for Tramadol, and that they discussed advancing Petitioner's work restrictions to 25#. It was noted that Petitioner understood that in six weeks when she saw Dennis if she was not ready for full duty, then they would begin the process of ordering an FCE to be performed six months following the wrist arthroscopy. At the time of the May 7, 2018 visit with Darren Sawyer, NP, it was noted that Petitioner was three months status post left wrist scope. It was noted that Petitioner was still complaining of overall weakness and general soreness, that she was especially painful that day after completing some spring cleaning over the weekend, and that she still had increased pain with pronation/supination, twisting, and gripping/grasping activities. It was noted that Petitioner was currently on a 15# lifting restriction at work and was unsure of advancing her restrictions, and that they would advance her to a 17# weight restriction with the left upper extremity. Petitioner was recommended to follow-up in one month with Dr. Oakey and if she was not substantially improved at that time, consideration would be given for an FCE. (PX4).

The records of McLean County Orthopedics reflect that Petitioner was seen by Darren Sawyer, NP, on April 9, 2018, at which time it was noted that she reported mild improvement in her symptoms since her last visit. It was noted that Petitioner stated that she had a constant mild pain on the ulnar side of the left wrist, that she reported aggravating factors to be gripping and twisting of the left hand/wrist, and that alleviating factors included rest, physical therapy, and Tramadol. It was noted that Petitioner complained of ulnar-sided tenderness to palpation, that she was able to pronate and supinate, flex, and extend her wrist with mild limitation due to pain, and that she would be given a 15# weight restriction of the left upper extremity but must wear her brace. It was further noted that Petitioner wanted a refill of Tramadol when she returned to the office later that week, and that she was to follow-up with Dr. Oakey in one month. At the time of the March 12, 2018 visit with Dr. Oakey, it was noted that Petitioner stated that she had a constant mild or moderate pain in the left anterior wrist, that she reported aggravating factors to be gripping and twisting of the left hand/wrist, and that alleviating factors included rest, physical therapy, and Tramadol. It was noted that Petitioner noted some numbness/tingling of the left posterior hand that comes and goes and weakness in the left hand, and that she reported her discontinued use of the left wrist brace due to "pinching." It was noted that Petitioner also requested a Tramadol refill. Petitioner was recommended to continue therapy to increase her work restrictions to 10# wearing her

splint for comfort, and to see the nurse practitioner for further advancement of her work restrictions in a month. (PX4).

The records of McLean County Orthopedics reflect that Petitioner was seen by Darren Sawyer, NP, on February 12, 2018, at which time it was noted that she stated that she continued to have moderate pain in the wrist, but that she lived alone so she "has to use it still." Petitioner was given a referral for occupational therapy and was issued work restrictions. At the time of the January 22, 2018 visit with Dr. Oakey, it was noted that Petitioner had ongoing left wrist pain. It was noted that there was a substantial amount of ulnar-sided wrist pain that radiated proximally and distally with some associated crepitance, that in addition she noted right thumb pain that radiated towards the wrist, and that these both began following her fracture. It was noted that injections were not helpful in alleviating the symptoms. It was noted that Petitioner had left wrist pain following a fracture and that the MRI suggested a radial-sided TFCC tear, although she did not substantially improve following an intra-articular injection. It was noted that Petitioner had exhausted conservative measures and that she wished to proceed with a left wrist arthroscopy with TFCC debridement or repair and possible ulnar wafer procedure. It was noted that Dr. Oakey believed that the left wrist arthroscopy was causally connected to the wrist fracture for which he treated Petitioner previously, and that she would continue to work full duty and see "Darren" in six weeks if they did not have approval from work comp for surgery. (PX4).

The records of McLean County Orthopedics reflect that Petitioner was seen by Dr. Oakey on December 18, 2017, at which time it was noted that she presented for follow-up of left wrist status/post healed distal radius fracture. It was noted that Petitioner complained of increased mild to moderate aching and sometimes sharp pain in the radial aspect of the wrist and thumb as well as dorsally, and that aggravating factors included gripping, supination/pronation, and wrist flexion/extension. It was noted that alleviating factors included rest, and that Petitioner denied associated numbness/tingling or swelling. It was noted that Petitioner had left wrist pain following a distal radius fracture, that the etiology was unclear, and that an intra-articular injection was unhelpful in alleviating symptoms. It was noted that Petitioner's symptoms on that date were localized to the extensor compartments, although there were multiple involved. It was also noted that Petitioner previously had an MRI which did not show inflammation of the extensor tendons, but that as things change he would recommend a repeat MRI to better guide treatment. It was further noted that Petitioner was to continue working full duty until after the MRI. At the time of the November 20, 2017 visit with Dr. Oakey, it was noted that Petitioner reported some progress since her last visit, that she had moderate achy pain throughout the left hand and wrist, and that she denied associated numbness and tingling in the left hand. It was noted that aggravating movements were pronation/supination, gripping/grasping, lifting, and carrying objects, and that Petitioner had repeat x-rays at the visit that day. It was noted that Petitioner was going to be increased to full duty and was to return in six weeks for potential maximum medical improvement. (PX4).

Included within the records of McLean County Orthopedics was an interpretive report dated October 29, 2018 for an MRI of the left wrist, which was interpreted as revealing increased signal in the triangular fibrocartilage may relate to interval repair; mild distal radioulnar joint effusion. Included within the records of McLean County Orthopedics was an interpretive report dated January 2, 2018 for an MRI of the left wrist, which was interpreted as revealing limited due to motion; small tear at radial attachment of TFCC; mild fluid in the distal radioulnar joint. (PX4).

The records of McLean County Orthopedics reflect that Petitioner was given a work slip on August 8, 2018, which noted that she was issued permanent restrictions per the FCE; that a work slip was issued on July 18, 2018, which noted that she was to continue the 25-pound weight restriction with the left upper extremity and was to wear the brace for comfort; that a work slip was issued on June 6, 2018, which noted that she was able to return to work with restrictions of 25 pounds with the left upper extremity and was to wear the brace; that a work slip was issued on May 7, 2018, which noted that she

was able to return to work with an increased weigh restriction to 17 pounds and was to wear the brace for comfort; that a work slip was issued on April 9, 2018, which noted that she was to return to work with a 15-pound weight restriction with the left upper extremity and that she must wear her brace; that a work slip was issued on March 12, 2018, which noted that she could return to work with a 10-pound restriction and wearing a brace for comfort; that a work slip was issued on February 12, 2018, which noted that she could return to work with no use of the left upper extremity; that a work slip was issued on January 10, 2018, which noted that she could work full duty; that a work slip was issued on December 18, 2017, which noted that she could work full duty; and that a work slip was issued on November 20, 2017, which noted that she would work full duty. (PX4).

The Functional Capacity Evaluation dated August 2, 2018 was entered into evidence at the time of arbitration as Petitioner's Exhibit 5. The records were duplicative of those as contained in Petitioner's Exhibit 4. (PX5; PX4).

The medical records of Loyola University Medical Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 6. The records reflect that Petitioner was seen by Dr. Bednar on December 20, 2018, at which time it was noted that she returned after the MRI. It was noted that the MRI was read as mild effusion at the distal radioulnar joint and increased signal of the triangular fibrocartilage complex, which may be relative to the interval repair. It was noted that no other abnormalities were present. It was noted that Petitioner still persisted in having pain over the ulnar aspect of the wrist, that she persisted in having pain with stressing the distal radioulnar joint, and that no gross instability was appreciated. It was further noted that no crepitus was seen. It was noted that treatment options were discussed and that Dr. Bednar did not think that further procedures were likely to improve Petitioner's symptoms although another arthroscopy could be performed, and that there were no guarantees that the second arthroscopy would be helpful in identifying further pathology. It was noted that Petitioner stated that she would contact Dr. Oakey for final dispensation. (PX6).

The records of Loyola University Medical Center reflect that Petitioner was seen on September 4, 2018, at which time it was noted that she was a 58-year-old right hand dominant janitor, that she sustained a left distal radius fracture on June 20, 2017, that she stated that she was treated with a cast for a month, and that she was then in occupational therapy. It was noted that Petitioner had had persistent pain in the wrist, that she had a wrist arthroscopy performed by Dr. Oakey on February 1, 2018, that despite this she had persistent pain about the wrist, and that the pain was worse over the ulnar aspect of the wrist. It was noted that Petitioner stated that she returned to work on June 6, 2018 at a full duty level, that she denied numbness or tingling of the hand, and that she had pain worse over the ulnar aspect of the joint but present throughout the entire joint, which was bothering her. It was noted that Petitioner came to Dr. Bednar for another opinion concerning her wrist. It was noted that Petitioner was back working and felt that she could do her job, and that she felt that her hand kept her from doing hobbies and daily activities. The impression was noted to be that of ulnar-sided wrist pain. It was noted that Dr. Bednar recommended that Petitioner have another MRI to make sure that no new changes of the wrist were present since the arthroscopy. (PX6).

The CMS Work Comp Packet was entered into evidence at the time of arbitration as Respondent's Exhibit 1. The Illinois Form 45 that was dated June 22, 2017 noted that the date and time of accident was that of June 21, 2017 at 8:00 p.m., that Petitioner was going to plug in a side-to-side machine, that she put stripper on the floor, took a step and fell, and that she sustained a coccyx fracture and a compound fracture of the left wrist. The Workers' Compensation Employee's Notice of Injury dated June 21, 2017 noted that the location of Petitioner's accident was that of Room 308 at U-High in Normal, that she walked into the room to plug in the machine, and that she slipped and fell, injuring the left wrist and hips. (RX1).

Various Medical Documents were entered into evidence at the time of arbitration as Respondent's Exhibit 2. The records reflect that Petitioner was seen at St. Joseph Medical Center on June 21, 2017, at which time it was noted that she presented to the emergency room with complaints of pain in the area of her coccyx as well as the left forearm. It was noted that Petitioner stated that she was tripping [*sic*] a floor when she slipped and fell on the wet floor, that she denied hitting her head or any loss of consciousness, and that she believed that she hit her hand on a countertop. It was noted that Petitioner stated that she landed directly on her buttocks when the fall occurred. The OSF St. Joseph Medical Center note dated June 23, 2017 noted that on Wednesday night Petitioner slipped and fell on a stripped floor, that she went to the emergency room and had a piece of bone broken off in the left wrist, that she saw Dr. Armstrong on that date and that a cast was put on, and that she still had pain and swelling. It was noted that Petitioner also had a broken coccyx, and that she had difficulty getting up and pain. It was noted that ISU was requesting work restrictions. The chief complaint was noted to be that of tail bone pain. (RX2).

The Payment Ledger was entered into evidence at the time of arbitration as Respondent's Exhibit 3.

CONCLUSIONS OF LAW

With respect to disputed issue (C) pertaining to accident, the Arbitrator finds that Petitioner sustained an accident arising out of and in the course of her employment with Respondent on June 21, 2017.

To obtain compensation under the Illinois Workers' Compensation Act, a claimant must show by a preponderance of the evidence that he has suffered a disabling injury arising out of and in the course of his employment. 820 ILCS 305/2; *Metropolitan Water Reclamation District of Greater Chicago v. Illinois Workers' Compensation Comm'n*, 407 Ill. App. 3d 1010, 1013 (2011); *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill. 2d 52, 57 (1989). However, the fact that an injury arose "in the course of" the employment is not sufficient to impose liability, for to be compensable, the injury must also "arise out of" the employment. *Id.* at 58.

The "arising out of" component refers to an origin or cause of the injury that must be in some risk connected with or incident to the employment, so as to create a causal connection between the employment and the accidental injury. *Id.* There are three categories of risk to which an employee may be exposed: (1) risks distinctly associated with the employment; (2) risks personal to the employee; and (3) neutral risks, which have no particular employment or personal characteristics. *Springfield Urban League v. Illinois Workers' Compensation Comm'n*, 2103 IL App (4th) 120219WC, ¶ 27; *Young v. Illinois Workers' Compensation Comm'n*, 2014 IL App (4th) 130392WC. Injuries resulting from a neutral risk are not generally compensable and do not arise out of the employment unless the employee was exposed to the risk to a greater degree than the general public. *Id.*

The "in the course of" component refers to the time, place and circumstances under which the accident occurred. *Illinois Bell Telephone Co. v. Industrial Comm'n*, 131 Ill. 2d 478, 483 (1989). If an injury occurs within the time period of employment, at a place where the employee can reasonably be expected to be in the performance of her duties, and while she is performing those duties or doing something incidental thereto, the injuries are deemed to have been received in the course of the employment. *Caterpillar Tractor Co.*, 129 Ill. 2d at 58. "Injuries sustained on an employer's premises, or at a place where the claimant might reasonably have been while performing his duties, and while a claimant is at work, or within a reasonable time before and after work, are generally deemed to have been

received in the course of the employment." *Johnson v. Illinois Workers' Compensation Comm'n*, 2011 IL App (2d) 100418WC, ¶ 21.

In the case at hand, the evidence reveals that Petitioner slipped on the liquid stripping solution she had placed on the floor of an office as part of her job duties as assigned to her by Respondent. The Arbitrator finds that Petitioner was exposed to a risk – *i.e.*, a wet and slippery floor – which is causally connected to her employment which required her to strip wax from the floors. Furthermore, Petitioner was exposed to a hazard to a greater degree than the general public, particularly given the fact that the area in which Petitioner was injured was not open to the general public as it was inside the building at U-High in a teacher's office.

As a result thereof, the Arbitrator finds that Petitioner met her burden of proof in establishing that she sustained accidental injuries that arose out of and in the course of her employment with Respondent on June 21, 2017.

With respect to disputed issue (F) pertaining to causation, the Arbitrator finds that Petitioner has met her burden of proving that her current condition of ill-being is causally related to the accident of June 21, 2017.

The evidence reveals that Respondent had Petitioner seen for a Section 12 Independent Medical Examination with Dr. O'Leary. When asked of his diagnosis of her current condition, Dr. O'Leary indicated in his report dated August 30, 2018 that Petitioner had non-specific low back pain and resolved coccydynia. It was noted that Dr. O'Leary opined that there was no causal relationship now for ongoing low back complaints, that they were not limiting Petitioner in any way, that he suspected that she had age-appropriate mild back pain and degenerative findings, and that he did not see the need for any further interventions. It was also noted that Dr. O'Leary opined that Petitioner likely had a temporary coccydynia as a result of a fall on her tailbone. (PX1).

The evidence further reveals that Respondent had Petitioner seen for a Section 12 Independent Medical Examination with Dr. Williams. When asked of his diagnosis of her current condition, Dr. Williams indicated in his report dated August 30, 2018 that Petitioner had a left distal radius fracture which was directly related to her work injury and that the radial-sided TFCC tear was typically a degenerative-type tear, as well as with the wafer excision. It was noted that Dr. Williams believed that Petitioner's TFCC tear was most likely degenerative and that this was probably an aggravation of a pre-existing problem, that she may always have discomfort on this side of the wrist, and that he was not sure any further treatment was necessary. (PX2).

Furthermore, the medical records of McLean County Orthopedics also contained a causation opinion from Dr. Oakey who, in the note dated January 22, 2018, indicated that he believed that the left wrist arthroscopy was causally connected to the wrist fracture for which he treated Petitioner previously. (PX4).

Having considered and reviewed the entirety of the medical evidence in this matter, the Arbitrator finds that Petitioner has met her burden of proving that her current condition of ill-being is causally related to the accident of June 21, 2017.

With respect to disputed issue (J) pertaining to reasonable and necessary medical services, in light of the Arbitrator's aforementioned conclusions, the Arbitrator finds that Petitioner's care and treatment was reasonable, necessary and causally related to her work accident of June 21, 2017. As a result thereof, Respondent shall pay all reasonable and necessary medical services as contained in Petitioner's Exhibit 7

as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit for all medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

With respect to disputed issue (K) pertaining to temporary total disability benefits, the Arbitrator notes that Petitioner claims that she is entitled to temporary total disability benefits for the timeframes of June 22, 2017 through October 22, 2017; February 1, 2018 through June 5, 2018; and August 2, 2018. (AX1).

"[T]o prove temporary total disability, the employee must demonstrate not only that he did not work, but also that he was unable to work." *Ming Auto Body/Ming of Decatur, Inc. v. Industrial Comm'n*, 387 Ill. App. 3d 244, 256, 899 N.E.2d 365, 378, 326 Ill. Dec. 148 (2008). The Arbitrator finds that Petitioner has demonstrated that she did not work and was unable to work for the timeframes of June 22, 2017 through October 22, 2017 and February 1, 2018 through June 5, 2018, but that she has failed to demonstrate that she did not work and was unable to work on August 2, 2018.

At the time of arbitration, Petitioner testified that while treating at McLean County Orthopedics she was placed under various restrictions which Respondent was not able to accommodate. The Arbitrator notes that Respondent offered no evidence to refute Petitioner's assertions as to the accommodation issue. Petitioner further testified that she underwent surgery by Dr. Oakey on February 1, 2018 and that she was released to return to work on June 6, 2018. As a result thereof, the Arbitrator finds that Petitioner has demonstrated that she did not work and was unable to work for the timeframes of June 22, 2017 through October 22, 2017 and February 1, 2018 through June 5, 2018.

As to the August 2, 2018 date – which was the date on which the FCE was performed – the evidence reveals that no work slip was issued by any physician taking Petitioner off work or placing her under work restrictions for that specific date. As a result thereof, the Arbitrator finds that Petitioner has failed to demonstrate that she did not work and was unable to work on August 2, 2018.

As a result of the foregoing, the Arbitrator finds that Petitioner has demonstrated that she did not work and was unable to work for the timeframes of June 22, 2017 through October 22, 2017 and February 1, 2018 through June 5, 2018, but that she has failed to demonstrate that she did not work and was unable to work on August 2, 2018.

With respect to disputed issue (L) pertaining to the nature and extent of Petitioner's injuries, and consistent with 820 ILCS 305/8.1b, permanent partial disability shall be established using the following criteria: (i) the reported level of impairment pursuant to subsection (a) of Section 8.1b of the Act; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. 820 ILCS 305/8.1b. No single enumerated factor shall be the sole determinant of disability. *Id.*

With respect to Subsection (i) of Section 8.1b(b), the Arbitrator notes that neither party submitted an AMA impairment. As a result thereof, the Arbitrator gives no weight to this factor.

With respect to Subsection (ii) of Section 8.1b(b), the Arbitrator notes that Petitioner testified that she was a janitor/building service worker for Respondent at the time of the accident at issue. The Arbitrator places greater weight on this factor when making the permanency determination.

With respect to Subsection (iii) of Section 8.1b(b), Petitioner was 57 years old on the date of the accident at issue. In light of Petitioner's release with permanent restrictions by her treating physician, 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 Petitioner testified that she returned to work as a janitor/building service worker for Respondent upon the completion of her medical treatment with Dr. Oakey. As there was no evidence proffered at arbitration to demonstrate that Petitioner's work accident has impaired or otherwise affected her future earnings capacity, the Arbitrator places lesser weight on this factor when making the permanency determination.

With respect to Subsection (v) of Section 8.1b(b), the Arbitrator notes that Petitioner testified that her left wrist aches all the time. Petitioner testified that she no longer has much strength in her left hand anymore and that she believes that she can lift up to 10 pounds with her left hand. Petitioner testified that she does not have much range of motion in her left wrist. Petitioner testified that she uses mostly her right hand at work to mop and vacuum and that before her accident, she was ambidextrous for cleaning. Petitioner testified that she has difficulty cleaning the white boards in classrooms, as she is unable to use her left hand because it hurts with swiping back and forth. Petitioner testified that she is unable to open a jar with her left hand and that she has to hold it against her body and twist the lid off with her right hand. At the time of the August 8, 2018 visit with Dr. Oakey, it was noted that Petitioner was seen for her left wrist. It was noted that Petitioner stated that she had too much pain to work following the FCE, that she complained of mild, dull pain in the wrist, and that the pain was constant and worse with pronation and supination. It was noted that aggravating factors included work and use of the left wrist, that Petitioner could not identify any alleviating factors, and that associated symptoms included swelling. It was noted that Petitioner had left wrist pain of uncertain etiology following a work injury. It was noted that it was Dr. Oakey's opinion that Petitioner was done with treatment, that they discussed options, and that while he thought it was reasonable for her to have restrictions at the U.S. Department of Labor Light level which he believed were permanent they discussed a second opinion, and that she was being referred to Dr. Bednar at Loyola to assume her care. It was noted that Petitioner was at work restrictions outlined in the FCE until she was able to establish with Dr. Bednar, and that she was to return as needed. (PX4). The Arbitrator concludes that Petitioner's evidence of disability at the time of arbitration was somewhat corroborated by her treating records at the conclusion of her treatment. The Arbitrator accordingly places lesser weight on this factor in determining permanency.

The Arbitrator notes that the determination of permanent partial disability benefits is not simply a calculation, but an evaluation of all of the factors as stated in the Act in which consideration is not given to any single factor as the sole determinant. Based on the above factors and the record in its entirety, the Arbitrator concludes that Petitioner sustained permanent partial disability to the extent of **30% loss of use of the left hand** as provided in Section 8(e) of the Act.

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 Up	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Isabelle Adams,

Petitioner,

vs. NO: 15 WC 39694

Dollar General-Ottawa,

Respondent.

20IWCC0423

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

Regarding the issue of accident, the Commission notes that the "Findings" section of the Decision of the Arbitrator refers to an accident date of August 4, 2015. However, the Arbitrator's conclusions of law refer to an accident date of August 9, 2015, which is consistent with the evidence in this matter. Accordingly, the Commission modifies the Arbitrator's Decision to reflect an accident date of August 9, 2015.

Regarding the issue of temporary disability benefits, the Commission notes that the "Order" section of the Decision of the Arbitrator refers to an initial date of September 24, 2015. However, the Arbitrator's conclusions of law refer to an initial date of September 14, 2015, which is consistent with the date stated in the Request for Hearing and the Decision's stated award of 5 and 6/7ths weeks of benefits. Accordingly, the Commission modifies the Arbitrator's Decision to reflect an initial date of September 14, 2015.

In all other respects, the Commission affirms and adopts the Decision of the Arbitrator.

IT IS FOUND BY THE COMMISSION that Petitioner proved she sustained an accident arising out of and in the course of her employment with Respondent on August 9, 2015.

20IWCC0423

IT IS FURTHER FOUND BY THE COMMISSION that Petitioner proved her current condition of ill-being is causally connected to the accident.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent is liable to pay Petitioner's outstanding reasonable and necessary medical expenses included in Petitioner's Exhibit 1 pursuant to the fee schedule and §§8(a) and 8.2 of the Act. Respondent is entitled to a credit for all medical benefits paid by its group medical carrier and is held harmless for any claims for which it receives credit, pursuant to §8(j) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $438.88 per week for the period from September 14, 2015 through October 24, 2015, for a period of 5 and 6/7ths weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $394.97 per week for a period of 50 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused a 10% loss of use of the person as a whole.

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

Bond for the removal of this cause to the Circuit Court is hereby fixed at the sum of $23,100.00. 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: JUL 28 2020
d: 7/9/20
BNF/kcb
045

Barbara N. Flores

Deborah L. Simpson

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ADAMS, ISABELLE
Employee/Petitioner

Case# **15WC039694**

DOLLAR GENERAL-OTTAWA
Employer/Respondent

20IWCC0423

On 10/3/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.79% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0190 PETER F FERRACUTI LAW OFFICES
ALEXIS P FERRACUTI
110 E MAIN ST PO BOX 859
OTTAWA, IL 61350

1886 LEAHY EISENBERG & FRAENKEL
SHALEIGH JANSEN
33 W MONROE ST SUITE 1100
CHICAGO, IL 60603-5317

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

ISABELLE ADAMS
Employee/Petitioner

Case # **15 WC 39694**

v.

DOLLAR GENERAL-OTTAWA
Employer/Respondent

20IWCC0423

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **PAUL SEAL**, Arbitrator of the Commission, in the city of **OTTAWA**, on **8/26/19**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **8/4/15**, Respondent ***was*** operating under and subject to the provisions of the Act.

On these dates, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

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

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

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

In the year preceding the first injury, Petitioner earned **$34,231.08**; the average weekly wage was **$658.29.**

On the first date of accident, Petitioner was **46** years of age ***single*** with **0** dependent children.

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

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

Respondent shall be given a credit of **$0.00** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$0.00.**

Respondent is entitled to a credit of for all reasonably related group medical under Section 8(j).

ORDER

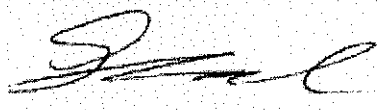
Based on the Arbitrator's Conclusions of Law attached hereto, Respondent shall pay Petitioner's reasonably related medical expenses contained on Exhibit 1 of Petitioner's Exhibits submitted at trial.

Respondent shall pay Temporary Total Disability benefits for the time period of 5 6/7 weeks from 9/24/15 until 10/24/15 at the rate of $438.88 per week.

Petitioner is hereby awarded permanent partial disability benefits of $394.97 per week for 50 weeks because the injuries sustained caused a 10% loss of use of her person as a whole under section 8(d) (2) of the Act.

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

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



Arbitrator

September 30, 2019
Date

OCT 3 - 2019

FINDINGS OF FACTS

The Petitioner presented at trial as a single 50-year-old woman with three children well over the age of 18. The Petitioner testified that her highest education level was two years of college and that she currently worked at Dollar General. TX 12, TX 13. The Petitioner testified at hearing that she worked at Dollar General a little over eight years and was originally hired on as a cashier before being moved to an assistant position, then a training manager position before eventually being promoted to store manager of the Ottawa location. TX 13.

The Petitioner testified that prior to the accident at work on August 9, 2015, she had never had anxiety while she was working at Dollar General. She described her work environment as enjoyable and that she was happy to go to work and often came in at 6:00 a.m. and worked by herself in that space until that store opened. TX 14. The Petitioner testified that she was on salary but was actually scheduled to come in every day between 7:30 and 8:00 to open the store, but testified that she came in on her own time so the store could continue to thrive and so that it would be easier on her employees throughout the day prior to the date of accident. TX 15.

In the six months prior to the accident in question, the petitioner had been promoted and was serving as the store manager for the Ottawa store. She testified that during this time period she felt comfortable at the store as if it was her home away from home and prior to the incident in question she had not sought any type of psychological help nor had she had any type of anxiety since beginning her work at Dollar General eight years prior. TX 15. The Petitioner did testify that she underwent 36 weeks treatment for hepatitis C for which she was sent to North Central for evaluations and group sessions due to the medication she was taking and its side effects on the mental health of the person taking that specific medication. TX 16. Specifically, the petitioner testified that the medication itself could cause suicidal tendencies to occur and depression – so, her doctor wanted to make sure that she had adequate help to get her through the 36-week medication period. TX 16. The petitioner testified that treatment occurred in 2011 and since that group treatment in 2011, she had not undergone any type of psychological health treatment between 2011 and the date of accident in 2015. TX 17.

The petitioner testified that the date of the accident in question was August 9, 2015. She described that she arrived at 6:00 a.m. to begin setting the Halloween decorations out of the back room so that the next truckload of goods to be sold at Dollar General could be unloaded from the truck into the back room of the store. TX 18. The petitioner testified that the incident in question occurred after 10:00 a.m. and that she had been the only person in the store until the cashier arrived at 10:00 a.m. that same day. The Petitioner testified that she was doing peg hooks and setting the Halloween theme up around the store at the time of the incident. The petitioner had gone near the register to help the cashier void a sale when a woman came up to the cashier indicating that there was a woman hunched over a box in the aisle.

Petitioner responded to the aisle and called 911 where she was kept on the phone with emergency services. Petitioner testified that emergency services asked her to check the woman's pulse which she did, and she indicated to emergency services that she was unable to find a pulse. Petitioner was then instructed to turn the woman over to see if she had any chest palpitations. When the petitioner turned the woman over, she found that she was blue and had track marks down her leg. Due to Petitioner's hepatitis C diagnosis, she backed up from the woman and knew that she could not help her because she knew that this was an overdose.

Petitioner testified at trial that her biggest fear both at the time of the incident and at trial was that she could not help this woman and that had she helped her perhaps the woman would have survived. Petitioner was instructed by emergency services to try to resuscitate the woman in question but because of her diagnosis another woman in the store had to perform the task and try compression. Petitioner testified that she felt like she had turned into Jell-O and anxiety started to overcome her. TX 20. The petitioner testified that she did not know the woman and had not seen the woman before. TX 20.

She testified that a gentleman came in shortly after the incident and indicated that prior to having the incident in the store, the woman who had overdosed had been in the car with one of her friends and the woman's two children and had been doing heroin in the car prior to coming into the store. The man had the woman's friend and the two children with him when he came in to talk to the petitioner. The petitioner testified that the smallest child asked why her mom had to be put into an ambulance and the petitioner was forced to lie to her telling her that she hurt her foot in the store and everything was going to be okay. TX 21. The petitioner asked the other girl what the woman who overdosed came in to buy and ended up purchasing the diapers for the children herself and giving them to the gentleman who brought them into the store after the incident. The gentleman who brought them in was a local police officer who gave the petitioner the name of the victim and let her know that she had been resuscitated and sent to Peoria for further treatment at the hospital. TX 21.

The petitioner testified that she later learned that the woman died in the hospital a week after. She found this out when the mother of the woman who overdosed reached out to thank her for all of her help when her daughter took her last breath. TX 22. The mother of the victim told the petitioner that she knew she was in good hands and that she had done all she could prior to her daughter's passing. The petitioner testified that made her feel worse because she felt that she hadn't helped her the way she needed to help her. TX 22. Sometime after the incident, while attending an event with her grandchildren at the school where they attend, Petitioner found out that the two children of the woman who overdosed attended school with her grandchildren. Since the incident in question, the children have become a regular part of the petitioner's life because she sees them at every school event. TX 21.

Petitioner reported the incident to her DM, Randy Battles, immediately after the incident occurred. Mr. Battles instructed the Petitioner at the scene to go through the woman's things to find an ID before the police got to the store and the Petitioner told Mr. Battles that she did not

feel comfortable touching the woman and she knew that she was already gone. The Petitioner filled out an incident report on the date of the accident and faxed it to corporate for their records. TX 23. The Petitioner testified that immediately after the incident occurred, she felt as though she couldn't think straight and like she was trying to block things out. She had difficulty sleeping and testified that she didn't know what to do with herself if she was alone for any period of time. TX 24. She testified that rather than going in at her normal 6:00 a.m. time to work she started showing up at 7:45 a.m. or as close to 8:00 as she could possibly get to the store.

The Petitioner testified that as a part of her job she is required to do mandatory early days wherein she is forced to be in the store by herself. Those days occur on Tuesdays and she begins work every Tuesday at 6:00 a.m. Prior to the incident in question, she had no issue going in early and working alone, but after the date of the accident, the Petitioner testified that she would have to have one of her friends on the phone with her from 6:00 a.m. when she walked in until she opened the doors and another cashier walked into work with her at 8:00 a.m. TX 25. The Petitioner went on to testify that she was totally avoiding a certain area of the store and that all of the comfort that she felt in that store prior to the date of accident was now gone. The Petitioner realized that she was avoiding the diaper area specifically where the girl had fallen and passed away. The Petitioner testified at hearing that she avoided that portion of the store until she was finally able to transfer to another store location. TX 25.

The Petitioner testified in the week after the accident she began having panic attacks and would have to go outside to get air. She testified that she felt as though her anxiety was sucking the life out of her and the person she used to be before the date of the accident in question. She testified that she began having headaches which she believed were related to stress and tense muscles in her neck. As a result, in the three weeks following the accident, she began to push significantly on the back of her neck to try to work out the muscles so that her headaches would get better. Eventually she got a knot in the back of her neck for which she went to treat with Dr. Syed who identified that that was an arachnoid cyst caused by the pressure she was putting on the neck to try to relieve her headaches. Petitioner testified that Dollar General never provided any sort of training for if there's a medical emergency in the store. In fact, she testified that an overdose or medical emergency of that sort is not something that a store manager would typically understand or encounter as a part of their job duties. The ongoing stress and anxiety caused headaches and physical symptoms for which the Petitioner was eventually forced to seek medical treatment. TX 28.

The Petitioner first sought medical treatment on September 3, 2015, at OSF St. Elizabeth emergency room in Ottawa, Illinois. She testified at hearing that she reported to the emergency room after having difficulty concentrating and jumbling numbers at work to the point where she felt like she could not function, speak, or think clearly. TX 27 and 28. When she arrived at the emergency room she complained of headaches that fogged her thinking and they performed a CT of the brain and upper cervical disks in the Petitioner's neck wherein they found an arachnoid cyst in the same area of the Petitioner's neck where she was pushing to try to control the headaches that she was having.

The Petitioner then followed up at Liberty Medical Center on September 8, 2015, with Dr. Syed who noted the Petitioner's continuing dizziness and confusion and scheduled her for an MRI at Morris Hospital. TX 29. That MRI occurred on September 10, 2015, and Petitioner then followed up with Dr. Analytis on September 16, 2015 at which point he found that the headaches were getting worse, that she had photo phobia, and visual change complaints. The doctor also noted that the Petitioner had daytime sleepiness, anxiety and she noted waking up multiple times at night. TX 30.

On September 30, 2015, she underwent a second MRI at Provena St. Joe's which showed no abnormality and no physical issues in her brain. She then followed up with Dr. Syed on October 9, 2015, at which point Dr. Syed asked the Petitioner about her sleeplessness and other symptoms of anxiety. It was during this appointment that the Petitioner told him about the traumatic death of the woman at her workplace on August 9, 2015, for which she was unable to help the woman and was carrying significant guilt as a result of the same. The Petitioner was prescribed Xanax for anxiety, panic attacks and continued to be off work at this point in time by Liberty Medical Center. Petitioner followed up again on October 13, 2015, at which point she was checked for sleep apnea, hypertension and ataxia and was found to be negative for all three.

She was instructed to follow up again with Dr. Syed on October 16, 2015. He gave her a release to return to work based on her neurological evaluation and the result of the MRI which were clear. TX 32. The Petitioner followed up again with Dr. Syed on November 10, 2015. He noted that Petitioner was having increased panic attacks since returning to work. Dr. Syed diagnosed her with panic anxiety disorder on November 10, 2015 relating back to the date of accident of August 9, 2015. TX 33. Dr. Syed in that appointment noted that Petitioner was having a panic attack several times a day and sometimes more than once an hour. He noted that the Petitioner did not feel comfortable staying alone at her own home and that she had been living with her daughter to feel more secure after the date of the accident in question. The Petitioner was diagnosed with post-traumatic stress disorder, major depressive disorder and generalized anxiety related to the incident in question for which he prescribed Paxil and Xanax and referred Petitioner to a psychiatrist of her choosing at North Central Behavioral. TX 34.

The Petitioner began treatment at North central in June of 2016 because prior to that time North Central had been shut down and was not taking patients due to budgetary constraints in the state of Illinois. TX 35. The Petitioner during her first interview with the counselor at North Central reported the incident in detail, including reporting a dead body, and noted that she was having difficulty functioning either at work or at home after the accident in question. TX 35. The Petitioner testified that she constantly heard noises, was fearful of death, and continued to have flashbacks of finding the woman on the floor dead and being unable to help her. The Petitioner testified at trial that her daughter found her sitting in her granddaughter's closet one night because she couldn't sleep and was having nightmares which included seeing dead people who were blue that would wake her up from her sleep. She indicated that she felt cold and alone

and often times shaky after having these nightmares. During this point in time, the Petitioner testified she was seeking help at North Central every week and sometimes twice a week. TX 36.

She returned on June 13, 2016, at which point she was still reporting helplessness, frightening dreams and flashbacks to the original accident on August 9, 2015. The Petitioner reported at that time she was still working at the Ottawa store and that she was still avoiding the area of store where the diapers were located as a result of the incident in question. The Petitioner noted that during this time period, she became reactive when she was exposed to clues that resembled the event in question. During this time period the Petitioner testified that her nephew had run into a tree and had passed away.

The Petitioner expressed remorse at hearing and indicated that she could not bear to go to the wake or funeral and that she continued to have a strong fear of death after the accident in question. The Petitioner also reported at hearing and to her counselor that she was having difficulty going into any store either by herself or other people for fear that something like this could happen again. The Petitioner continued to have difficulty sleeping and concentrating and she found herself being startled by even small responses. The Petitioner testified at trial that the entire time she treated for his injury she was in single person therapy and that she continued to take Paxil and Xanax as prescribed by her physician through the date of the trial. TX 39. The Petitioner noted at hearing that she found herself keeping her grandchildren at home protecting them from harm and found herself personally afraid to leave her daughter's house due to her fear of death or injury. TX 40. Prior to the incident at work, the Petitioner testified that she was extremely outgoing and was often in public or outside on the weekends camping or at the park with her family. After the incident in question the Petitioner testified that she felt like she lost herself and that she became a hermit due to her increasing anxiety and depressive state. TX 40.

The Petitioner followed up again on June 20, 2016, at North Central Behavioral at which time they found that the Petitioner was having difficulty coping with her symptoms of illness and despite using deep breathing techniques to try to ease her anxiety, she was still having symptoms of trauma, flashbacks, recurrent depressing dreams and avoidance of the reminders related to the trauma. The Petitioner followed up again on June 27, 2016, at which point the counselors indicated that they needed to work on her daily routine in order to get her to go shopping again and even perform minimal daily tasks. The Petitioner testified that she was afraid to go in public at all because she was afraid that she would find somebody dead again if she went into another store but she expressed that she wanted to overcome anxiety at this time and wanted to regain her normal life back. TX 42. The Petitioner testified at trial that she used breathing exercises to focus on the positive and pull herself back from what it is that she was afraid of when a panic attack occurred. The Petitioner testified that she carried this paper around with her throughout 2016 and 2017 to help her know that everything was going to be okay. The Petitioner testified at hearing that trauma was not something specifically new to her. She testified that she had grown up in the city and she had seen trauma in her lifetime, but nothing had ever affected her to a point where she could function, couldn't think straight and couldn't perform normal daily activities.

The petitioner followed up again on July 5, 2016, at North Central at which point she noted that she was finally able to cook a meal in the past week for the first time. She reported that the prior week she was supposed to go to the zoo with her grandchildren but was unable to attend because she had a major panic attack about the crowds that they would encounter at the zoo. TX45.

She followed up again on July 12, 2016, at which point she told her physician that she had gotten into a fight with her daughter because of the symptoms she was experiencing from her mental illness. The Petitioner testified at hearing that it put a lot of strain in her daughter and their family for her to be constantly living at their house. She was encouraged by her counselor at that time to talk to her daughter about PTSD and how it affected her so that they could have a better relationship. TX 47. The Petitioner missed out on a vacation with her family where they would have gone to a water park again, during this time period, because of her ongoing anxiety and mental illness. She acknowledged during her appointments that her grandson was a major help because she focused on him rather than anything going on around her but that her psychiatrist encouraged her to acknowledge the trauma and the impact on her life as her life enfolded from day to day. TX 48. The Petitioner was instructed to write down what she was dealing with and to start taking her life back little by little by walking around the block with her grandson and coming back to the house to start. TX 49. During this time period, she was still stalled and could not go into a large place or store due to her fear of death and anxiety regarding the incident in question. TX 49.

The Petitioner followed up again on July 21, 2016, after she had gone camping with her mother. TX 49. The Petitioner indicated that prior to the incident in question, she had gone out there every weekend and was active in whatever events were being held at the campground. The Petitioner testified that this weekend in July of 2016 was the first weekend since the accident that she felt happiness again. TX 50. The Petitioner testified that she had attended an open interview at Aldi's because she felt that the Dollar General store was the reason her life continued to be stuck in an anxious place. The Petitioner testified that that is where her life changed. TX 51. The Petitioner testified at hearing that her co0workers and managers knew she was getting treatment for her PTSD and anxiety and told her she was crazy. During this time period, she was not offered any transfers. She was left alone in the store despite her telling management that she was uncomfortable being alone there. TX 52.

She followed up again on July 28, 2016, at North Central, at which point she was told not to let the bad days control her and focus on the positive by taking baby steps to try to regain her life back. Her counselors reported that the Petitioner was fearful during that session because she was under stress and anxiety relating to the conflict with her daughter about having to live in her home due to her anxiety of living along and being along in any one place following the incident in question. TX 54. The Petitioner followed up again on August 3, 2016, at which point she noted her anxiety was worse because she was coming close to the one-year anniversary of the event in question. The Petitioner testified that she still was working at the Ottawa store at the

time of hearing and she was putting up Halloween decorations again just as she had been a year prior when the incident occurred.

The Petitioner followed up again on August 31, 2016, at which time she indicated she had taken her vacation time to have a hernia fixed and was off work. TX 56. During the time period the Petitioner was off work she testified at trial that she did not have any panic attacks at home and that she felt at peace when she didn't have to go into work at Dollar General in Ottawa. The Petitioner was still applying for other jobs during this time period because she felt the specific Dollar General Store in Ottawa was bad for her mental health. TX 57. The Petitioner following up again on September 8, 2016, at which point she noted that she had no anxiety because she didn't have to go to work as she had to attend a sleep study for her grandson. The Petitioner specifically noted at that appointment that her coworkers were talking about her and keeping tabs on her when she was at work and when she was not at work as an employee lived only two blocks from her house. The specific employee the Petitioner testified to having trouble with at hearing was a woman named Kari Sue who had once been a manager prior to Isabelle taking her place as manager in the store but who had been demoted as manager prior to Isabelle taking that position. TX 58.

She followed up again on September 19, 2016, at which point she indicated to her counselor that she was given good news from Dollar General. Petitioner was asked to spearhead a new store and manage the store. The Petitioner would be in charge in bringing the store from ground zero from its open space to a functioning state. TX 59. The Petitioner testified that she felt she could breathe better and her anxiety decreased after making the decision to go to the new store as opposed to maintaining the same position in the Ottawa store. TX 60. The Petitioner followed up again on September 30, 2016 and noted she was not having anxiety at the new store as much as she did in the Ottawa store. She also indicated that she was still having difficulties going out in public – but, her psychiatrist had praised her at that time for doing so well and continuing to take baby steps to improve her mental health. TX 61.

The Petitioner returned again on October 14, 2016, at which time she noted that she was getting anxious and having a difficult time because she was having to train employees in the Ottawa store and the old manager Kari Sue she felt was constantly trying to sabotage her training in order to get Isabelle fired. The Petitioner testified at trial that her panic attacks and increased anxiety at this time were directly related from her having to reenter the Ottawa store and train her new employees in that Ottawa environment.

She followed up again on November 8, 2016, at which point she testified that she felt like she was back at her home away from home in her work at Dollar General in the new location. Again, the Petitioner was serving in the same job and management position in the new store that she had served in the Ottawa location. At the time of this appointment, the Petitioner testified that she had gone to Walmart twice by herself at this point and even though she had to stop every time she had to turn a corner in the store due to her fear, she felt that she was functioning more and more each day. TX 63.

The Petitioner followed up again on December 1, 2016, at which point she noticed increased anxiety because the manager of the Ottawa store was talking to her DM, Randy Battles, and trying to influence his decision as to whether or not to keep Isabelle as a manager following the incident in question. The Petitioner testified for the record that she was evaluated in her new store shortly after this time period and the DM found that he could see a change in her in the new store versus who she had become while working in the Ottawa store.

She followed up again on December 6, 2016, at which point she indicated she still wanted to continue with therapy because she was having issues with panic attacks, anxiety and PTSD. The Petitioner testified that this was around the time her nephew passed away and she was still unable to attend the wake or the funeral given her fear of death. At this time, the Petitioner was still warranting a diagnosis of PTSD due to her continuing fear, difficulty sleeping, recurrent thoughts and irritability. The Petitioner testified that she felt at this time that it was a battle against herself and against everybody else and she couldn't express herself in a manner that people could understand. TX 65. Petitioner testified that during this time period if she fell asleep for an hour and awake for three more, that was a normal night. Prior to the incident in question, the Petitioner testified that her sleep patterns were not like the ones previously described after the accident and that she could fall asleep on a dime with no difficulty.

The Petitioner followed up again on December 22, 2016, at which point she had anxiety related not being herself around the holiday time. The Petitioner indicated to her counselor at that time that she was putting in extra hours at work and, when Christmas was over, she was going to take more time for herself so that she could make sure that her mental health remained stable. TX 68. The Petitioner testified that when the store first opened, she was not taking even her normal day off and was working seven days a week during this period of time in question. TX 68.

The Petitioner was discharged from treatment on February 14, 2017, because her insurance didn't cover North Central. The Petitioner testified as a result of the work accident she was off work by a physician from September 4, 2015, through October 24, 2015, during which time period she was not paid by any source, workers' compensation or otherwise. TX 70. The Petitioner also testified at hearing that all of her medical treatment was paid for by her personal group health insurance of Blue Cross Blue Shield of Tennessee and the medical card which carried her through the time period that she was not working. TX 72.

The Petitioner testified that she was not having panic attacks the same way now that she did after August 9, 2015 initially. The Petitioner testified at trial that the panic attacks are not as intense and are more manageable and maintainable because she knows how to cope with them following her treatment. TX 73. The Petitioner also testified that she only has panic attacks now once or twice a month but that those panic attacks increase specifically around the time that she has to put out the Halloween decorations because it reminds her of the anniversary of the incident in question. The Petitioner testified at trial that since she has been fully in her new store

with trained employees, she has not returned to the Ottawa store for any reason, personal or business, whatsoever. TX 73.

The Petitioner testified that during the first week of August of every year she feels unable to sleep and she feels that she withdraws from society and secludes herself from the people she loves. TX 74. The Petitioner testified at trial that she has had to change her normal life and the way she lives because of the incident on August 9, 2015. The Petitioner testified as though she couldn't be social anymore and that now her relaxation is to sit inside and watch TV or read a book rather than attending cookouts or being with family as she did prior to the incident in question. The Petitioner testified at hearing that as of the date of trial she was not able to grocery shop alone and that her daughter helps her grocery shop. TX 75. The Petitioner testified that the change in getting her out of the Ottawa store has made her realize that when she was in the Ottawa store her anxiety was causing her to gasp for air. The Petitioner testified at hearing that she felt that the Ottawa store following the August 9, 2015, incident pulled every ounce of who she was away from her and caused her to freeze in fear anytime she entered the store. TX 76.

The Petitioner testified that as of the date of trial she was still having traumatic nightmares where she wakes up feeling cold and empty and that she believes that this is not something that will ever go away. Prior to the incident in question, the Petitioner testified that she was never diagnosed with PTSD or anxiety and that she had not sought any type of psychological treatment other than what was ordered for her hepatitis C medication in 2011. Petitioner testified that the symptoms she had after taking the medication for hepatitis C were totally different. The Petitioner testified that it was an anxious feeling but that it revolved around the fact that she had to get her shot for the hepatitis C and that she couldn't do anything that day. The Petitioner testified credibly at hearing that she was working full time prior to the date of incident, coming in early of her own accord, and that she was not using any kind of alcohol or drugs before or during the incident on August 9, 2015. TX 80. The Petitioner testified at trial, when asked if there was anything else that she wanted to add for the record, she still wishes that she could have done more or was able to save this one person for the two kids that have to grow up without a parent. She testified that she has difficulty seeing the happy beautiful girls and school and knowing she feels responsible on the inside for not being able to help resuscitate their mother when she overdosed in the store on August 9, 2015. TX 81.

Testimony of Dr. Dinwiddie

Dr. Dinwiddie begins by stating that he is a faculty member at Northwestern and his practice is through Northwestern. Dr. Dinwiddie has been licensed to practice psychiatry in the state of Illinois since 1996. He is board certified in general psychiatry with added subspecialty in both addiction psychiatry and forensic psychiatry. He graduated from East Virginia Medical School in 1982. He did a residency in adult psychiatry at Barnes hospital affiliated with Washington University School of Medicine which he completed in 1986. He was a faculty member at Washington university until he moved to Chicago in 1996. After his move to Chicago

he attended Chicago Medical School, now Rosalind Franklin School of Medicine, as a faculty member and later became inpatient director at Elgin Mental Health Center.

Dr. Dinwiddie first saw Isabelle Adams for an independent medical examination on March 13, 2017. In preparation for this examination her review Isabelle's medical treatment records which are detailed as a narrative in his report. The records he reviewed are reasonably relied upon by experts in his field when formulating opinions and have been formed to a reasonable degree of medical certainty. The examination took three hours and ten minutes to complete during which time a family history was completed. The family history revealed that Isabelle's maternal grandmother as psychiatrically hospitalized for a considerable length of time. Isabelle's mother showed evidence of a mood disorder and anxiety. Her mother's sister may have a dementing illness and a distant relative had epilepsy.

Dr. Dinwiddie also reviewed Isabelle's childhood and early development. Her background revealed evidence of severe childhood sexual abuse lasting about 18 months to which she was not the only victim within the household. She was kicked out of her home at the age 16 and it took a decade to reconcile with her mother. Based on this history, Dr. Dinwiddie does not believe Isabelle had a stable family life as a child. As an adolescent, Isabelle reported a few disciplinary issues such as an incident in which she was 14 years old that involved her stealing a teacher's car and frequent violations of curfew.

Dr. Dinwiddie further reviewed Isabelle's legal and behavioral history which revealed a period of imprisonment as an adult for the sale of illicit drugs. These behavior as well as Isabelle's other history is not enough evidence to diagnose her with antisocial personality disorder. Isabelle's marital and relationship history revealed abuse. Her first husband was very abusive leaving her with a fractured jaw and several fractured ribs forcing Isabelle to leave and seek protection at a battered women's shelter. In her second relationship Isabelle's lover was shot and murdered and he died in her arms. Isabelle's work history revealed periods where she was not always fully employed including an incident where she walked off a job. Eventually Isabelle secured a position at Dollar general where she was eventually promoted to Store Manager.

Dr. Dinwiddie began to describe an incident that occurred on August 9, 2015. On that day, Isabelle witnessed an individual slumped over a box and she later found out that that person had died in the store. Isabelle's prior history revealed potential substance abuse issue and the prior use of illicit drugs. There was a period of time in which Isabelle drank more than the amount recommended by the FDA, but that did not seem to cause her to develop any issues. There is no evidence of an alcohol abuse disorder. However, Isabelle did develop a cocaine use disorder that developed from her use of cocaine. Her cocaine used led to her felony conviction and her loss of custody of her children for a period of time. Isabelle's cocaine problem is currently in remission. Isabelle also stated that one period in time she used cannabis. According to Dr. Dinwiddie, Isabelle's medical history reveals postpartum depression, injuries sustained

from domestic violence, type 2 diabetes, hypertension, obstructive sleep apnea, and hepatitis C which is perhaps related to her prior substance use.

Isabelle reported having prior mental health issues before the incident that occurred on August 9, 2015. She sought treatment for anxiety problems while in the battered women's shelter. She also developed difficulties after the death of her boyfriend and after her hepatitis diagnosis. Isabelle also reported having periods of anxiety prior to the incident on August 9, 2015 for which she did not seek treatment. Isabelle was diagnosed with generalized anxiety disorder by her primary care physician Dr. Syed.

Isabelle reported to Dr. Dinwiddie a further description of the incident that occurred on August 9, 2015. She stated, "it was a Sunday afternoon, around noonish. She was setting Halloween decorations up. Her daughter and granddaughter came in while she was grabbing decals for the window. She was helping a cashier do a void and they said did somebody call an ambulance. She said the victim was dumped over a box. She was on the phone and they said to turn her over and she saw the victim purple. She had track marks on her legs." She further described seeing the customer who had collapsed who she ultimately found out died in that store. Isabelle described how the incident affected her. She initially did not have symptoms for almost a month, then she began to develop episode of what she described as panic attacks which didn't really substantiate the diagnosis of panic attacks according to Dr. Dinwiddie. They appeared to be anxiety spells. Isabelle saw her primary care doctor. They appeared to be anxiety spells. Isabelle saw her primary care doctor. Days later she saw her primary care doctor for a different reason. She had previously been prescribed Lorazepam, but she had not been taking them. The next visit to her primary care doctor was primarily for anxiety. During Isabelle's visit in December of 2015 her anxiety had substantially improved. During her mental status examination on March 13, 2017, Isabelle seemed anxious, but she displayed no physical signs of anxiety.

Following Isabelle's examination and review of her history and records, Dr. Dinwiddie thought she had a problem with substance abuse that has been in remission for years. She also has symptoms of anxiety and those that one might see in post- traumatic stress disorder, but there were not enough symptoms to diagnose Isabelle with PTSD. Dr. Dinwiddie stated that Isabelle's obstructive sleep apnea is of significance because it can cause health problems including headaches, anxiety symptoms, high blood pressure, cognitive problems and can make mood disorders more difficult to treat. Dr. Dinwiddie also stated that he does not believe these findings were related to the incident that occurred on August 9, 2015. Dr. Dinwiddie believes that there is good evidence that Isabelle's problems developed prior to the incident and they may have been exacerbated by the incident, but they were not caused by the incident because they pre-existed. He does not believe Isabelle has suffered from PTSD. Dr. Dinwiddie expressed that although, Isabelle had traumatic experiences over her lifetime she has not demonstrated other problems to substantiate a diagnosis of PTSD.

Referenced in Dr. Dinwiddie's report on September 3, 2015, is an MRI that reveals a brain cyst that he believes is unrelated to the incident in August of 2015. Dr. Dinwiddie believes that the source of Isabelle's anxiety, headaches, and sleep disorders is her history. He had serious concerns that Isabelle was attempting to mislead him because she told him that prior to August 9, 2015, she had no anxiety problems even though her medical records indicate she had treatment for anxiety. He noted that he did not believe that Isabelle intentionally misreported her symptoms. There was evidence of symptom misattribution, but this could be a conscious thing, or it could be the way people process. Dr. Dinwiddie believed Isabelle reached maximum medical improvement in December of 2015. Dr. Dinwiddie believes Isabelle's medical treatment was reasonable, necessary and appropriate.

Regarding the incident in August of 2015, Dr. Dinwiddie agrees that Isabelle could benefit from further treatment, but additional treatment is not needed or necessary. In reference to DR. Dinwiddie's narrative report dated June 28, 2017, Dr. Dinwiddie referenced the addendum in which he spoke of the difference in methodology that he a Dr. Langgut used. Dr. Langgut used a psychological assessment instrument that Dr. Dinwiddie did not use. Dr. Dinwiddie believes that he elicited more previous traumatic events than Dr. Langgut. Dr. Langgut's review of Isabelle's testing results were consistent with Dr. Dinwiddie's clinical findings. Both doctors found evidence of anxiety in Isabelle's life. Dr. Dinwiddie does not believe there are any active problems reasonably related to the event on August 9, 2015, and he believes that both he and Dr. Langgut both agreed on that point. When asked of the significance in Isabelle's initial concealment of her abusive history to Dr. Langgut, Dr. Dinwiddie stated it could be that she is consciously trying to conceal them to make a better case for causal relationship or that the question was phrased in a way where there was simply a miscommunication. It is hard to know. Dr. Dinwiddie does agree with Dr. Langgut that Isabelle did not appear to reach a diagnostic level necessary for a PTSD diagnosis. Dr. Dinwiddie also agrees that while Isabelle had significant emotional distress it is likely not necessarily the direct result of the incident in August of 2015. Dr. Dinwiddie agreed that following his review of Dr. Langgut's reports his opinion remains that none of Isabelle's diagnoses were cause by the incident that took place in August of 2015. He still believes Isabelle does not have PTSD. He still feels that Isabelle had returned to maximal medical improvement as of December 2015. Each opinion was rendered to a reasonable degree of medical and psychiatric certainty.

On cross examination by, Dr. Dinwiddie revealed that he had not examined Isabelle since his interview on March of 2017. He has not been made aware of Isabelle's further medical treatment since his initial report. He has not reviewed Dr. Langgut's curriculum vitae only an internet search to look up publications. Dr. Dinwiddie's addendum referenced a medical record contained in Dr. Langgut's report that was not supplied to him prior to his initial report. There was a medical chronology supplied to Dr. Dinwiddie on February 13, 2017 which addressed 15 questions answered by his first chronology. Dr. Dinwiddie was not supplied Isabelle's medical for September 30, 2016 which suggest that he did not receive a complete selection of her medical record. When asked how many patients he treats per year, Dr. Dinwiddie stated that he was an attending psychiatrist on one of the teaching inpatients services which is always going to have

six inpatients assigned. He does consultation work in the general hospital at least once a week which will typically service 20 or so inpatients of which he will take his share. At times he has flown solo or had one other person to divvy the load. One afternoon a week he sees outpatients then at different times he has weekend coverage or covers for a colleague. He has very different kinds of patients at any given time. He performs 10 to 15 independent medical examinations per year and not all of them are worker's compensation. Dr. Dinwiddie has been retained by both defense and plaintiff's case at a varying rate. Dr. Dinwiddie has been retained by Leah, Eisenberg, and Fraenkel in the past. He has not been retained in cases involving Dollar General. He has not spoken with the respondent's counsel prior to today's deposition they only met just prior to the deposition. He did discuss Isabelle while preparing for the deposition with respondent's counsel. He reviewed Isabelle's medical records and Dr. Langgut's report in preparation for the deposition. Nothing further.

Testimony of Dr. Langgut

Dr. Mark Brian Langgut is a licensed clinical psychologist. He has practiced in the state of Illinois since 1988 with offices in Chicago, Oak Park, Rockford, and Ottawa, Illinois. Dr. Langgut attended the State University of New York, The College of Brockport where he earned an undergraduate degree and master's degree in social psychology and statistic. He went to George Williams College in Downers Grover, Illinois where he earned a master's degree in counseling psychology. He later attended Northwestern University where he earned a PHD in clinical psychology. He specializes in testing diagnostics and working with children and families.

On November 14, 2017, Dr. Langgut rendered services to the Plaintiff, Isabelle Adams. He subsequently recorded a report of his psychological assessment of Isabelle Adams in the form of a psychological assessment. The method used in Dr. Langgut's assessment of Isabelle Adams was a clinical interview using the Minnesota Multiphasic Personality Inventory. Prior to conducting the interview Dr. Langgut review records specifically the record of Dr. Dinwiddie from June 28, 2017; records from Liberty Medical Center in Ottawa, health records, and an incident report from the Ottawa Police Department. Isabelle Adams was referred to Dr. Langgut for a psychological evaluation to better understand whether her current psychological symptoms are related to PTSD.

Dr. Langgut stated that his understanding of the incident that occurred on August 9, 2015, was that Isabelle witnessed a female customer collapse in the store at Dollar General in Ottawa, Illinois. Isabelle reported that the customer was not responsive, had turned blue, and Ms. Adams had noticed that the customer had track marks on her leg. Isabelle called for the paramedics at that point. The customer survived the initial collapse and later died in the hospital.

Dr. Langgut stated that his initial observations of Ms. Adams were that she was anxious, but cooperative and she gave reasonable responses to questions asked. She discussed her sadness and disappointment about the outcome of the event and appeared to be a credible client who did not seem to exaggerate or inhibit her responses. When asked about Isabelle's emotional

functioning, Dr. Langgut stated that her emotional functioning is a lengthy, convoluted issue. He stated that Isabelle has a long history of depression and anxiety and said that she first sought mental health therapy in 2011. She had a history of depression. Following the incident, she was engaged in weekly individual therapy and had to terminate it due to insurance issues. She also attended therapy in 2010 and 2011 due to her diagnosis of Hepatitis C. She was taking medication for hypertension, diabetes, anxiety and depression. She denied any history or current suicidal ideation or self- harm. She denied aggressive behavior, hallucinations or delusions. She did indicate that she sought treatment from Dr. Syed who diagnosed her with PTSD and prescribed Paxil for treatment. She also saw a therapist at North Central Behavioral Systems who saw her twice a week for two months and then weekly.

When asked about Isabelle's history with substance abuse, Dr. Langgut stated that between 18 and 21 Isabelle indicated that she drank daily to cope with physical abuse that she was experiencing from her ex-husband, and now she drinks very seldom or rarely. Isabelle admitted to cocaine use between 1991 and 1995 but she is not currently using and has been clean for 17 years. She was diagnosed with cocaine use disorder that was classified as in remission by North Central Behavioral Systems, and she began smoking four cigarettes a day since age 13 or 14. Dr. Langgut also stated that from ager 27 to 30 Isabelle indicated that she drank a 12 pack of beer every other day. From age 34 through an unspecified age, she drank two to three beers once a week. She used marijuana from age 14 to 15 once or twice a week smoking once to two joints each time. She used cocaine from age 27-30 every other day at a rate of one quarter to one- half gram and then she stated she also used crack cocaine between age 27 to 30 every other day. A report from 2016 noted that she abused cocaine years ago, but she has been clean for 17 years. She has been arrested and convicted of intent to deliver 2,000 grams of cocaine on an unspecified dated and was sentenced to three years in Kankakee County, Illinois. She was released after serving a year and a half.

Dr. Langgut began describing Isabelle's trauma history in reference to her 2015 workplace trauma, Isabelle indicated that she witnessed what she described as an overdose and resulting death of a woman at her workplace. She stated, "She was blue, and she died in the store, and since then I ain't been the same." Isabelle was not able to return to work or focus. She tried to work at the store for one month and then was away from work for seven weeks and unable to concentrate. She reported that immediately after the event she began experiencing symptoms of PTSD to include nightmares, anxiety, and panic attacks related to the incident. It appears that these symptoms were present until 2016 when she reported a diminution of PTSD symptoms except anxiety. However, at the time of the interview she denied having flashbacks, hostility, cutting, hyperviolence or reexperiencing the traumatic event of 2015. She said that she does have vivid and disturbing memories of the event and anxiety surrounding the circumstances of the event but is not reliving the experiences.

Dr. Langgut indicated that his conclusions state that reliving the experience is a central diagnostic indicator that is used in concert with other symptoms to determine the presence of PTSD. Accompanying records indicate that Isabelle has not been functional at work or home

since the incident. She reported constantly hearing noises and being extremely fearful of death. She stated that between 2015 and 2016 she kept having flashbacks. Dr. Langgut state that in a report from September 20, 2016 noted that Isabelle was stress free and not having any anxiety going back to work or while at work. This was in contrast to her present presentation where she reports nearly debilitating anxiety that interferes with her ability to breathe and sleep. Isabelle indicated that she took an interest in the victim and became overwhelmed when she received a phone call from the victim's mother. Isabelle stated, "I felt I couldn't help her"—the victim – "enough." Dr. Langgut concluded that while those reports point to clear anxiety and panic feature, her reactions do not appear to reach a diagnostic level for the diagnosis of PTSD at this time.

Isabelle reported her anxiety began in 2015. Her current level of anxiety is a 6 on a scale of one to ten. She reported frequent panic attacks that occur one to two times per month that is triggered by death and funerals. She stated that she is anxious and becomes irritable, and if her anxiety escalates, she has difficulty breathing, another symptom of a panic disorder. She used Xanax and Paxil for her anxiety and depression.

Dr. Langgut concluded that Isabelle's mental status report indicates that she has intact skills in memory, recall, abstract reasoning, judgment, and basic calculation skills. She appears to have the necessary cognitive skills to make good use of psychotherapeutic interaction. Her thought processes were normal in speed. She was fully coherent, but she had somewhat heightened levels of suggestibility. She did not present with evidence of delusions but had mild obsessive ideations. She presented with evidence of phobias of moderate intensity surrounding the circumstance of the traumatic event that she witnesses in 2015 with a heightened sensitivity to these events. Dr. Langgut concluded that although her psychiatric report by Dr. Dinwiddie does not indicate the need for further intervention or emotional assistance, he would strongly recommend it. Dr. Langgut concluded that Isabelle has longstanding vulnerabilities and her treatment has been interrupted by nontherapeutic issues, lack of access, and she appears to be in need of specific assistance in accepting and managing her emotions, learning effective coping skills and augmenting her fragile defensive style that leaves her vulnerable to further episodes of break through emotional dysfunction in the face of traumatic memories or additional negative events.

When asked what his diagnostic considerations were, Dr. Langgut stated Isabelle has a generalized anxiety disorder with panic features. He stated post-traumatic stress disorder is clearly indicated, although Isabel is not having symptoms presently it may bear some further discussion. Isabelle's history of cocaine abuse appears to be in a sustained remission for approximately 17 years. In reference to addendum added on February 13, 2018, Dr. Langgut described trauma treatment as treatment developed to assist adults in coping with the effects that emerge from experiencing trauma. Fr. Langgut's diagnosis of Isabelle without clinical is generalized anxiety disorder and resolved PTSD. He recommends continued treatment.

When asked whether the event in question was the cause, or a contributing cause, for the need for treatment to a reasonable degree of medical certainty, Dr. Langgut responded, "Yes, it was." Dr. Langgut stated it is not clear whether or not it was the only cause for treatment. In fact, Dr. Langgut suspected it was not the sole cause for treatment but believed that it was certainly absolutely and without a doubt a contributing factor for the need for treatment received by the Petitioner. Dr. Langgut believed the treatment received by the Petitioner was necessary but insufficient. Dr. Langgut stated that he did not understand how the symptoms of PTSD that occurred subsequent to incident were not considered a contributing cause of Isabelle's concerns by Dr. Dinwiddie.

As to the Arbitrator's decision regarding Section C, DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF THE PETITIONER'S EMPLOYMENT BY THE RESPONDENT, the Arbitrator finds as follows:

In order to obtain an award of benefits under the Workers' Compensation act, a claimant need only prove that an employment risk was a cause of his condition of ill-being. 820 Ill.Comp.Stat.Ann. 305/1 et.seq. To obtain compensation under the Workers' Compensation Act, a claimant bears the burden of showing, by a preponderance of the evidence, that she has suffered a disabling injury which arose out of and in the course of his employment. *Id.* Both "arising out of" and "in the course of" employment must both be present at the time of claimant's injury in order to justify compensation under the Act. *Id.* An injury occurs "in the course of employment," within the meaning of the Act, when it occurs within the time and space boundaries of employment, and it "arises out of employment" when 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.

Based upon the facts detailed above and the Petitioner's credible testimony at trial, as well as the submitted Ottawa Police Department report marked as Exhibit 7, the Arbitrator finds that Petitioner did have an accident at work which arose out of and in the course of her employment.

There is no doubt that the Petitioner was in the course of her employment acting as a store manager during a time of crisis in the store while she observed this woman's death and acted to prevent it. Certainly, this is an uncommon occurrence for a store manager to have to deal with – but ultimately, it is the job of the store manager to handle issues which arise within the store which the Petitioner did on August 9, 2015, when she called 911 and observed this woman's overdose and eventual death. Petitioner's inability to help resuscitate the woman due to her Hepatitis C diagnosis and the immediate anxiety and guilt the Petitioner felt at the scene restricted the Petitioner's ability to respond in an emergency situation which occurred in the course of her employment as the store manager at the Dollar General in Ottawa, Illinois. The Arbitrator hereby finds that there was an accident which occurred on August 9, 2015, which arose out of and in the course of the Petitioner's employment as a store manager for Dollar General.

As to the Arbitrator's decision regarding Section F, IS THE PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE ACCIDENT IN QUESTION, the Arbitrator finds as follows:

According to the *Pathfinder* case, when an employee suffers a sudden, severe emotional shock which results in apparent psychic injury and is precipitated by an uncommon event of significantly greater proportion or dimension than that to which the employee would otherwise be subjected in the normal course of employment, then the Petitioner's condition is causally connected to the incident in question. There is no doubt in this claim that the Petitioner suffered a sudden, severe emotional shock which resulted in injury and was precipitated by an uncommon event of significantly greater proportion than that to which the Petitioner would otherwise have been subjected in the normal course of her employment as a store manager at Dollar General.

In this case, there is proof of a specific time, place and event which caused the Petitioner to develop a mental disability attributable to the overdose the Petitioner witnessed and could not prevent in her own store. There's no question that an overdose in the Petitioner's store is an uncommon event of significantly greater proportion to that to which she would normally have to deal with as a store manager. It is clear from the Petitioner's medical records that she immediately began to exhibit anxiety, depression, headaches, dizziness, fear, and sadness following the date of accident in question.

The Petitioner testified at hearing that she couldn't think straight immediately after the accident and she began to block things out. She testified that sleeping was extremely hard for her during the first week and a half after the incident in question. She testified that she was going into work late at almost a quarter to 8:00 instead of her usual 6:00 a.m., and if she did have to go in early she kept one of her friends on the phone with her from 6:00 a.m. until approximately 10:00 a.m., when another co-worker would show up to the store in question. TX 24. The Petitioner testified that she realized she was avoiding the same area of the store, the diaper aisle, where the girl had overdosed. She testified that she was getting panicky and she felt like she couldn't breathe in the store. She began to get headaches and found herself pushing on the back of her neck to try to release the stress and tense from her neck and her head while she was in the store and working.

Petitioner testified that two weeks later she was trying to check in a shipment for the store and her brain couldn't match the numbers to the shipment she was trying to check in. It was at that point that the Petitioner decided she needed to seek treatment. TX 27. Initially, doctors did not check the Petitioner for mental health injury. Instead, the doctors tried to find any physical manifestation or reason for the entirety of her mental health symptoms. After finding an arachnoid cyst which was caused by the pressure Ms. Adams was putting on her neck while she went through the initial stress of this event, Ms. Adams began to explain to Dr. Syed why she was constantly pushing on her neck causing the arachnoid cyst. Dr. Syed asked her about stressful situations in her life at which point Ms. Adams related the accident which occurred at the store on August 9, 2015. Dr. Syed immediately referred her for mental health treatment as a

result of this accident to try to relieve her ongoing symptoms of anxiety, stress, anger, sadness and depression.

Petitioner's treater at North Central Behavioral Center is consistent in her records in relating her ongoing treatment as related at trial and in the above medical summary to the work accident in question. Dr. Langgut, the Petitioner's Independent Medical Examiner found that the Petitioner's ongoing anxiety and PTSD occurred as a direct result of the August 9, 2015, work accident in question. Additionally, the Petitioner testified that prior to the August 9, 2015, work accident in question, she had not sought mental health treatment other than the mental health treatment which was required as a result of her Hepatitis C medication approximately 14 years prior to the incident in question.

While it is true that the Petitioner does have traumatic psychological issues in her past, there was no dispute from the Respondent and no evidence presented at hearing that the Petitioner was either treating for a mental health injury prior to the incident in question, that she had any sort of prior PTSD diagnosis before the date of accident in question, or that the Petitioner was working full duty with no issues for the Respondent prior to August 9, 2015. The Petitioner's credibility was again sustained in that the Petitioner found relief from her ongoing symptomology as a result of her transfer from the Ottawa Dollar General store to a new store in Newark, Illinois. The Respondent attempted to allege in their independent medical exam that the petitioner's ongoing condition was a result of stress from her job as a general manager at Dollar General prior to the date of the accident. The Petitioner credibly testified that she remains in that position even in a new store, and her condition has improved since she started working in the new store and was able to leave her position in the Ottawa Dollar General store where this incident occurred.

An accident under the Illinois Workers' Compensation Act does not have to be the sole cause of the Petitioner's current condition of ill-being, but it does have to be at least a contributing factor to her ongoing disability and condition. It is clear in this case, that while the Petitioner did have pre-existing mental health issues, she had not received treatment for those issues in 14 years prior to the date of accident and she did not have any disabling conditions which prevented her from working full time for Dollar General prior to the incident in question. It is significant that the Petitioner was promoted six months prior to the accident in question, showing that the Petitioner, prior to August 9, 2015, was competent and able to fulfill her role as an employee benefiting Dollar General in their course of business.

The pre-existing trauma in the Petitioner's life may have been a factor in how she reacted to the incident in question on August 9, 2015, and only made the guilt she carried with her worse after that date as she wondered if she should have done more to prevent this woman's death. The question is whether or not the August 9, 2015, work accident is *a* cause of the Petitioner's current condition of ill-being and need for treatment, and based upon the testimony, medical records, and opinions of Dr. Langgut, it is.

The Arbitrator finds that based upon the Petitioner's testimony presented at trial, the entirety of the evidence contained within the Petitioner's medical records sustaining her fears following the date of accident, and the fact that the Petitioner's symptoms have improved since

she was transferred into a different store in the same position of authority that she had in the Ottawa store, the Petitioner's condition of ill being is causally related to the August 9, 2015, work accident.

As to the Arbitrator's decision regarding Section J, WAS THE MEDICAL TREATMENT RECEIVED BY THE PETITIONER REASONABLE, NECESSARY, AND RELATED TO THE DATE OF ACCIDENT IN QUESTION AND IS THE RESPONDENT RESPONSIBLE FOR THE CHARGES ASSOCIATED WITH THAT TREATMENT, the Arbitrator finds as follows:

Based upon the weight of the evidence presented at trial and the testimony of the Petitioner, the Arbitrator finds that the medical bills listed in Petitioner's Exhibit 1 are reasonable, related, and were necessary to the treatment of the mental health injury sustained by the Petitioner as a result of the August 9, 2015 work accident. The Respondent is hereby ordered to pay all of the medical bills listed on Petitioner's Exhibit 1 to Petitioner. The Respondent is entitled to a credit under Section 8(j) for any bills paid through their own group insurance plan, and it must hold harmless the petitioner for those payments made through group insurance and reimburse Petitioner for any out of pocket payments made as a result of the claim.

As to the Arbitrator's decision regarding Section K, WHETHER THE PETITIONER IS ENTITLED TO TEMPORARY TOTAL DISABILITY BENEFITS AS A RESULT OF HER TIME OFF OF WORK, the Arbitrator finds as follows:

Based on the above testimony and opinions, the Arbitrator hereby awards temporary total disability benefits to the petitioner from the period of 9/14/15 until 10/24/15 while she was off work at the direction of Dr. Syed due to injuries sustained as a direct result of the 8/9/15 work accident in question.

As to the Arbitrator's decision regarding Section L, WHAT IS THE NATURE AND EXTENT OF THE PERMANENCY OF THE PETITIONER'S CONDITIONS, the Arbitrator finds as follows:

The Arbitrator has taken into consideration the five factors found in Section 8.1b of the Act to determine the permanent partial disability of the Petitioner in this case. Those factors include: (1) the reported level of impairment pursuant to subsection (a); (2) the occupation of the injured worker; (3) the age of the employee at the time of the injury; (4) the employee's future earning capacity; and (5) evidence of disability corroborated by the treating medical records.

(1) The reported level of impairment - Neither party submitted an AMA impairment rating. Thus, the Arbitrator does not give any consideration to this factor.

(2) The occupation of the injured worker – The Arbitrator notes that Petitioner is still employed by Dollar General as a general manager but has switched stores and was entrusted with opening a new store since the date of accident in question. The Petitioner testified at hearing that she is still instructed at times to attend the Ottawa store where the incident occurred for training. She testified that attending these trainings is particularly difficult for her and that she still does not enter the Ottawa store willingly outside of these trainings due to the incident in question. The arbitrator gives this factor more weight.

(3) The age of the employee at the time of the injury – The Petitioner was 47 years old at the time of the incident in question. The arbitrator gives this factor some weight.

(4) The employee's future earning capacity – There was no evidence in the record that Petitioner's future earning capacity was affected by these injuries. The arbitrator gives this no weight.

(5) Evidence of disability corroborated by the treating medical records – The medical treatment records are consistent with Petitioner's testimony that she suffered great emotional distress, post traumatic stress disorder, anxiety, and depression following the work accident in question. The Petitioner credibly testified at hearing that she moved in with her daughter as a result of the incident in question because she didn't feel that she could be alone anymore after witnessing this woman's death. The Petitioner also credibly testified at hearing that she had ongoing difficulties going out in public, even to a grocery store, in any capacity- whether alone or with family- following the incident because of her continuous fear of this tragedy occurring again before her eyes and her not being able to help another person as they took their final breath. The Petitioner testified that she became withdrawn, sleepless, angry at times, emotional, anxious, scared, nervous, and even aggressive at times due to her condition and her inability to process her feelings of guilt regarding not being able to save this customer's life.

It is also significant that the Petitioner was continually subjected to seeing this woman's children who were in her grandchildren's class at school, and that the family of the woman continued to reach out to her to thank her for calling 911 when she harbored feelings of guilt over not being able to save the woman's life and freezing up when she felt she should have acted in response to this woman's overdose. It is clear from both the Petitioner's testimony at trial and

the medical records themselves that the Petitioner had significant disability as a result of these psychological injuries and that it is only as recent as one year ago that the Petitioner has began again to even momentarily participate in some of the activities she used to enjoy like camping or even just going grocery shopping alone. The Petitioner's disability clearly extends into the present time as she continues to fight her way through her anxiety by using the tools given to her by her physicians during her medical treatment of her Post Traumatic Stress Disorder and Anxiety diagnoses.

The Arbitrator gives this factor greater weight.

Based upon the entirety of the evidence and the consideration of the five factors as indicated above, the Arbitrator finds that the petitioner is entitled to an award of 10% loss of use of the person as a whole. Respondent shall pay Petitioner the sum of $394.97/week for a further period of 50 weeks, as provided in Section §8(d) (2) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Brenda Burnett,	)	
	)	
Petitioner,	)	
	)	
v.	)	NO: 17 WC 2548
	)	
Windmill Nursing Pavillion,	)	
	)	
Respondent.	)	

ORDER AND RULE TO SHOW CAUSE

This matter comes before Commissioner Barbara N. Flores pursuant to the law firm of Dworkin and Maciariello's Petition for Attorney Fees, Petitioner's Motion to Submit Fresh Evidence, and on the Commission's own motion for a Rule to Show Cause why Petitioner's oral argument should not be deemed waived for failure to timely file a Statement of Exceptions and Supporting Brief pursuant to Section 9040.70(d) of the Rules Governing Practice Before the Illinois Workers' Compensation Commission.

Petitioner, Brenda Burnett, filed her *pro se* Petition for Review in this matter on August 8, 2019. Petitioner's motion to proceed *in forma pauperis* pursuant to Section 20 of the Act was granted on October 8, 2019.

The law firm of Dworkin and Maciariello filed a Petition for Attorney Fees through attorney Patrick Shifley on November 13, 2019, stating in part that the firm represented Petitioner through August 6, 2019. The Petition has been continued until final disposition and a hearing on fees.

On January 13, 2020, Petitioner filed a Motion to Submit Fresh Evidence before the Commission on review, asserting that she was denied her right to a proper defense during the arbitration hearing. On February 21, 2020, Petitioner's motion was continued for consideration with Petitioner's Petition for Review.

Meanwhile, Petitioner has failed to file a timely Statement of Exceptions and Supporting Brief pursuant to Section 9040.70(c) of the Rules Governing Practice Before the Illinois Workers' Compensation Commission. Section 9040.70(d) of the Rules provides in relevant part that the "[f]ailure of any party to timely file any Statement of Exceptions and Supporting Brief or

Response Brief required by this Section *** shall constitute a forfeiture of the right to oral argument by that party." 50 Ill. Adm. Code 9040.70(d) (2016).

Therefore, the Commission having jurisdiction over said matter:

IT IS ORDERED that attorney Patrick Shifley shall file his evidence in support of the law firm of Dworkin and Maciariello's Petition for Attorney Fees with the Commission on or before August 10, 2020.

IT IS FURTHER ORDERED that Petitioner may file a Response to the Petition for Attorney Fees and any evidence submitted by attorney Patrick Shifley or the law firm of Dworkin and Maciariello on or before August 19, 2020.

IT IS FURTHER ORDERED that Respondent may file a Response to the Petition for Attorney Fees, any evidence submitted by attorney Patrick Shifley or the law firm of Dworkin and Maciariello, and any response filed by Petitioner on or before August 24, 2020.

IT IS FURTHER ORDERED that Petitioner shall file her Statement of Exceptions and Supporting Brief in support of her Petition for Review, as well as any evidence in support of her Motion to Submit Fresh Evidence, on or before August 24, 2020.

IT IS FURTHER ORDERED that Respondent shall file any Response Brief and any Response to Petitioner's Motion to Submit Fresh Evidence on or before September 8, 2020.

IT IS FURTHER ORDERED that Petitioner, Brenda Burnett, attorney Patrick Shifley and Respondent's counsel, Susan Walsh, are directed to appear before Commissioner Flores at the Chicago Review Call on September 10, 2020 at 9:00 a.m. The parties are reminded to observe the Illinois Workers' Compensation Commission notices relating to Special Circumstance and Monthly Review Call Procedures posted on the Commission's website in light of the pandemic at https://www2.illinois.gov/sites/iwcc/Pages/default.aspx. Failure to file the required documents or appear on that date shall constitute a waiver of argument on any issues pending before the Commission in this matter. See 50 Ill. Adm. Code 9040.70(d) (2016).

DATED: July 28, 2020

Commissioner Barbara N. Flores

JUL 30 2020

STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Blanche Wilfore,

Petitioner,

vs. No. 12 WC 18666

United Airlines, Inc.,

Respondent.

ORDER

This matter comes before the Commission on Respondent's motion to bar oral argument, with proper notice given. The Commission having been advised of the facts and law, bars the oral argument for the reasons stated below.

On March 26, 2019, the Arbitrator issued a decision in this matter. On April 23, 2019, Petitioner through her attorney timely filed a petition for review. However, Petitioner never filed her Statement of Exceptions and Supporting Brief, which was due July 29, 2019.

Respondent first filed its motion to bar oral argument on March 6, 2020. Thereafter, Respondent re-noticed and refiled the motion to bar oral argument for review calls in April, May, June and July of 2020. A telephonic hearing was conducted on July 9 and July 13, 2020. Respondent presented its motion, but Petitioner's attorney failed to appear. Respondent's counsel showed that he gave proper notice of the hearing.

The Commission grants Respondent's motion to bar oral argument, pursuant to Rule 9040.70 of the Rules Governing Practice before the Illinois Workers' Compensation Commission.

The Commission denies Respondent's contemporaneous request to summarily affirm the decision of the Arbitrator. Respondent's request is contrary to section 19(e) of the Illinois Workers' Compensation Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent's motion to bar oral argument is granted. The Commission will issue a decision on the merits in due course.

This order is interlocutory and not immediately appealable.

DATED: JUL 31 2020

Stephen J. Mathis

Stephen Mathis

SM/sk
44

STATE OF ILLINOIS)
) SS.
COUNTY OF CHAMPAIGN)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ROBERT TALBOTT,

Petitioner,

20 IWCC0424

vs. NO: 15 WC 37649

CITY OF SPRINGFIELD,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Respondent herein and notice given to all parties, the Commission, after considering the issues of temporary total disability, the benefit rates, and permanent partial disability, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part thereof.

I. Findings of Fact

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

II. Conclusions of Law

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

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

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

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

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

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

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

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

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

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

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

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

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

DATED: JUL 30 2020

Deborah L. Simpson

Barbara N. Flores

Marc Parker

DLS/met
O: 6/4/20
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

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TALBOTT, ROBERT
Employee/Petitioner

Case# **15WC037649**
15WC037650

CITY OF SPRINGFIELD
Employer/Respondent

On 7/17/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

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

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

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STATE OF ILLINOIS)
)SS.
COUNTY OF Champaign)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Robert Talbott
Employee/Petitioner

v.

City of Springfield
Employer/Respondent

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

Consolidated cases: **15 WC 37650**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael Nowak**, Arbitrator of the Commission, in the city of **Urbana**, on **9/25/18**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **4/11/15**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

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

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

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

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

Respondent shall be given a credit for TTD benefits paid.

ORDER

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

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

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

Respondent shall pay Petitioner permanent partial disability benefits of $735.37/week for 50 weeks, because the injuries sustained caused a 10% loss of a person as a whole, as provided in Section 8(d)(2) of the Act.

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

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

Signature of Arbitrator

7/12/19
Date

JUL 17 2019

FINDINGS OF FACTS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Petitioner first saw Dr. Pan on 9/15/15, on referral from Dr. Vasconcelles. At that time, Petitioner described the incident occurring on 4/11/15 and how it affected him. He indicated to Dr. Pan that he had been seeing Vincent Flammini. Petitioner continued to see Dr. Pan until August 15, 2017. As of 3/17/16, Dr. Pan indicated that his recommendation was that Petitioner not return to active duty for the fire department. On 3/02/17, Petitioner reported to Dr. Pan that he was receiving temporary total disability benefits. There were still some issues to be worked out and he was frustrated by the lack of resolution. He was also frustrated that on TTD he could not work otherwise. Dr. Pan's impression was that Petitioner was doing well at that time. In a letter dated 3/02/17, Dr. Pan indicated that Petitioner had made a great deal of improvement and was reasonably stable with treatment. It remained the doctor's opinion that Petitioner should not return to work as a firefighter. He felt that the inability to return to full duties as a firefighter or in emergency medical situations was indefinite

(PX7). Dr. Pan indicated in a letter to Petitioner's attorney dated 8/02/18 that he did not feel Petitioner should accept the position as fire inspector/public educator because being on the scene and investigating fires would likely trigger his PTSD. He did note that Petitioner would be able to perform any of the positions listed on pages 8 and 9 of the labor market survey from Elizabeth Skyles (PX8).

Dr. Vasconcelles, in response to an inquiry from Petitioner's attorney, indicated that on perusing the job description, she did not see any that would be a clear concern for flaring up Petitioner's PTSD. She went on to indicate that she had not specifically reviewed them with the patient to see if he would foresee a problem. The doctor noted that Petitioner was physically capable of doing the jobs, but that it would depend upon his ability to emotionally handle the situations (Joint Exhibit 1).

Petitioner was seen for an independent medical evaluation by Dr. Ganellen on 11/28/16. Dr. Ganellen reviewed medical records and talked with Petitioner. His opinion was that Petitioner should not return to work as a firefighter. He thought it would be a good idea for Petitioner to resume involvement in the work force and would encourage Petitioner's efforts to pursue a new career (RX1). With respect to Petitioner's claim for disability pension benefits, he was evaluated by Dr. Terry Killian on 5/17/17. Dr. Killian talked to Petitioner and reviewed medical records. He essentially agreed with Dr. Pan and Dr. Ganellen. He indicated that Petitioner should be considered permanently disabled from his position as a firefighter (PX12).

Petitioner was evaluated by Elizabeth Skyles, a vocational consultant, in 2017. Her initial report with regard to her evaluation of Petitioner was dated 7/31/17. She felt that Petitioner was employable and that positions were available for him (RX2). Elizabeth Skyles also performed a labor market survey and issued a report dated 8/23/17. In the course of that evaluation, Petitioner indicated that he likely would have the opportunity to return to work at the funeral home. He indicated that it was to be determined whether he would be able to work full time there, which would depend upon how much work they had. Petitioner advised that this definitely could be a good possibility and option for him. Petitioner also reported to Elizabeth Skyles that he had independently built three houses for himself. He further reported that he bought, renovated, repaired and flipped homes as well. He noted that he had acted as a general contractor and performed all the labor. He did state that he had subcontracted out some plumbing and sewer work (RX3).

CONCLUSIONS

Issue (G): What were Petitioner's earnings?

In addition to the testimony about earnings, Respondent offered into evidence wage records which include Petitioner's actual earnings from the Fire Department in the 52 weeks preceding the accident (RX9). In addition, Petitioner entered into evidence wage records which include Petitioner's actual earnings from Butler Funeral Home in the 52 weeks preceding the accident (PX14).

For the Fire Department, Petitioner's average pay period was 100 hours and forty eight minutes, or 100.8 hours every two weeks. 100.8 ÷ 2 = 50.4 hours per week. From 4/11/14 through 2/28/15, 46 2/7 weeks, Petitioner earned $34.3939 per hour. From 3/1/15 through 4/10/15, 5 6/7 weeks, Petitioner earned $34.9098 per hour.

$34.3939 x 50.4 hours per week = $1,733.45 x 46 2/7 weeks = 80,232.85. $34.9098 x 50.4 hours per week = $1,759.45 x 5.857 = $10,305.12. Therefore, Petitioner's straight time earnings in the 52 weeks preceding the accident were $90,537.97.

The Arbitrator notes that Petitioner earned overtime in 13 of the 26 pay periods preceding the accident. In 9 of the pay periods, including one after the pay increase, Petitioner worked 12.0 hours. In the other pay periods he worked 1.0, 8.0, 4.0, and 12.5 hours of overtime for a total of 25.5 hours for these periods. However, there is no evidence in the record which addresses whether the overtime was mandatory, therefore the Arbitrator declines to include these hours in the wage calculation.

There is also evidence in the record, including both parties questioning of Petitioner, to establish that during the 52 weeks prior to the accident Petitioner had concurrent employment with Butler Funeral Home. Petitioner's exhibit 14, which was admitted without objection, shows Petitioner earned $6,880.50 in the 52 weeks preceding the accident. The Arbitrator finds that these earnings should be included in the wage calculation.

Therefore, the Arbitrator finds that in the 52 weeks preceding the accident Petitioner earned $90,537.97 + $6,880.50 = $97,418.47 for an AWW of 1,873.43.

Issue (K): What temporary benefits are in dispute?

Petitioner claims entitlement to TTD from 1/6/18 through 2/11/18 (5 2/7 weeks). This is the only period the parties placed in dispute at the hearing. Petitioner last worked for Respondent on 8/27/15. Petitioner stopped working for Butler Funeral Home in September of 2015 and did not return to work for them until 2/18/18. There is no evidence in the record to establish Petitioner performed any work within the period for which TTD is claimed. The Arbitrator therefore concludes Petitioner is entitled to the claimed 5 2/7 weeks of TTD.

Respondent shall pay Petitioner temporary total disability benefits of $1,248.95/week for 5 2/7 weeks, commencing 1/6/18 through 2/11/18, as provided in Section 8(b) of the Act. Respondent shall be given a credit for temporary total disability benefits that have been paid for the 5 2/7 weeks awarded herein.

The Arbitrator notes that Respondent seeks credit for TTD benefits paid from 5/28/17 through 1/5/18. because in an office visits with his psychologist, on 5/27/17 Mr. Flammini notes "[s]ignificantly more stress related to legal issues re PTSD and retirement," and on 8/17/19 he notes "stress related to legal issuers PTSD and retirement," Petitioner considered himself retired as of 5/27/17. The totality of the evidence in the record clearly indicates that Petitioner had not retired on 5/27/17. In fact, Petitioner had applied for a line of duty disability pension from the Firefighters' Pension Board but did not have a hearing before that Board until 6/30/17. He was there after awarded the line of duty disability pension effective as of 6/30/17. There is absolutely no question Respondent is not entitled to any credit for benefits paid during the period of 5/28/17 through 6/29/17.

With respect to the period of 6/30/17 through 1/5/18, firefighters' line of duty pensions are awarded pursuant to 40 ILCS 5/4 110 et seq. Specifically, 40 ILCS 5/4-114.2 deals with reduction in line of duty

disability benefits for corresponding benefits payable under the Workers' Compensation Act. Section 5/4-114.2 provides, in pertinent part:

> **(a)** Whenever a person is entitled to a disability or survivor's benefit under this Article and to benefits under the Workers' Compensation Act [820 ILCS 305/1 et seq.] or the Workers' Occupational Diseases Act [820 ILCS 310/1 et seq.] for the same injury or disease, the benefits payable under this Article shall be reduced by an amount computed in accordance with subsection (b) of this Section. There shall be no reduction, however, for any of the following: payments for medical, surgical and hospital services, non-medical remedial care and treatment rendered in accordance with a religious method of healing recognized by the laws of this State and for artificial appliances; payments made for scheduled losses for the loss of or permanent and complete or permanent and partial loss of the use of any bodily member or the body taken as a whole under subdivision (d)2 or subsection (e) of Section 8 of the Workers' Compensation Act [820 ILCS 305/8] or Section 7 of the Workers' Occupational Diseases Act [820 ILCS 310/7]; payments made for statutorily prescribed losses under subdivision (d)2 of Section 8 of the Workers' Compensation Act [820 ILCS 305/8] or Section 7 of the Workers' Occupational Diseases Act [820 ILCS 310/7]; and that portion of the payments which is utilized to pay attorneys' fees and the costs of securing the workers' compensation benefits under either the Workers' Compensation Act [820 ILCS 305/1

40 ILCS 5/4-114.2(a). Clearly this provision does not contemplate elimination of obligation to pay TTD benefits otherwise payable based on the award of a line of duty disability pension.

Respondent next alleges that when Petitioner failed to accept a position offered by Respondent on 12/13/17 which was allegedly "within Petitioner's restrictions" he refused the offer and had voluntarily removed himself from the work force. The Arbitrator disagrees. No physician ever cleared Petitioner to return to work in that position. Dr. Vasconcelles, in response to any inquiry of 7/23/18, wrote:

> ...I have been managing Robert's medications for his PTSD. It is under good control as long as he is not exposed to any triggers that can exacerbate his PTSD symptoms. Unfortunately, that seems to be any activities that remind him of his job as a fireman and EMT. On perusing the jobs descriptions enclosed, I do not see any that would be a clear concern for flaring his PTSD but I have not specifically reviewed them with the patient to see if he foresees any concerns. He is physically capable of doing any of these positions but it will depend on whether he can emotionally handle the rigors. I am not equipped as a primary care doctor to render a decision in this regard....

(JX 1). The Arbitrator does not believe this to be an opinion that Petitioner was capable of returning to work in one or more of the offered positions. Instead, it is a fairly clear statement that the doctor is not qualified to render an opinion of the matter. Further, the statement was not rendered until many months after the last requested payment of TTD.

Respondent does not claim credit for any benefits paid during the requested benefit period of 5 2/7 weeks from 1/6/18 through 2/11/18.

Based upon the foregoing the Arbitrator concludes Respondent is not entitled to the credit claimed.

Issue (L): What is the nature and extent of the injury?

Pursuant to §8.1b of the Act, permanent partial disability from injuries that occur after September 1, 2011 is to be established using the following criteria: (i) the reported level of impairment pursuant to subsection (a) of §8.1b of the Act; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. 820 ILCS 305/8.1b. The Act provides that, "No single enumerated factor shall be the sole determinant of disability." 820 ILCS 305/8.1b(b)(v).

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that neither party submitted an impairment rating. The Arbitrator therefore gives *no* weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes Petitioner was a firefighter and described his job activities in great deal. The Petitioner testified that he is unable to perform his job activities given the level of psychological impairment he still feels to date. His symptoms and treatment thereof continue through the date of trial. The Arbitrator therefore gives *greater* weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 53 years old as of the date of his workplace injury. Petitioner will likely live the rest of his life afflicted by the ongoing results of the psychological trauma sustained in this injury. The Arbitrator therefore gives *greater* weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes Petitioner is unable to work in any emergency field due to his psychological triggers from the trauma of the incident. The emergency service field was his chosen occupation and primary source of income to provide for himself and his family, that field as a whole is no longer available to Petitioner. The Arbitrator therefore gives *greater* weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that Petitioner testified to the ongoing psychological problems he is enduring. Respondent did not offer any evidence or testimony to refute the testimony of Petitioner, nor did Respondent offer the testimony of any expert to refute the Petitioner's condition. The Arbitrator finds the Petitioner to have testified credibly and the medical records to corroborate his medical condition. Petitioner entered into evidence the report of Dr. Pan, who indicated that Petitioner is certified as permanently disabled from firefighter service as a result of cumulative effects of acts of duty as a firefighter. (PX 7). Also submitted into evidence are the medical records of Dr. Pan which indicate a history of medical treatment and exams given by Dr. Pan to Petitioner.

All of the treating medical records entered into evidence without objection from Respondent corroborate the symptoms and the impact on Petitioner in his personal life. The records of the treaters in this case indicate the protracted duration of recovery, if there is even any recovery to be had in this matter. Because the medical

records and evidence taken as a whole corroborate the Petitioner's complaints, the Arbitrator therefore gives *greater* weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 50% loss of use of the person as a whole pursuant to §8(d)2 of the Act.

STATE OF ILLINOIS)
) SS:
COUNTY OF KANE)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jaime Perez,

Petitioner,

vs. NO: 14 WC 17641

Sonoco Alloyd,

Respondent.

ORDER

An Amended Motion for Extension having been filed by Respondent herein and a Motion to Strike Respondent's Brief and Deny Respondent's Request for Oral Argument having been filed by Petitioner herein, due notice having been given, this cause came before Commissioner Thomas J. Tyrrell for hearing on July 22, 2020, in Chicago, Illinois. The Commission, after being fully advised in the premises, hereby denies Respondent's motion and grants Petitioner's motion for the reasons set forth below.

Background

On May 23, 2014, Petitioner filed an Application for Adjustment of Claim alleging he sustained injuries due to an accident arising out of and in the course of his employment with Respondent on April 14, 2014. The case proceeded to a hearing on all disputed issues on November 19, 2019. Arbitrator Ory filed a Decision of the Arbitrator with the Commission on January 31, 2020, and awarded benefits to Petitioner including medical expenses, temporary total disability, and permanent partial disability. Petitioner filed a Petition for Review on February 21, 2020. Respondent then filed its Petition for Review on February 25, 2020. A review of the IWCC mainframe shows the court reporter who transcribed the arbitration hearing filed the completed transcript on March 6, 2020. The Return Date on Review was May 8, 2020. Pursuant to the Section 9040.70 of the IWCC Rules, both parties were to file Statements of Exceptions and Supporting Briefs by June 8, 2020.[1]

[1] The Commission notes that 30 days from the Return Date on Review is June 7, 2020. As that is a Sunday, the parties' Statements of Exceptions were due on June 8, 2020.

Due to the devastating worldwide pandemic, the Commission first suspended normal in-person Arbitration and Commission Review Proceedings initially for a two-week period beginning March 17, 2020. In the memorandum, the Chairman wrote:

> "All other Commission operations will continue as usual. **Parties are advised that any statutory filing deadlines and statutes of limitation will not be affected by these measures, and the Commission will continue to process all usual documents and filings, made in person or by mail."**

(March 17, 2020 Memorandum) (emphasis added). This initial two-week period has been extended multiple times pursuant to Governor Pritzker's Executive Orders. However, at all times the Commission has continued to process documents and filings and statutory deadlines have remained in effect.

On April 27, 2020, at Petitioner's prodding, Respondent and Petitioner met in the parking lot of Respondent's office to review and authenticate the transcript. Over the next month, Petitioner continued to reach out to Respondent in an attempt to discuss whether the parties should seek a continuance for filing their Statements of Exceptions. After not receiving a response from Respondent, Petitioner filed his Statement of Exceptions on June 5, 2020. On June 8, 2020, Respondent finally delivered a motion seeking an extension to file its brief to the Commission (the day its Statement of Exceptions was due). In the motion, Respondent sought an additional month to file the required brief in part due to difficulties caused by the pandemic and the Governor's corresponding Executive Orders drastically limiting the conduct non-essential businesses through June 1, 2020. Respondent also wrote, "Respondent's Attorney had limited access to files and **has been unable to obtain the necessary documentation to prepare their Statement of Exceptions** due to the Pandemic." (emphasis added). Respondent filed its Statement of Exceptions on July 8, 2020. Respondent's original motion was scheduled to proceed during Commission Tyrrell's July 10, 2020, Chicago Review Call; however, due to technical difficulties with Webex, the Commission continued the Call.

At Petitioner's request, Commissioner Tyrrell held a hearing with both parties via telephone on July 13, 2020. During this call, Respondent admitted that the invoice from the court reporter for the arbitration transcript remained unpaid. Petitioner objected to the sought-after extension and stated that Respondent's behavior has served to further delay Petitioner's receipt of the benefits awarded by Arbitrator Ory almost six years after the work injury. Commissioner Tyrrell allowed the parties to fully brief their positions and set this matter for an in-person hearing on the record on July 22, 2020, in Chicago. On July 16, 2020, Respondent filed the current amended motion seeking an extension. Petitioner filed the current motion seeking to strike Respondent's Statement of Exceptions and deny Respondent's request for oral argument on July 20, 2020.

On July 22, 2020, Commissioner Tyrrell conducted an in-person hearing on both pending motions. Counsel for Petitioner, Ms. Mary Pat Donohue, was present as was

Counsel for Respondent, Mr. Bradley Meltzer. Both parties had an opportunity to fully argue their positions on the record. Mr. Meltzer stated that due to a mix-up in his office, his client never received the court reporter's outstanding invoice. Other than this initial internal miscommunication, Mr. Meltzer offered no explanation for why the court reporter remained unpaid for four months. He further stated that his law firm finally paid the court reporter on July 16, 2020—the same day Respondent filed its amended motion.

Conclusion

After carefully considering the briefs and arguments presented on the record, the Commission denies Respondent's motion for an extension of time and grants Petitioner's motion to strike Respondent's untimely filed Statement of Exceptions. The Commission further denies Respondent's request for oral arguments in this matter.

The Commission is greatly disturbed by Respondent's seemingly cavalier attitude toward paying the court reporter for her hard work in preparing the transcript of the arbitration hearing. While we have all been affected by the ongoing pandemic, there is absolutely no excuse for Respondent's failure to pay the outstanding invoice for four months. Respondent's egregious behavior was then compounded by Mr. Meltzer's apparent inability to properly communicate with both the court reporter regarding the outstanding invoice, and Ms. Donohue regarding his need for an extension of time to file Respondent's Statement of Exceptions. The Commission is especially troubled by the somewhat disingenuous nature of both Respondent's original motion and the current amended motion. While Respondent takes great care to blame its failure to meet its deadline on the effects of the ongoing pandemic, the Commission finds Respondent's failure to pay for and thus obtain the full arbitration transcript was the primary issue driving the need for an extension of time. Respondent did not want to pay for the transcript, yet it needed the transcript to complete its Statement of Exceptions. If Respondent truly gave this matter the time and consideration it deserved, it had ample time to rectify whatever internal communication breakdown led to the transcript invoice remaining unpaid for a little over four months.

Pursuant to Section 9040.60 of the IWCC Rules, the Commission shall grant a party an extension of time for filing its Statement of Exceptions and Supporting Briefs "only for good cause shown." After considering the totality of the circumstances surrounding Respondent's pending request for an extension of time to file its Statement of Exceptions, the Commission finds Respondent has failed to show good cause for the request for additional time. There is no question that everyone, including Counsel for Respondent and Counsel for Petitioner, has had to endure unprecedented circumstances over the past almost five months. However, Respondent simply cannot blame its current situation on the ongoing pandemic. A delay in obtaining the documentation necessary to complete its brief in a timely manner is not good cause for an extension when the party's inability to obtain the documentation is due to its failure to pay for the hearing transcript.

While the Commission finds Respondent's conduct in this matter to be indefensible, the Commission's power to properly address this situation is limited.

Pursuant to Section 9040.70(d) of the IWCC Rules, the failure of any party to "timely file any Statement of Exceptions and Supporting Brief or Response Brief required by this Section...shall constitute a forfeiture of the right to oral argument by that party." Pursuant to the Act and the IWCC Rules, the Commission hereby denies Respondent's request for an extension of time to file its Statement of Exceptions and strikes the brief Respondent filed on July 8, 2020. Furthermore, the Commission denies Respondent's request for oral arguments. As this is a cross-review, Petitioner may proceed with oral argument if Petitioner timely requested orals. If Petitioner proceeds with oral argument, Respondent shall only be allowed two (2) minutes for a rebuttal argument.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent's Amended Motion for Extension is hereby denied.

IT IS FURTHER ORDERED that Petitioner's Motion to Strike Respondent's Brief and Deny Respondent's Request for Oral Argument is hereby granted.

This is an interlocutory order and is therefore not subject to review in the Circuit Court.

DATED: JUL 29 2020

Thomas J. Tyrrell

r-7/22/2020
TJT/jds
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STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

LLOYD IVY II,

Petitioner,

vs. NO: 13 WC 1058
14 WC 42164

HOUSING AUTHORITY OF LASALLE COUNTY ILLINOIS,

Respondent.

ORDER

This matter comes before the Commission on Respondent's Motion to Strike Petitioner's Petition for Review. A hearing was held before Commissioner Portela on July 6, 2020, in Chicago, Illinois, and a record was made.

Procedural History

1) The hearing on Arbitration took place before Arbitrator Erbacci on October 24, 2019. The Arbitration Decision issued on December 2, 2019.

2) On or about December 17, 2019, Petitioner filed a Petition for Review of the Arbitrator's Decision.

3) On January 30, 2020, Notice of Return Date on Review issued to the parties showing a return date on review of March 27, 2020.

4) On or about January 27, 2020, Petitioner's attorney filed the transcript with the Commission. He subsequently discovered it had not been authenticated.

5) The parties arranged to meet to authenticate the transcript on either February 26 or February 27, 2020. Although counsel for both parties appeared at the predetermined site, due to an apparent miscommunication, the parties were unable to locate one another.

6) In March of 2020, before the expiration of the running of the return date on review of March 27, 2020, there were a few email exchanges between the parties' counsel, but the transcript

was not authenticated prior to March 27, 2020.

7) On or about March 17, 2020, the Commission altered its normal operating procedures due to the COVID pandemic. The Governor issued a Stay at Home Order on March 20, 2020. In light of same, the Commissioner has been hesitant not to grant continuances to authenticate transcripts and show some leniency, given these extenuating circumstances.

8) On or about April 22, 2020, Respondent filed its Motion to Strike Petitioner's Petition for Review.

9) On April 24, 2020, the Commission issued a Rule to Show Cause which extended the deadline to authenticate that transcript until May 4, 2020.

10) At no time either before or after the Commission issued a Rule to Show Cause did Petitioner's counsel attempt to contact the Commission to inquire if he could withdraw the original transcript so the parties could authenticate same, nor did he request an extension. Furthermore, Petitioner's counsel made no attempt to present the transcript to Arbitrator Erbacci for authentication pursuant to 820 ILCS 305/19(b), when he believed Respondent's counsel was being uncooperative in efforts to have the transcript authenticated.

11) Only *after* the deadline for filing the transcript pursuant to the Commission's Rule to Show Cause expired on May 4, 2020, did the Petitioner's counsel address a letter to the Commission dated May 5, 2020, wherein he enclosed his Response to the Statement of Exceptions filed by Respondent, requested oral argument, and therein indicated his willingness to authenticate the transcript.

Conclusions of Law

50 Ill.Admin.Code 9040.10(c)(1) sets forth how to perfect a Review before the Illinois Workers' Compensation Commission, including the requirement that the transcript of arbitration proceedings *shall* be authenticated in the manner provided by Section 19(b) of the Workers' Compensation Act. 820 ILCS 305/19(b) sets forth that the parties file an agreed statement of facts or correct transcript of evidence *authenticated by the signatures of the parties or their attorneys*, and in the event they do not agree as to the correctness of the transcript of evidence it shall be authenticated by the signature of the Arbitrator designated by the Commission.

At no time prior to the return date on review of March 27, 2020, nor prior to the May 4, 2020 date designated by the Commission's Motion to Show Cause, was an authenticated transcript filed as required by the Administrative Rules governing the practice before the Commission.

As the Petitioner has failed to comply with 50 Ill.Admin.Code 9040.10(c)(1), the Respondent's Motion to Strike Petitioner's Petition for Review is granted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent's Motion to Strike is Granted.

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: JUL 30 2020

Maria Elena Portela

Maria E. Portela

MEP/dmm
R: 7/6/20
49

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

Thomas Petitti,

Petitioner,

20IWCC0425

vs.

NO: 18 WC 8477

Friendly Ford, Inc.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, temporary disability, bills and prospective medical and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 8, 2019, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

20 IWCC0425

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUL 30 2020
o7/23/20
DLS/rm
046

Deborah L. Simpson

Barbara N. Flores

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

20 IWCC0425

PETITTI, THOMAS
Employee/Petitioner

Case# **18WC008477**

FRIENDLY FORD INC
Employer/Respondent

On 11/8/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.53% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

5625 GRAUER & KRIEGEL LLC
ANDREW KRIEGEL
1300 E WOODFIELD RD SUITE 205
SCHAUMBURG, IL 60173

0766 HENNESSY & ROACH PC
NATALIE BAGLEY
140 S DEARBORN ST SUITE 700
CHICAGO, IL 60603

20 IWCC0425

STATE OF ILLINOIS)
)SS.
COUNTY OF DuPage)

- [ ] Injured Workers' Benefit Fund (§4(d))
- [ ] Rate Adjustment Fund (§8(g))
- [ ] Second Injury Fund (§8(e)18)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Thomas Petitti,
Employee/Petitioner

v

Friendly Ford, Inc.
Employer/Respondent

Case # **18** WC **008477**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Arbitrator Frank Soto**, Arbitrator of the Commission, in the city of **Wheaton**, on **August 16, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [x] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [ ] Is Petitioner entitled to any prospective medical care?
L. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On the date of accident, **January 9, 2018**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident ***was*** given to Respondent.

Petitioner's current condition of ill-being ***is*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**69,584.32** the average weekly wage was $**1,338.16**.

On the date of accident, Petitioner was **60** years of age, ***single*** with **0** dependent children.

Respondent ***has not*** paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $**7,136.80** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**7,136.80**.

Respondent is entitled to a credit of $**0.00** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $26,003.40 ($892.11/wk. for 29-1/7 weeks) for the periods of 4/26/18 through 9/5/18 and 5/3/19 through 7/16/19 (the date of the hearing) as provided in the Act. Respondent shall also pay to Petitioner TTD from the date of the hearing, as set forth in the Conclusions of Law attached hereto;

Respondent shall pay directly to Petitioner the following unpaid reasonable and necessary medical bills: 1.) Ortho Illinois, f/k/a Associates in Orthopedic Surgery -- $13,891.83; 2.) Enhanced Medical Imaging – Elgin -- $1,474.00; 3.) Midwest Anesthesia Partners -- $ 3,961.00; 4.) Sherman Hospital -- $18,386.00; 5.) Richmond SA Services, Inc. -- $6,868.38; 6.) Athletico -- $7,541.98; 7.) Prescriptions -- $59.56, as delineated in Petitioner's Exhibit 5 through Exhibit 11, pursuant to the fee schedule and Sections 8(a) and 8.2 of the Act. Respondent shall receive a credit for any medical bills which Respondent had previously paid, as set forth in the Conclusions of Law attached hereto;

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

11/6/2019
Date

ICArbDec19(b)

NOV 8 - 2019

Procedural History

This matter was tried on August 16, 2019. The disputed issues were whether Petitioner had an accident that arouse out of and in the course of his employment, whether Petitioner's current condition of ill-being is causally related to the injury, whether Respondent is liable for medical expenses and whether Petitioner is entitled to TTD benefits.

Findings of Fact

On July 9, 2018, Thomas Petitti (hereinafter referred to as "Petitioner") was employed by Friendly Ford, Inc. (hereafter referred to as "Respondent") as a journeyman mechanic. (Tr. p. 9). Petitioner testified that he has been a mechanic for thirty-five years and worked for Respondent for twenty-eight years. Petitioner testified that his position as a mechanic required a great deal of heavy work and overhead work, including working on heavy duty trucks and cars. (Tr. p. 11).

Medical treatment prior to January 9, 2018

Prior to July 9, 2018, Petitioner was undergoing medical treatment for an injury to his left shoulder. Petitioner underwent a left shoulder arthroscopic biceps tenodesis and arthroscopic rotator tuff repair surgery, on October 18, 2017, with Dr. Mox an orthopedic surgeon at Ortho Illinois. On November 7, 2017, Petitioner returned to Dr. Mox for a post-surgery follow up visit. At that visit, Dr. Mox noted that Petitioner was doing well. Petitioner had active flexion of ninety degrees in both planes. Dr. Mox proscribed physical therapy. In his office notes, Dr. Mox noted that Petitioner should advance to active exercises and could be able to return to his regular duties, as auto mechanic, in about three months. (PX 3)

Petitioner returned to Dr. Mox on December 5, 2017. At that time, Petitioner reported that he was in therapy and was doing well. Dr. Mox noted that Petitioner had more strength and more range of motion. The examination showed that Petitioner had forward flexion against gravity of 140 degrees laterally and his supraspinatus strength was rated as 4/5 without pain. In his office notes, Dr. Mox indicated that Petitioner will be released to his full mechanic duties after Petitioner returns from his vacation in the middle of January. (PX 3).

Work incident of January 9, 2018

Petitioner testified that he was involved in a work accident on January 9, 2018. Petitioner testified that, prior to January 9, 2018, he returned to work with light duty restrictions of no lifting more than 25 pounds floor to waist and no lifting more than 10 pounds overhead. (Tr, Pg. 45-47).

Petitioner testified that while at work, on January 9, 2016, he was driving a push truck, which is a vehicle used to push disabled cars into the garage. Petitioner testified that as he put the

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push truck into low gear the peddle got stuck causing and the push truck propelled forward causing the front wheels to come off the ground. Petitioner testified that the push truck did a wheelie until it landed on the hood of a car and bounced off. Petitioner testified that was trying to hold on for his life. After the push truck bounced off the car and veered off he was able to turn vehicle off. (Tr, Pg. 13).

Petitioner testified that he immediately reported the accident to Matt Yockey and Dan Maciunas, his managers. (T. pg. 18). Petitioner testified that, at that time, he believed that he was only slightly, and he did not know the extent of his injury. Petitioner testified that he was actually shaking after the incident. Petitioner testified he reported that he was injured. (T. Pg. 19).

Petitioner testified that he already had an appointment previously scheduled with Dr. Mox for his left shoulder and, at that appointment, he discussed the incident with Dr. Mox. Petitioner testified that he was experiencing throbbing, pounding and fatigue in his left shoulder after the incident. (T. pgs. 19-21).

Testimony of Derrick Eskridge

Petitioner called his co-worker, Derrick Eskridge, as a witness. Mr. Eskridge testified that he was working with Petitioner on January 9, 2018. Mr. Eskridge testified that he was going to move a car from the parking lot into the garage with Petitioner, who was operating the push truck. Mr. Eskridge testified that he was in the car when he saw the front of the push truck move quickly and the front wheels to come off the ground. Mr. Eskridge testified the push truck was coming toward him and he could see the whole bottom of the push truck. Mr. Eskridge testified that the push truck handed on the car he was in and bounced off the hood before veering off. (T. Pgs. 54-56).

Mr. Eskridge also testified that he works in the bay next to Petitioner and, prior to January 9, 2018, he does not recall Petitioner ever complaining of right shoulder pain (T. 58, 59).

Testimony of Ken Schneck

Respondent called Ken Schneck as a witness. Mr. Schneck testified that he is the facility manager and he inspects the push trucks. Mr. Schneck testified that on January 10, 2018, he inspected the push truck and found no issues with the throttle. (T. pgs. 62-66).

Testimony of Randy Yockey

Respondent called Randy Yockey to testify. Mr. Yockey is Respondent's co-owner and he oversees the fixed operations which includes the parts, service and the body shop operations.

(T. pg. 78). Mr. Yockey testified that, prior to the work incident of January 9, 2018, Petitioner was previously off for a left shoulder injury from October 17, 2017 through October 29, 2017. Mr. Yockey testified that Petitioner was working light duty prior to his January 9, 2018 work incident. (T. Pgs. 83,84).

Mr. Yockey testified that after the January 9, 2018 work incident, Petitioner continued to work on January 10, 11 and the 12th of 2018. Mr. Yockey testified that January 13th and 14th were the weekend which Petitioner doesn't work. Mr. Yockey further testified that Petitioner went on vacation for seven days, from January 15, 2018 through February 17, 2018 and he returned to work on January 24, 2018. (T. Pg. 89).

Mr. Yockey testified that upon returning from vacation, Petitioner advised him of his injury. Mr. Yockey testified that Petitioner came to his office at 8:56 a.m., on January 24, 2018, and said that he injured the same shoulder he previously had surgery and he believes that another surgery may be required. (T. pgs. 89, 90).

Mr. Yockey also testified that day following the January 9, 2018, incident Petitioner reported that his shoulder was hurting and that he was going to return to the doctor to see if he had reinjured his shoulder to the service manager, Dan Maciunas. (T. Pg. 91).

Petitioner's medical treatment

On January 22, 2018, Petitioner returned to Dr. Mox for a follow up appointment involving the prior left shoulder arthroscopy. At this appointment, Petitioner reported that he was involved in a work accident on January 9, 2018. Petitioner said that he was working light duty driving a vehicle that pushes car when the throttle stuck which caused the vehicle to run into several cars and severely injuring his left shoulder. Petitioner denied any other injuries. Petitioner reported severe pain and weakness in his left shoulder since the on-the-job injury. (Px 3).

Dr. Mox examined Petitioner. In his office notes, Dr. Mox noted that Petitioner's forward flexion against gravity range of motion was 130 degrees laterally and 120 with severe pain in the subacromial space. The supraspinatus test and strength were at 3/5, with lots of pain. In his office notes, Dr. Mox wrote "I am worried that Petitioner may a new left shoulder rotator cuff injury". An MRI of the left shoulder was ordered. (PX 3).

Petitioner returned to Dr. Mox on February 12, 2018. At that time, Petitioner reported pain with any reaching and overhead activities which he did not have prior to the on-the-job incident. In his office notes, Dr. Mox indicated that Petitioner recently underwent a left shoulder arthroscopy

arthroscopic rotator cuff repair and biceps tenodesis in October of 2017 and was doing very well postoperatively and since the January 9th incident Petitioner's symptoms had not improved. Dr. Mox reviewed the February 5, 2018 MRI and compared it with a prior MRI and noted the new MRI showed supraspinatus thickening with chronic tendinopathy, since previous exam, and a chronic mild undersurface partial tear small subacromial bursitis. Dr. Mox opined that the MRI showed a new rotator cuff tear of the supraspinatus. Dr. Mox recommended surgery which was scheduled for February 28, 2018. (PX3).

Petitioner underwent left shoulder arthroscopy and arthroscopic rotator cuff repair on April 26, 2018. (Px. 3). The operative report identified a significant, greater than 50%, partial rotator cuff tear in the anterior aspect of the supraspinatus. (Px. 3).

After surgery, Dr. Mox restricted Petitioner from working. (Tr. p. 23 and Px. 3). Petitioner followed up with Dr. Mox on May 2, 2018. Petitioner was issued a prescription for Norco. (Px. 3). Petitioner returned to Dr. Mox on May 16, 2018 who ordered physical therapy, recommended a home exercise program, pendulum exercises and continued use of the sling until beginning therapy. (Px. 3). Petitioner followed up with Dr. Mox on May 16, 2018. At that time, Dr. Mox ordered therapy for the next month followed by active range of motion therapy. (Px. 3).

Petitioner testified that he started to develop right shoulder pain after he had been using his right arm for everything since his left arm hurt too much to use after surgery (Tr. p. 23).

Petitioner followed-up with Dr. Mox on June 4, 2018. At that appointment, Petitioner reported right shoulder pain. (Px. 3). In his office notes, Dr. Mox indicated that Petitioner developed a gradual onset of subacromial right shoulder pain following his left shoulder surgery because Petitioner has been using his right arm and shoulder more while recovering. Dr. Mox diagnosed impingement of the right shoulder. (Px. 3).

Petitioner returned to Dr. Mox on June 13, 2018. At that visit, Petitioner reported his pain level as 3/10 during rest but that his pain worsens during physical therapy. Petitioner also reported feeling pain, stiffness and catching. (Px. 3).

On August 8, 2018, Petitioner followed up with Dr. Mox complaining of bilateral shoulder pain. Petitioner continued taking Norco, meloxicam and participating in home therapy. Dr. Mox noted that Petitioner's range of motion was improving, but there was still pain with supraspinatus testing. (Px. 3). Petitioner followed up with Dr. Mox on June 13, 2018. At that time, Petitioner reported his pain levels as 3/10 at rest and 10/10 during physical therapy. (Px. 3).

Petitioner returned to Dr. Mox on September 5, 2018. Petitioner continued to complain of bilateral shoulder pain and that he was having pain with overhead pulling and raising his arm to the side. Petitioner had been participating in a home exercise regimen two times daily. At that appointment, Dr. Mox released Petitioner to modified work with a 25-pound lifting restriction and a 10-pound overhead lifting restriction. (Px. 3).

Petitioner testified he returned to work following his light duty release he was unable to continue with physical therapy as of September of 2018 because his health insurance would not cover the appointments. (Tr. p. 25).

Petitioner followed up with Dr. Mox on October 3, 2018. At that time, Petitioner reported that he was unable to lay on either side due to his ongoing shoulder pain. (Tr. p. 26) (Px. 3). Petitioner was still taking hydrocodone and meloxicam. (Tr. p. 26). Petitioner continued to work restricted duty as a mechanic.

On October 31, 2018, Petitioner returned to Dr. Mox reporting right shoulder pain. Dr. Mox administered a steroid injection in the right shoulder. (Px. 3). Petitioner returned to Dr. Mox on November 28, 2018. At that visit, Petitioner reported that he was performing a lot of overhead lifting, pushing, and pulling with both shoulders and he was experiencing bilateral shoulder pain. Dr. Mox noted inflammation and impingement of the right shoulder and diagnosed bursitis of the right shoulder and he administered another steroid injection into the right shoulder. (Px3).

Petitioner continued to work in pain following the November 2018 injection. Petitioner returned to Dr. Mox on January 23, 2019. Petitioner testified he continued to experience throbbing, pounding pain and fatigue. Petitioner testified that he was having severe pain and fatigue with overhead reaching, and that he was unable to leave his arms up. (Tr. p. 28). Dr. Mox's records indicate that Petitioner reported feeling constant throbbing, aching pain. Dr. Mox's records also note that Petitioner's range of motion was limited, and Petitioner reported difficultly sleeping due to his pain. Dr. Mox ordered MRIs of both shoulders. On February 5, 2019, Petitioner underwent the MRIs of both shoulders. (Px. 3).

The February 5, 2019 left shoulder MRI showed:

1.) Tendinopathy in the supraspinatus, subscapularis, and infraspinatus tendons, being severe in the supraspinatus and infraspinatus tendons; and
2.) A high-grade infrasubstance concealed partial tear of the infraspinatus tendon as well as a small infrasubstance/concealed partial tear of the supraspinatus tendon.

The February 5, 2019 right shoulder MRI showed:

1.) Moderate tendinopathy of the supraspinatus, infraspinatus, and subscapularis tendons;
2.) A small intrasubstance concealed partial tear of the infraspinatus tendon;
3.) A moderate intrasubstance concealed partial tear of the upper 3rd of the subscapularis tendon; and
4.) Moderate superior labral fraying. (Px. 3).

Petitioner followed up with Dr. Mox on February 8, 2019. At that visit, Petitioner complained of sharp, throbbing, aching pain. Dr. Mox's records indicate that he reviewed the MRI's which, he believed, showed severe tendinopathy of the rotator cuff tendonitis. Dr. Mox noted, at that time, Petitioner was not a surgical candidate. (Px. 3).

Petitioner continued to treat at OrthoIllinois through June 14, 2019 and was administered additional corticosteroid injections. During this time, Petitioner reported pain levels of 6/10. Petitioner also reported that he was working light duty but was having difficulties performing his job duties because of numbness and tingling in his fingers. On May 3, 2019, Petitioner taken off work and administered another corticosteroid injection into the subacromial space of the right shoulder. (Px. 3).

On June 14, 2019, Petitioner returned to OrthoIllinois and reported the injections had not reduced his symptoms. Petitioner was administered another injection into the right shoulder. (Px3).

Testimony of Dr. Michael Grear, the Section 12 examiner

Dr. Grear evidence deposition was taken on November 2, 2018. Dr. Grear examined Petitioner on August 3, 2018. Dr. Grear testified that he obtained a history from a combination of the records reviewed and information elicited from Petitioner. Dr. Grear testified that Petitioner reported on January 9, 2018, he was pushing a vehicle with a push tug when it accelerated resulting in an uncontrolled forward motion of the vehicle causing a collision which irritated his left shoulder. (Rx 2).

During the exam, Dr. Grear noted mild tenderness with palpation over the AC joint and over the anterior and lateral posterior aspects of Petitioner's left rotator cuff. The active range of motion abduction was 120 degrees with complaints of pain at the extreme of motion. The forward flexion was approximately 50 degrees with pain in the extreme motions. The external rotation was approximately 90 degrees and the internal rotation was approximately 70 degrees. The examination of the right shoulder showed essentially normal with virtually unrestricted range

of motion. Dr. Grear diagnosed status post arthroscopic rotator cuff repair for a partial degenerative tear of the left rotator cuff and a normal right shoulder. (Rx 2).

Dr. Grear opined that Petitioner sustained a temporary exacerbation of his pre-existing left shoulder as a result of the January 9, 2018 work accident. Dr. Grear testified that it was a temporary aggravation or irritation of a pre-existing condition of a degenerative tear of the rotator cuff. Dr. Grear also testified that the April 2018 surgery was a reevaluation and the surgical intervention was not directly caused by the January 9, 2018 work accident. Dr. Grear further testified that the work accident of January 9, 2018 caused a temporary aggravation of the pre-existing condition and the following surgery was not directly causally related to the work incident of January 9, 2018. (Rx 2).

Regarding the right shoulder, Dr. Grear testified that he didn't find that Petitioner had any problems with the right shoulder, so he didn't feel there was any significant contribution of the accident to a normal right shoulder. (Rx 2).

Dr Grear opined that it was improbable that the mechanism of injury would have any significant causal relationship to the recurrent tear of the rotator cuff because Petitioner was just holding onto something and experienced a jerking motion. (Rx 2).

On cross examination Dr. Grear testified that a fall with full outstretched arm or a fall on the shoulder and a lot of other things could be sufficient force to a pre-existing partial rotator cuff tear to become symptomatic. Dr. Grear testified that he did not know what a push tub was and that he believed it was something the Petitioner held and pushed. (Rx 2).

Regarding the issue of whether Petitioner's right shoulder condition was caused by overuse Dr. Grear testified that his prior response was not about whether the right shoulder condition was caused by overuse. Dr. Grear testified that his prior opinion was based upon the question whether Petitioner's work accident of January 9, 2018 might or could contribute to the condition. Dr. Grear testified that he was not asked whether Petitioner's right shoulder condition was caused by overuse. (Rx 2).

Petitioner testified that he continues to experience throbbing pain in both of his shoulders which increases with activity. Petitioner testified that it is difficult to lift anything with his right side and his shoulder pain limits his ability to sleep at night. (Tr. Pg. 32).

The Arbitrator found the testimony of Petitioner to be credible.

Conclusions of Law

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law as set forth below. The claimant bears the burden of proving every aspect of her claim by a preponderance of the evidence. *Hutson v. Industrial Commission*, 223 Ill App. 3d 706 (1992).

With regards to issue (C) whether Petitioner sustained an accident with arose out of and in the course of his employment and issue (D) what is the date of accident, the Arbitrator finds as follows:

The Arbitrator finds that Petitioner has proven by the preponderance of the evidence that he sustained an accident which arose out of and in the course of his employment by Respondent on January 9, 2018.

The Arbitrator finds Petitioner testified credibly regarding his January 9, 2018 work accident. The Petitioner was operating a push truck while attempting to move a disabled vehicle into the body shop. Petitioner testified that the front tires of the push truck lifted off the ground and landed on the hood of another vehicle. Petitioner's testimony was supported by the testimony of his co-worker, Derrick Eskridge. (Tr. p. 55). The occurrence witness testified to the quick speed the push truck was moving, and that it came up so high he could see the entire bottom of the truck. (Tr. p. 55).

Petitioner immediate reported the incident. Mr. Yockey testified that day following the January 9, 2018, incident Petitioner advised the service manager, Dan Maciunas, that his shoulder was hurting, and he was going to return to the doctor to see if he had reinjured his shoulder. (T. Pg. 91). Petitioner's work accident was further corroborated by a January 24, 2019 letter authored by Randy Yockey. The letter documents that following the incident Petitioner "felt his shoulder was hurting him, therefore he was going back to the doctor to see if he reinjured it." (Rx 4). Dr. Mox's January 22, 2018 medical records show that Petitioner reported an incident at work, on January 9, 2018, when he was driving a vehicle that pushes cars at a car dealer when the throttle stuck, causing it to run into several cars. (Px. 3).

Respondent proffered evidence that the push truck was inspected and a problem with the throttle was not discovered. The Arbitrator does not find this issue persuasive. Whether the cause of the push truck's rapid execration was caused by a problem with the throttle or by accidently placing the vehicle in the wrong gear does not show the accident with the push truck did not occur. The overwhelming evidence shows that it did.

With respect to issue (F), whether Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator finds as follows:

When a worker's physical structures, diseased or not, give way under the stress of their usual tasks, the law views it as an accident arising out of and in the course of employment. *Sisbro v. Indust. Com'n*, 207 Ill.2d 193, 205 (2003). Workers need only prove that some act or phase of employment was a causative factor in her ensuing injuries. *Land and Lakes Co. v. Indust. Com'n*, 359 Ill.App.3d 582, 592 (2005). The work-related task need not even be the sole or principal causative factor of the injury, as long the work is a causative factor. See *Sisbro*, 207 Ill.2d at 205. Even if the claimant has a preexisting degenerative condition which makes him more vulnerable to injury, recovery for an accidental injury will not be denied as long as she can show that her employment was also a causative factor. *Id.* At 205. Employers are to take their employees as they find them. *A.C.&S v. Industrial Commission*, 710 N.E.2d 8347 (Ill. App. 1st Dist. 1999) citing *General Electric Co. v. Industrial Commission*, 433 N.E.2d 671, 672 (1982).

The Arbitrator has carefully reviewed and considered all medical evidence along with the testimony. The Arbitrator concludes that Petitioner has proven by the preponderance of the evidence that his current bilateral shoulder condition of ill-being are causally related to his work accident of January 9, 2018.

Petitioner immediately reported the accident to his employer and notified his employer that he reinjured his left shoulder and he was going back to the doctor to have it checked out. The Arbitrator is aware Petitioner underwent arthroscopic biceps tenodesis and arthroscopic rotator cuff repair surgery on October 17, 2018. (Px. 3) The Arbitrator is also aware that Petitioner was working light duty at the time of the January 9, 2018 work accident. The Arbitrator notes that Petitioner's treating orthopedic surgeon, on December 5, 2017, expected to release Petitioner to full duty work after Petitioner returned from his vacation in January. At that December 5, 2017 appointment, Dr. Mox noted that Petitioner's forward and lateral flexion was at 140 degrees and his strength was 4/5 without pain. However, on January 22, 2018, after the January 9, 2018 accident, Dr. Mox noted that Petitioner's forward flexion against gravity range of motion was only 130 degrees laterally and 120 with severe pain. Dr. Mox also noted the supraspinatus test and strength was only at 3/5, with lots of pain. In his records, Dr. Mox wrote "I am worried that Petitioner may a new left shoulder rotator cuff injury". (Px3).

Dr. Mox reviewed the February 5, 2018 MRI and compared with a prior MRI, and noted that the new MRI showed supraspinatus thickening with chronic tendinopathy since previous exam subscapularis and chronic mild undersurface partial tear small subacromial bursitis. Dr. Mox opined that the MRI showed a new rotator cuff tear of the supraspinatus. Dr. Mox recommended surgery. Petitioner underwent left shoulder arthroscopy and arthroscopic rotator cuff repair on April 26, 2018 and the operative report showed a significant, greater than 50%, partial rotator cuff tear in the anterior aspect of the supraspinatus. (Px. 3).

The Arbitrator also notes that the MRI's correlate to the opinions of Dr. Mox. The June 17, 2017 MRI showed: (1) Subscapularis fraying from partial-tear; suprspinatus abnormality from tendinopathy; and (2) Biceps fraying from partial-tear and fluid from tenosynovitis. The February 5, 2018 MRI showed: (1) Supraspinatus mild undersurface and bursal surface from previous exam; (2) Infraspinatus thickening from chronic tendinopathy since the previous exam; and (3) Subscapularis chronic mild undersurface partial-tear. The Arbitrator notes that Dr. Mox reviewed the February 5, 2018 post-injury MRI and diagnosed a traumatic incomplete tear of the left rotator cuff. And tearing of the bursal surface of the supraspinatus. (Px. 3). The Arbitrator notes that the post-accident MRI finding were consistent with Dr. Mox's opinions and were confirmed by April 26, 2018 surgical report.

Dr. Grear opined that Petitioner sustained a temporary exacerbation of his pre-existing left shoulder as a result of the January 9, 2018 work accident. Dr. Grear further opined that there was no "direct causal relationship" between Petitioner's January 9, 2018 accident and his current left shoulder condition. The Arbitrator notes that Dr. Grear did not proffer an opinion regarding whether or not Petitioner's work accident was a causative factor of his current condition of ill-being. The work-related task need not even be the sole or principal causative factor of the injury, as long the work is a causative factor. See *Sisbro*, 207 Ill.2d at 205. Even if the claimant has a preexisting degenerative condition which makes him more vulnerable to injury, recovery for an accidental injury will not be denied as long as she can show that her employment was also a causative factor. *Id.* At 205.

As to the mechanism of the injury, Dr. Grear opined that it was improbable that s significant casual relationship existed between Petitioner's work accident and his current condition of ill-being. The Arbitrator notes that Dr. Grear testified that he did not know what a push truck or push tub was. Dr. Grear testified that he believed that it was a something Petitioner pushed or held. The

Arbitrator notes that Dr. Grear was not aware the push truck was a vehicle Petitioner drove. As such, the Arbitrator finds that Dr. Grear's opinion regarding the mechanism of the injury not being causally related to Petitioner's work accident not to be persuasive because Dr. Grear was not aware of the facts to render his opinion. It is axiomatic that the weight accorded an expert opinion is measured by the facts supporting it and the reasons given for it; an expert opinion cannot be based on guess, surmise or conjecture. *Wilfert v. Retirement Board*, 318 Ill.App.3d 507, 514-15 (First Dist. 2000). The Arbitrator finds the opinions of Dr. Mox to be more persuasive than the opinions of Dr. Grear.

Regarding his opinion regarding whether Petitioner's right shoulder condition was caused by overuse, Dr. Grear answered that his prior opinion was based upon a different question. Dr. Grear testified that he was asked whether the work accident of January 9, 2018 might or could contribute to the right shoulder condition. Dr. Grear testified that he did not believe Petitioner sustained a right shoulder injury at that time. Dr. Grear testified that he was not asked whether Petitioner's right shoulder condition was caused by overuse. Dr. Grear further testified that overuse could cause a shoulder condition. The Arbitrator notes that Dr. Grear was not aware that Petitioner was performing his duties as a mechanic, which included overhead work, while working light duty. As such, the Arbitrator finds the opinions of Dr. Mox to be more persuasive regarding the cause of Petitioner's right shoulder condition than the opinions of Dr. Grear. The Arbitrator notes that Dr. Grear testified that he believed Petitioner was working light duty as a foreman telling people what to do. (Rx 2. Pg. 44). It is axiomatic that the weight accorded an expert opinion is measured by the facts supporting it and the reasons given for it; an expert opinion cannot be based on guess, surmise or conjecture. *Wilfert v. Retirement Board*, 318 Ill.App.3d 507, 514-15 (First Dist. 2000).

Based on the objective findings of the MRI following Petitioner's January 9, 2018 work injury, the medical records of Dr. Mox documenting a traumatic incomplete tear of the rotator cuff following the injury, and Petitioner's near normal range of motion and strength following his October, 2017 surgery, the Arbitrator finds Petitioner sustained an incomplete tear of the left rotator cuff as a result of the January 9, 2018 work accident, which required surgical repair. The Arbitrator further finds Petitioner's right shoulder became symptomatic following overuse after his April 26, 2018 surgery. The right shoulder becoming symptomatic from overuse was documented in Dr. Mox's medical records. The Arbitrator notes that Dr. Grear conceded that

Petitioner's shoulder condition could be the result from overuse. (Rx. 2, pgs. 45). Based on the totality of the evidence Petitioner's current condition of ill-being in his right and left shoulders are causally related to his January 9, 2018 work accident.

With respect to issues (J); Whether the medical services provided were reasonable, the Arbitrator concludes the following:

Under Section 8(a) of the Act, a claimant is entitled to recover reasonable medical expenses, the incurrence of which are causally related to an accident arising out of and in the scope of 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).

The Arbitrator finds that Petitioner has proven by the preponderance of the evidence that Petitioner's medical treatment for his bilateral shoulder conditions are reasonable and necessary to diagnose, relieve or cure the effects of the Petitioner's injury. The Arbitrator notes that Respondent did not claim that Petitioner's treatment was unnecessary or unreasonable. Respondent disputed the treatment based upon accident and causation.

Petitioner claims that Respondent is liable for the following medical expense:

Exhibit	Medical Provider	Amt. of Bill
Px. 5:	Ortho Illinois, f/k/a Assoicates in Orthopedic Surgery	$ 13,891.83
Px. 6:	Enhanced Medical Imaging – Elgin	1,474.00
Px. 7:	Midwest Anesthesia Partners	3,961.00
Px. 8:	Sherman Hospital	18,386.00
Px. 9:	Richmond SA Services, Inc.	6,868.38
Px. 10:	Athletico	7,541.98
Px. 11:	Prescriptions	59.56

The Arbitrator has reviewed Petitioner's medical records and bills and finds that these bills were unpaid by the workers' compensation carrier, and that the only services Petitioner received were for medical services associated with the January 9, 2018 work injury.

The Arbitrator finds the medical bills detailed in Petitioner's Exhibit 5 through Petitioner's Exhibit 11, totaling $52,182.75, to be reasonable and causally related to Petitioner's January 9, 2018 work injury. As such, the Arbitrator orders Respondent to pay to Petitioner the unpaid medical bills of $52,182.75 as delineated in Petitioner's Exhibit 5 through Exhibit 11, pursuant to

the fee schedule and Sections 8(a) and 8.2 of the Act. Respondent shall receive a credit for any medical bills which Respondent had previously paid.

With Regards to issue (L); what temporary disability benefits are in dispute, the Arbitrator finds as follows:

"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 MM.I. *Sunny Hill of Will County v. Ill. Workers' Comp. Comm'n*, 2014 IL App (3d) 130028WC at 28 (June 26, 2014, Opinion Filed); *Mechanical Devices v. Industrial Comm'n*, 344 Ill. App. 3d 752, 760 (4th Dist. 2003). To show entitlement to temporary total disability benefits, a claimant must prove not only that he did not work, *but also that he was unable to work. Gallentine*, 201 Ill. App. 3d at 887 (emphasis added); *see also City of Granite City v. Industrial Comm'n*, 279 Ill. App. 3d 1087, 1090 (5th Dist. 1996).

The parties have stipulated that Petitioner's average weekly wage was $1,338.16. Therefore, Petitioner's TTD rate is $892.11 per week. The Arbitrator finds Petitioner was unable to work from the time of his left shoulder surgery on April 26, 2018 through September 5, 2018 and from May 3, 2019 through the date of trial, July 16, 2019. The Arbitrator finds that Petitioner's condition has not stabilized. The Arbitrator further finds that Petitioner is still unable to work.

Therefore, based on the totality of the evidence, along with the Arbitrator's findings regarding causal connection and that an accident arose out of and in the course of Petitioner's employment, Petitioner is entitled to TTD benefits in the amount of $892.11 per week for the period April 26, 2018 through September 5, 2018 and for the period May 3, 2019 through the date of trial.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse Choose reason	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jon Casey,

Petitioner,

vs. NO: 15 WC 29789

20IWCC0426

Village of Schaumburg
Fire Department,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issue of the nature and extent of Petitioner's permanent partial disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 6, 2020, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

20 IWCC0426

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: JUL 3 1 2020
TJT:yl
o 7/14/20
51

Thomas J. Tyrrell

Kathryn A. Doerries

Maria E. Portela

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CASEY, JON
Employee/Petitioner

Case# **15WC029789**

VILLAGE OF SCHAUMBURG FIRE DEPARTMENT
Employer/Respondent

20IWCC0426

On 2/6/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.52% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0787 MEYERS & FLOWERS LLC
GREGORY H BOOTH
3 N 2ND ST SUITE 300
ST CHARLES, IL 60174

0481 MACIOROWSKI SACKMANN & ULRICH
ROBERT B ULRICH
105 W ADAMS ST SUITE 2200
CHICAGO, IL 60603

20 IWCC0426

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

JON CASEY
Employee/Petitioner

v.

VILLAGE OF SCHAUMBURG FIRE DEPARTMENT
Employer/Respondent

Case # 15 WC 29789

Consolidated cases: None

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by Arbitrator **Joseph Amarilio**, in the city of **Chicago**, on **January 15, 2020**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [ ] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [ ] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [ ] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other

FINDINGS

On **August 20, 2015,** Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did*** 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 **$94,151.75**; the average weekly wage was **$1,810.61**.

On the date of accident, Petitioner was **41** years of age, ***married*** with **2** dependent children.

Respondent ***has*** paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$147,090.07** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$147,090.07,**

Respondent is entitled to a credit of **$0** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits and maintenance benefits of $1,207.07/week for 121 6/7 weeks, commencing 9/10/15 through 10/21/15; 7/1/16 through 7/10/16 and 11/10/16 through 3/10/19, as provided in Section 8(b) of the Act. Respondent shall be given a credit of $147,090.07. A total of $0.00 shall be paid to Petitioner in TTD benefits; all TTD and Maintenance having been paid.

Respondent shall pay Petitioner the sum of **$755.22**/week for a further period of **237.5** weeks, as provided in Section **8(d)(2)** of the Act, because the injuries sustained caused **loss of use of the person as whole to the extent of 47.5% (loss of trade).**

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.

Joseph D'Amalio
Signature of Arbitrator

2/5/2020
Date

FEB 6 - 2020

BEFORE THE ILLINOIS WORKERS' COMPENTATION COMMISSION

JON CASEY,	)	
Petitioner,	)	
	)	
Vs.	)	**No. 15 WC 029789**
	)	
VILLAGE OF SCHAUMBURG FIRE DEPARTMENT,	)	
Respondent.	)	
	)	

Statement of Facts

This matter was tried on January 15, 2020. The issues in dispute were causal connection and nature and extent of the Petitioner's injuries.

The Petitioner testified that he started working for the Village of Schaumburg in February of 2010 as a Firefighter/Paramedic. He also testified that before he was hired, he took a physical test which measured his agility and strength including dragging dummies, pulling hoses and using a sledgehammer.

According to the Petitioner he passed all of the physical parts of the test and that he performed all of the elements of his job as a Firefighter/Paramedic from February of 2010 until August 20, 2015.

The Petitioner testified that on August 20, 2015, he was 41 years old, married, with two dependent children.

The Accident

The Petitioner testified that on August 20, 2015 he was participating in a "firefighter down" drill wearing full firefighting gear. As part of the drill he and another firefighter were to climb through a window to rescue a "downed firefighter" by lifting and carrying that firefighter back through the window.

This accident occurred as the Petitioner was lifting the "downed firefighter" and felt a pop and a painful sensation in his left upper extremity.

The Petitioner testified that he told his lieutenant about the accident and the drill was stopped. Petitioner testified that this was a mandatory training and that he was required to perform a certain number of training hours per year.

Northwest Community Hospital

The next day, (August 21, 2015) the Petitioner was sent to Northwest Community Hospital. According to those records, the Petitioner reported that he felt a pop in his left arm and reduced strength while training to transfer a victim out of a house through a window (PX#1). X-rays of his left elbow were ordered, and the Petitioner was released to return to work with restrictions of no lifting more than 5 pounds with his left arm. There he was diagnosed with a left bicep strain and shortly thereafter he started treating with Dr. Joshua Alpert.

Dr. Albert

On August 24, 2015 the Petitioner started treating with Dr. Joshua Alpert at Midwest Bone & Joint Institute (PX #2). The Petitioner was examined, and because his symptoms were consistent with a bicep rupture, an MRI of the left elbow was ordered and was eventually performed on September 2, 2015.

On September 3, 2015 the Petitioner returned to Dr. Alpert who reviewed the MRI of his left elbow. He thought it showed a high-grade partial-thickness tear of the distal biceps' tendon with moderate underlying tendinopathy. During this visit, Dr. Alpert and the Petitioner discussed left bicep surgery.

First Surgery

On September 8, 2015 the Petitioner underwent a left elbow repair and a distal biceps repair using an Arthrex button technique, performed by Dr. Alpert.

On September 23, 2015 Dr. Alpert returned the Petitioner back to work with restrictions and ordered physical therapy.

On September 29, 2015 the Petitioner began physical therapy at ATI in order to strengthen his arm and increase his range of motion. They recommended that he attend physical therapy 2-3 times per week, for 6-8 weeks.

The Petitioner testified that after the surgery he continued to have numbness and tingling in his left hand and his left middle finger was triggering. The Petitioner testified that he continued under the care of Dr. Alpert who eventually recommended an EMG because of the Petitioner's ongoing symptoms.

According to Dr. Albert's December 2, 2015 notes, the Petitioner now had numbness around his forearm, his thumb, index finger and was experiencing left long finger triggering. As a result, Dr. Alpert diagnosed a left middle trigger finger and left sided carpal tunnel syndrome. He also released the Petitioner to return to work but with restrictions of no lifting greater than 10 pounds and he recommended more physical therapy.

On January 27, 2016 the Petitioner had an EMG which found mild carpal tunnel syndrome on the left (PX #6).

On February 1, 2016 the Petitioner returned to Dr. Alpert, who reviewed the EMG and diagnosed mild left sided carpal tunnel syndrome. Dr. Alpert also indicated that the numbness and tingling in Petitioner's left hand and the left index trigger finger had started after this accident and therefore Dr. Alpert concluded that these are work related conditions. Dr. Alpert recommended a left carpal tunnel release.

Because of Dr. Albert's surgical recommendations, the Respondent sent the Petitioner to Dr. Sagerman for a Section 12 examination which took place on April 6, 2016. Dr. Sagerman also thought the carpal tunnel syndrome was work-related and that surgery was reasonable and necessary (PX #7).

Second Surgery

On June 28, 2016 Petitioner underwent surgery for a left carpal tunnel release and trigger finger release. According to the operative report, Dr. Alpert performed a left carpal tunnel release and an A1 pulley release. It was his post-operative diagnosis that the Petitioner had left carpal tunnel syndrome and a left-hand long finger trigger finger.

Despite that surgery, the Petitioner continued to have numbness and tingling in his left hand and instead of fixing his problem, the surgery seemed to have made it worse. One of the post-surgical complications included a suture that was left in his left wrist and Dr. Albert was having a hard time removing it.

Third Surgery

This led to another surgery on November 10, 2016, which was also performed by Dr. Alpert. The surgery removed the retained suture and revised the carpal tunnel release.

After the November 10, 2016 surgery, the Petitioner did not get any better but in fact had more pain and more numbness in his wrist and hand. At this point, Dr. Alpert referred the Petitioner Dr. Biafora at Hand to Shoulder Associates.

Fourth Surgery

On November 17, 2016 the Petitioner started treating with Dr. Biafora (PX #3). After examining the Petitioner, Dr. Biafora recommended another surgery to repair a lacerated median nerve. The lacerated median nerve was caused by one or more of the earlier surgeries. Dr .Biafora recommended that surgery proceed as soon as possible. Dr. Biafora performed surgery on November 21, 2016.

Dr. Biafora

On November 21, 2016 the Petitioner underwent the surgery recommended by Dr. Biafora to repair the lacerated median nerve. According to the operative report, the Petitioner had a lacerated median nerve and the surgery included a median nerve repair (ulnar and radial) side.

The surgery had mixed results. The Petitioner treated with physical therapy until December 21, 2017, when Dr. Biafora pronounced the Petitioner at maximum medical improvement and imposed permanent restrictions of no lifting over 30 pounds, no repetitive gripping, and no repetitive use (PX #3 p.4). He also discharged the Petitioner from any further treatment.

As a result of those restrictions, the Petitioner was unable to return to work as a firefighter or paramedic. The Respondent was unable to accommodate his permanent restrictions, He subsequently applied for and received a line of duty disability pension.

Pension Board Doctors

During the course of the Petitioner's line of duty disability pension hearing, he was examined by three doctors: Dr. Vitello, Dr. Williams and Dr. Phillips.

Dr. Vitello examined the Petitioner on August 23, 2018 (PX #9). In addition to examining the Petitioner, he also reviewed the Petitioner's medical records and offered the opinion that the Petitioner's current condition is causally connected to the August 20, 2015 accident. He also indicates that the Petitioner has lost muscle strength and sensation in his left upper extremity and he diagnosed a left bicep tendon repair, a middle finger trigger digit release and a left median nerve repair.

Although the shoulder surgery was described as "successful", the median nerve repair was not. According to Dr. Vitello the Petitioner's loss of sensation in the median nerve and left upper extremity is permanent and the Petitioner would be unable to return to work as a firefighter.

Dr. Craig Williams examined the Petitioner on August 22, 2018 (PX #10). He also reviewed the Petitioner's medical records and diagnosed four different conditions:

1.) a left distal bicep tendon rupture,
2.) post left carpal tunnel repair, post carpal tunnel release,
3.) a left long trigger finger, status post trigger finger release and
4.) a median nerve laceration which has resulted in permanent neuropathy along the disc depletion of the median nerve.

As a result, Dr. Williams thought these four conditions were causally connected to the Petitioner's August 20, 2015 accident and that the Petitioner would be unable to return to work as a firefighter.

Dr. Craig Phillips examined the Petitioner on September 11, 2018 (PX #8). He diagnosed the Petitioner with a left bicep tendon repair which he described as successful, a median nerve dysfunction because of carpal tunnel syndrome and a nerve laceration. Dr. Phillips thought the Petitioner's conditions were causally connected (either directly or indirectly) to the Petitioner's accident, that they were permanent and as a result, the Petitioner was unable to return to work as a firefighter for the Village of Schaumburg.

Residuals

The Petitioner testified that he now has constant numbness and tingling in his left hand along the median nerve distribution along with loss significant loss of dexterity and strength. Even activities of daily living are difficult. For example, the Petitioner testified that he has difficulty opening jars because he has no sensation and little left sided strength. Petitioner loss of activities of daily living are also well documented in he medical records and reports.

The Petitioner testified that his restrictions make it difficult to return to work as a Firefighter/Paramedic, because he would be unable to start any IV's, lifting or ladder climbing. He also testified that even heat would be dangerous because of the loss of sensation to most of his left hand he could burn his hand and not know it.

The Petitioner testified that he currently uses a ball to squeeze with his left hand to increase his strength and he will occasionally ice his hand and takes Ibuprofen for pain relief.

WITH RESPECT TO ISSUE (F), IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE WORK INJURY, THE ARBITRATOR FINDS:

The Arbitrator finds that Petitioner presented enough credible evidence to meet his burden that his current condition is causally related to the work injury.

The Petitioner sought medical treatment at the emergency room the day after his undisputed accident. (PX #1). X-Rays were negative for fracture and he was diagnosed with a left bicep muscle strain (PX #1 p. 4-8). Following an MRI ordered by Dr. Alpert at Midwest Bone & Joint, Petitioner was diagnosed with left elbow distal bicep 50% full thickness tear caused by the work-related injury. Dr. Alpert surgically repaired the tear. Following this surgery, Petitioner developed symptoms of numbness and tingling in his arm and hand. He was diagnosed with carpal tunnel syndrome and long finger trigger finger. Surgery was recommended by Dr. Alpert in include a carpal tunnel release and trigger finger release. Dr. Sagerman, the Respondent's Section 12 examiner, agreed that the left bicep tear and subsequent carpal tunnel were causally related to the work accident on August 20, 2015. He agreed that the bicep surgery was reasonable and necessary. He also stated that "as a consequence of postoperative swelling affecting the left upper extremity, the development of carpal tunnel syndrome postoperatively may be indirectly related to the work injury." (PX #7 p3). He agreed that the carpal tunnel release surgery recommended by Dr. Alpert was reasonable and necessary.

Dr. Alpert completed a carpal tunnel release surgery to relieve these symptoms. Upon postoperative evaluation, Dr. Alpert noted continued swelling and a residual black stitch left under his skin. Dr. Alpert completed a revision of the carpal tunnel syndrome release, and during the revision, Petitioner's median nerve was severed, causing loss of sensation in Petitioner's left hand. The median nerve laceration caused Petitioner numbness and pain in his left wrist and hand. Dr. Biafora surgical repair of the median nerve laceration failed to significantly improve Petitioner's symptoms. After one year of physical therapy following the final surgery, Petitioner had reached maximum medical improvement and he was provided with permanent work restrictions on December 21, 2017.

Petitioner was also examined by Dr. Phillips, Dr. Vitello, and Dr. Williams (PX #8,9,10). These doctors all agree that Petitioner's current condition of ill-being is causally related to the work injury on August 20, 2015. Dr. Phillips, Dr. Vitello and Dr. Williams agree that Petitioner's symptoms are permanent and are directly or indirectly caused by the work-related accident. Petitioner has never suffered from carpal tunnel symptoms or nerve dysfunction prior to the accident. No evidence was provided of any intervening accident, and the natural progression of Petitioner's medical treatment has led to permanent and significant loss of functional use and sensation in his left hand resulting in permanent work restrictions that prevent him from continuing his work as a firefighter and paramedic.

Petitioner credibly testified that he continues to feel numbness in most of his left hand and as well as weakness in his left hand. The Arbitrator finds it credible that Petitioner's left bicep injury and subsequent surgery and swelling caused the need for his carpal tunnel surgery and left long finger release, revision carpal tunnel surgery, and nerve repair surgery.

Based upon the above, and the record taken as a whole, the Arbitrator finds that Petitioner's current condition of ill-being is causally related to the work injury.

WITH RESPECT TO ISSUE (L) , WHAT IS THE NATURE AND EXTENT OF THE INJURY, THE ARBITRATOR FINDS:

The Arbitrator notes that Petitioner has waived any right to recover under a wage differential under Section 8(d)(1) of the Act. Section 8.1(b) of the 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. Section 8.1b states:

"In determining the level of permanent partial disability, the Commission shall base its determination on the following factors: (i) the reported level of impairment pursuant to subsection (a); (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability." 820 ILCS 305/8.1b.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no permanent partial disability impairment report and/or opinion was submitted into evidence. The Arbitrator therefore gives no weight to this factor.

With regard to subsection (ii) of §8. b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as a firefighter/paramedic at the time of the accident which is a physically heavy-duty job demand. The Arbitrator notes that Petitioner is permanently unable to return to work in his prior capacity as a result of said injury nor was the Respondent able to accommodate the Petitioner and offer an alternative position. The Arbitrator notes that the Petitioner never returned to work for the Respondent as a firefighter/paramedic. Petitioner was released to work with permanent restrictions which are undisputed, and he has not worked since the accident. He has permanently lost access to his trade. The Arbitrator gives great weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that petitioner was 41 years old at the time of the accident. Because of the relative youth of the Petitioner, his permanent disability, and the significant years remaining of his work life expectancy, the Arbitrator gives greater weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes Petitioner has not returned to the work force and is unable to perform his job as a firefighter/paramedic. Petitioner applied for and was awarded a line of duty disability pension. At the commencement of the hearing, Petitioner waived any claim for wage loss benefits under Section 8(d)(1).

With regard to subsection (v) of §8.1b(b), evidence of disability is corroborated by the treating medical records, the Arbitrator places great significance on the extent of the injury and the four (4) surgeries performed on Petitioner's left arm and hand: September 8, 2015, June 28, 2016, November 10, 2016 and November 21, 2016. The Arbitrator notes that the Petitioner sustained an undisputed left distal bicep tendon tear as a result of his work-related accident on August 20, 2015. Following the first surgery, Petitioner developed swelling in his arm and symptoms of carpal tunnel syndrome, and he underwent a carpal tunnel release and left long finger A1 pully release procedure on June 28, 2016. Following the second surgery, on November 10, 2016, Petitioner underwent a third surgery - a release revision surgery to remove a retained stitch and revised carpal tunnel release. During one of the release procedures, Petitioner sustained a lacerated median nerve. As a result of this work injury related treatment, Petitioner lost sensation of most of his left hand. On November 21, 2016, Dr. Biafora performed surgery to repair the median nerve laceration. The forth surgery did not significantly improve most of Petitioner's symptoms. The Petitioner was placed at MMI on December 21, 2017.

Petitioner still suffers from complete loss of sensation, numbness, and weakness in most of his left hand as a result of his treatment progression for his work-related injury. These injuries are permanent in nature and Petitioner has reached maximum medical improvement. All three of the Pension Board doctors that examined Petitioner agree that he is permanently disabled from performing the full duty work of a firefighter/paramedic.

Petitioner gave credible testimony that he suffers from pain, numbness, tingling, and loss of sensation in his left hand. Petitioner testified that he has difficulty grasping pills and other objects which require fine motor skills, as well as an inability to recognize heat exposure. Petitioner lost dexterity in his left hand. Petitioner cannot successfully complete simple daily tasks such as buttoning his shirt and opening a jar without significant difficulty or requiring assistance. He takes over the counter medication for the pain, ices his hand and wrist, and uses a squeeze ball to treat his daily symptoms. Petitioner' subjective complaints to his left hand are also consistent with the objective findings. The treating medical records corroborate permanent disability and the Arbitrator therefore gives greater weight to this factor.

Based upon the above, and the record taken as a whole, the Arbitrator finds that Petitioner has suffered a significant loss use of his left hand and a significant loss of use of his left arm, coupled with the loss of trade of being a firefighter/paramedic. Therefore, the Arbitrator awards the Petitioner permanent partial disability to the extent of 47.5% person as a whole (237.5 weeks) pursuant to Section 8(d)(2) of the Act, as he has a permanent disability and has permanently lost access to his trade and his ability to be a firefighter/paramedic.

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

William Lane, Jr.,

Petitioner,

vs. NO: 16 WC 3928

20IWCC0427

The American Coal Company,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of occupational disease, permanent partial disability, legal error, evidentiary error, §1(d), § 1(f), and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 25, 2019. is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

20 IWCC0427

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: JUL 3 1 2020
TJT:yl
o 7/14/20
51

Thomas J. Tyrrell

Maria E. Portela

Kathryn A. Doerries

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LANE JR, WILLIAM
Employee/Petitioner

Case# **16WC003928**

THE AMERICAN COAL COMPANY
Employer/Respondent

20IWCC0427

On 7/25/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.01% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

20 IWCC0427

STATE OF ILLINOIS)
)SS.
COUNTY OF Williamson)

- [ ] Injured Workers' Benefit Fund (§4(d))
- [ ] Rate Adjustment Fund (§8(g))
- [ ] Second Injury Fund (§8(e)18)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

WILLIAM LANE, JR.
Employee/Petitioner

v.

THE AMERICAN COAL COMPANY
Employer/Respondent

Case # 16WC 003928

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 **May 16, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [ ] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [ ] What temporary benefits are in dispute?
   [ ] TPD [ ] Maintenance [ ] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [x] Other **Sections 1(d)-(f) of the Occupational Diseases Act**

20IWCC0427

FINDINGS

On **July 31, 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 average weekly wage was **$2,171.38**.

On the date of accident, Petitioner was **61** years of age, ***married*** with **0** dependent children.

Petitioner claims no medical.

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$0**.

Respondent is entitled to a credit of **$0** under Section 8(j) of the Act.

ORDER

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

7/23/19
Date

JUL 25 2019

William Lane, Jr. v. The American Coal Company
16 WC 003928

FINDINGS OF FACT

The Arbitrator finds:

Petitioner was 65 years old at the time of arbitration. He graduated from high school in Equality, Illinois and took electrical classes at the coal mine after that. Petitioner had no other formal education. Petitioner testified that he had 40 years in coal mining employment with approximately 38 or 39 of those years being underground. In addition to the coal dust, he was regularly exposed to and breathed silica dust, roof bolting glue fumes and diesel fumes. His last date of employment was July 31, 2015, at Respondent's Galatia Mine. Petitioner was 61 years old on his last date of employment, just three days shy of his 62nd birthday. At that time, he was working as a mechanic boss. Petitioner testified that he told his wife he was going to get out of coal mining when he turned 62, which was his reason for retiring at the time he did. Petitioner did not work anywhere after his last day of employment with Respondent.

Petitioner began working in coal mining on May 10, 1975, at Island Creek Coal Company in Morganfield, Kentucky. He was hired on as a laborer, where he would clean the face, move beltlines, and rock dust. Petitioner described rock dusting as using a big machine with rock dust, pulling it with a jeep and dusting all the faces of the mine. He testified that this was to avoid explosions and that this was a dusty job. Petitioner also worked on scooping the beltlines and shoveling coal, which would also kick up dust. Petitioner also worked as a greaser before becoming a mechanic. As a mechanic, Petitioner worked on the machines while underground. Petitioner testified that he had the same exposure to dust and rock as any other miner in those positions. Petitioner testified that he worked at Island Creek Coal Mine for approximately eight years until it shut down. He then went to work at Wabash Mine between Grayville and Mt. Carmel in Illinois in 1984. He was hired on there as a mechanic. Petitioner testified that he worked for Wabash Mine for approximately 15 years before getting laid off. He then went to work for American Coal in April 1999. Again, he was hired on as a mechanic. Petitioner testified that one difference at American Coal was the longwall, where a big block of coal was cut off, causing a whole area to come out. Petitioner worked on the equipment that did these tasks. In this position, a lot of dust was created. Petitioner left American Coal in 2004 and went back to Wabash Mine. He testified that he did this because Wabash was a union mine and he wanted to get more time for his pension and medical card. He was at Wabash the second time for about three years as a mechanic before they shut down. He then returned to American Coal in 2007 and stayed there until he retired. Petitioner testified that the last four or five years at Respondent he took a job as a mechanic boss. He testified that he made more money and was responsible for more things in that position.

Petitioner testified that he first noticed breathing problems while having to walk underground a lot. He testified that he noticed that he would get short of breath. That

was approximately 10 to 15 years prior to arbitration. From the time he first noticed breathing problems until the time he left the mine he believed his breathing remained about the same. From the time he left the mine until the time of arbitration he believed that his breathing had remained about the same. Petitioner testified that he could probably walk three or four flights of stairs before getting short of breath. Petitioner was not on any breathing medications at the time of arbitration. He testified that his breathing becomes worse at night when he goes to sleep, finding it hard to catch his breath and affecting his sleeping. Petitioner enjoys fishing and hunting and testified that his breathing does not affect his fishing, but if he has to do a lot of walking in the woods for hunting it can affect his hunting. His breathing does not cause him any difficulty in climbing to his deer stand for deer hunting. He testified that when mowing his lawn, he has difficulty sometimes when doing a lot of weed eating, but he does not have difficulties with riding a lawnmower.

Petitioner testified that his family doctor is Dr. Winkleman from Harrisburg. He testified that the only communication he and Dr. Winkleman had about his breathing was that Dr. Winkleman sent him for a sleep test for sleep apnea. Nothing was done for his sleep apnea. Petitioner testified that he is not a smoker, and only smoked a couple cigarettes when he was 12 or 13 until he was caught by his father. As far as other health concerns, Petitioner testified that he has had both knees replaced and both hips replaced. He takes medication for blood pressure and cholesterol as well as a blood thinner due to having two or three blood clots in his leg.

Petitioner testified that shortly after his retirement a big layoff was announced to the employees at Respondent. Petitioner testified that he signed up for Social Security after leaving the mine and began collecting a pension when he turned 62 a few days after retiring. He also got a medical card. He testified that from time to time, while employed at the various mines he had the opportunity to undergo chest x-ray screening from NIOSH for black lung. He testified that he believed he had one x-ray done with them but could not remember when it was. Petitioner testified that he has been honest with his primary care physician, Dr. Winkleman, regarding his complaints. Petitioner went to see Dr. Paul one time in Springfield, at the request of his counsel, in January of 2016. He testified that he also saw a doctor in Henderson, Kentucky at the request of Respondent's counsel. Petitioner testified that his other hobbies aside from fishing and hunting include honey-do jobs around the house. At the time of arbitration, he and his wife were getting ready to go to Georgia for a vacation. He also is active in his church. Petitioner testified that he owns approximately 32 acres and that he mows part of it and hunts on another part of it.

Petitioner saw Dr. Glennon Paul one time at the request of his counsel on January 19, 2016. (Petitioner's Exhibit No. 1, p. 44, Deposition No. 2). Dr. Paul was 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 is the senior physician at Central Allergy and Respiratory Services. Those physicians specialize in allergy and

pulmonary disease. They take care of patients with respiratory disease, critical care, allergic diseases and some internal medicine problems. Dr. Paul testified that he performs chest x-rays as part of his examinations and reads approximately 15 to 20 per day. He also has occasion to treat coal miners for coal mine-induced lung disease. (Petitioner's Exhibit No. 1, pp. 7-8). Dr. Paul is board certified in allergy, immunology and asthma. (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. He testified that most physicians who were interested in pulmonology were just interested in research and were trying to make machines that would measure pulmonary function. (Petitioner's Exhibit No. 1, pp. 10-11). Dr. Paul is not an A-reader or B-reader of films. He is also not board certified in pulmonary diseases. (Petitioner's Exhibit No. 1, p. 49). Dr. Paul testified that he has seen a hundred or more individuals at the request of Petitioner's counsel. (Petitioner's Exhibit No. 1, p. 44).

Dr. Paul testified that Petitioner worked as a coal miner for 40 years. (Petitioner's Exhibit No. 1, p. 21). Petitioner gave a history of having never been a smoker. Dr. Paul testified that Petitioner's physical examination of the chest exhibited rales throughout both lung fields. Dr. Paul described this as being the sound of mucous as he inhaled deeply down and snapping open the alveoli as he took a deep breath in. (Petitioner's Exhibit No. 1, pp. 11-12). Petitioner testified that every winter he would get an upper respiratory infection that goes into wheezing, coughing and shortness of breath. Dr. Paul attributed this to asthma. Dr. Paul testified that asthma can make that occur because asthma is a spasm of the windpipes and one of the major triggers for an asthma attack is a virus infection. (Petitioner's Exhibit No. 1, pp. 12-13). He believed Petitioner's past medical history included COPD, chronic bronchitis or asthma. Petitioner had taken medications for blood clots and high cholesterol. He also had two knee replacements. Petitioner related shortness of breath walking up stairs. (Petitioner's Exhibit No. 1, p. 45).

Dr. Paul testified that spirometry he performed on Petitioner showed a FVC of 3.33, but he did not use that figure because he believed that the testing was off. He testified that the baseline spirometry was pretty low. He believed Petitioner was having an asthma attack at the time and that is why the baseline was low and why there was such a good response to the bronchodilator. Dr. Paul testified that his impression of the spirometry was that it was valid and that Petitioner was not on any chronic medications that he knew of. (Petitioner's Exhibit No. 1, pp. 14-16). Dr. Paul testified that he also reviewed other spirometry that was done in May, which showed a baseline FVC of 116% of predicted and an FEV1 of 115% of predicted, with a post-bronchodilator that did not show very much of a change. (Petitioner's Exhibit No. 1, p. 17).

Dr. Paul testified that he was able to reach some conclusions, namely that he believed Petitioner had coal workers' pneumoconiosis, asthma, obstructive airways

disease, and a little bit of a restrictive lung disease, all of which he attributed to the coal dust and coal mine environment. Based on these diagnoses, he believed Petitioner could not have any further exposure to the environment of a coal mine without endangering his health. (Petitioner's Exhibit No. 1, pp. 18-19). Dr. Paul testified that he believed Petitioner had clinically significant pulmonary impairment as well as radiographically apparent pulmonary impairment, both of which he attributed to coal dust and the coal mine environment. Based on these diagnoses, Dr. Paul believed Petitioner was permanently precluded from working as a coal miner. (Petitioner's Exhibit No. 1, p. 20).

Dr. Paul testified that the gold standard for determining the existence of coal workers' pneumoconiosis is pathology. He testified that a person can have coal workers' pneumoconiosis despite having normal radiographic studies. (Petitioner's Exhibit No. 1, p. 21). 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. The scarring of coal workers' pneumoconiosis is also associated with a form of emphysema with a halo around it, called focal emphysema. By definition, if one has coal workers' pneumoconiosis, it is true that he would have some impairment in the function of the lung at the site of the scarring, whether it can be measured by spirometry or not. (Petitioner's Exhibit No. 1, pp. 23-24). Dr. Paul testified that a person can have coal workers' pneumoconiosis that is radiographically significant but not have shortness of breath, have normal pulmonary function testing, normal blood gases and normal physical examination of the chest. He testified that coal workers' pneumoconiosis is considered to be a progressive disease and with further exposure can progress to progressive massive fibrosis or complicated pneumoconiosis. (Petitioner's Exhibit No. 1, p. 27). Dr. Paul further testified that a person can have coal workers' pneumoconiosis and have a normal chest x-ray. He testified that a negative x-ray can never rule out the existence of coal workers' pneumoconiosis. (Petitioner's Exhibit No. 1, pp. 41-42).

Dr. Paul testified that he did not ask Petitioner if he had asthma, or chronic bronchitis, but he already knew Petitioner probably had asthma from his lung history. (Petitioner's Exhibit No. 1, p. 45). Dr. Paul testified that he did not review any medical records on Petitioner. Petitioner did not relate to Dr. Paul having ever undergone x-ray screenings by NIOSH for black lung. He did not come to Dr. Paul with a past history of black lung. (Petitioner's Exhibit No. 1, p. 46). Dr. Paul testified that shortness of breath with exertion can be due to things other than pulmonary disease. Deconditioning could be one of those causes. Petitioner did not relate to Dr. Paul that he retired when he did due to a pulmonary disease. He also did not relate to Dr. Paul that he left mining at the time he did on the advice of a physician. Dr. Paul testified that the spirometry he performed showed an obstruction; the lung volumes showed a restriction; and the diffusion capacity he performed showed a reduced diffusion capacity. He testified that all those findings can be associated with scarring of the lungs from the pneumoconiosis. Dr. Paul

testified that this was permanent. (Petitioner's Exhibit No. 1, pp. 47-48). Dr. Paul testified that he did not know the inhalation time for the tracer gas or the hold time for the tracer gas in the diffusion capacity that he performed. He did not measure the inhalation time for the tracer gas. He did not do methacholine stimulation testing on Petitioner. (Petitioner's Exhibit No. 1, p. 48).

Dr. Paul testified that he did not know the date of the chest x-ray that he reviewed. He testified that there were multiple different opacities present, all made up of coal dust. He did not determine a profusion for the film. Dr. Paul testified that he was not board certified in pulmonary disease. At the time of the deposition he testified he was semi-retired, coming into the office only one or two days a week and treating about 10 patients. He testified he was still doing work comp examinations. (Petitioner's Exhibit No. 1, p. 49).

Dr. Henry K. Smith, board certified radiologist and B-reader, interpreted a chest x-ray of Petitioner dated January 19, 2016. Dr. Smith interpreted the film as positive for pneumoconiosis, profusion 1/0 with P/P opacities in all lung zones. Dr. Smith graded the film as quality 1. (Petitioner's Exhibit No. 2).

Dr. Cristopher Meyer reviewed a PA and lateral chest x-ray from Central Illinois Allergy and Respiratory dated January 19, 2016. Dr. Meyer testified that the film was of diagnostic quality, specifically Quality 2 due to being slightly over-exposed. Dr. Meyer testified that the film showed that the lungs were clear and there were no small or large opacities. He testified that there were no findings of coal workers' pneumoconiosis. (Respondent's Exhibit No. 1, p. 40).

Dr. Meyer has been board certified in 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. 19-20). 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. 20-22). Dr. Meyer was on the American College of Radiology Pneumoconiosis Task Force, which was engaged in redesigning the course, the exam and submitting cases for the B-reader training module and exam. Dr. Meyer has recently been asked to have a more academic role in the B-reader program. He testified that the faculty for the B-reader program is typically experienced senior level B-readers. (Respondent's Exhibit No. 1, pp. 31-33). 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. One of the most important parts of the B-reader training and examination is making the distinction between a film with profusion of 0/1 versus a film with 1/0 profusion. (Respondent's Exhibit No. 1, pp. 34-35).

Dr. Meyer testified that the B-reader looks at the lungs to decide whether there are any small nodular opacities or any linear opacities. Based on the size and appearance of those small opacities, they are given a letter score. (Respondent's Exhibit No. 1, p. 22). Dr. Meyer testified that specific occupational lung diseases are described by specific opacity types. Coal workers' pneumoconiosis is characteristically described as revealing small round opacities. Diseases that cause pulmonary fibrosis, such as asbestosis, are described by small linear or small irregular opacities. (Respondent's Exhibit No. 1, pp. 27-28). The distribution of the opacities is also described as different pneumoconioses are seen in different regions of the lung. Coal workers' pneumoconiosis is typically an upper zone predominant process. The last component of the interpretation is the extent of the lung involvement or the so-called profusion. (Respondent's Exhibit No. 1, pp. 22-23). Dr. Meyer testified that the profusion is essentially an attempt to define the density of the small opacities in the lung. (Respondent's Exhibit No. 1, p. 30).

At the request of Respondent's counsel, Dr. James R. Castle reviewed medical records and a chest x-ray regarding Petitioner. (Respondent's Exhibit No. 2, p. 20). 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. 48). 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 who had coal workers' pneumoconiosis. (Respondent's Exhibit No. 2, p. 8). Dr. Castle was first certified as a B-reader in 1985 and was continuously certified as a B-reader through June 30, 2017. (Respondent's Exhibit No. 2, pp. 14-15).

Dr. Castle reviewed a chest x-ray from Central Illinois Allergy and Respiratory Service dated January 19, 2016. He testified that there were no parenchymal abnormalities consistent with pneumoconiosis on the film. He testified that the chest film was essentially normal. Dr. Castle testified that there is no such thing as radiographically apparent pulmonary impairment. He testified that for a proper reading of a chest x-ray for black lung, the reader needs to identify the patient and the date which the x-ray was done and then determine the quality of the film. Next, the reader has to determine whether or not there are any opacities present. This is determined by comparing the subject film to the standard ILO classification films. If there are opacities, they are classified according to their size and shape. The reader also notes the lung zones in which they are located as well as the profusion. (Respondent's Exhibit No. 2, pp. 43-44). Dr. Castle testified that it is very unlikely for simple pneumoconiosis to progress once the exposure ceases. (Respondent's Exhibit No. 2, pp. 43-44). Dr. Castle testified that he agrees with the position of the American Thoracic Society that an older worker with a mild

pneumoconiosis may be at low risk from working in currently permissible exposure levels until he reaches retirement age. (Respondent's Exhibit No. 2, pp. 44-45).

Dr. Castle testified that based upon a thorough review of all the data, he concluded 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 mining industry for a sufficient enough time to have possibly developed coal workers' pneumoconiosis if he were a susceptible host. He worked for 40 years in the coal mine industry and retired in 2015. (Respondent's Exhibit No. 2, pp. 45-46). Dr. Castle testified that Petitioner was a lifelong non-smoker. He had a history of having recurrent deep venous thrombosis involving the left lower extremity, however, he did not have any evidence of pulmonary embolism or respiratory symptoms of any kind at that time. He noted that the only respiratory symptoms he described were at the time of Dr. Paul's examination. Petitioner did not have any persistent and consistent physical findings indicating the presence of an interstitial pulmonary process. He did not have the persistent finding of rales, crackles or crepitations. Dr. Castle testified that virtually all of Petitioner's examinations of his chest and lungs by his primary care physicians were entirely normal. (Respondent's Exhibit No. 2, pp. 45-46).

Dr. Castle testified that he reviewed the spirometry done by Dr. Paul. He noted that the best value for the FVC appeared to be 3.33L as determined in trial six. The best FEV1 was not utilized which appeared to be 2.20L as seen in trial two. Dr. Castle testified that the best FVC and FEV1 were utilized by Dr. Paul in the post bronchodilator testing and the data post bronchodilator was normal. Dr. Castle noted that the total lung capacity was inaccurate as evidenced by the fact that the best forced vital capacity of 3.92L once added to the residual volume of 1.35L was greater than the total lung capacity reported of 4.38L. Dr. Castle testified that because of all the discrepancies this study was totally invalid and could not be utilized to determine impairment or disability. Dr. Castle testified that the best data that was presented indicated totally normal spirometry without evidence of obstruction. (Respondent's Exhibit No. 2, pp. 34-35). Dr. Castle further disagreed with Dr. Paul's reasoning for not using the best and second best forced vital capacity and FEV1 in the spirometry that he performed. Dr. Paul had testified that he used two values which were within 5%. Dr. Castle testified that that is not what the American Thoracic Society/European Respiratory Society state in their guidelines. (Respondent's Exhibit No. 2, p. 36). In terms of interpretative strategy as recommended by the ATS and ERS, one is to use the best FVC and best FEV1, regardless of which maneuver it comes from. Dr. Castle testified that if an individual has the best FVC on one attempt and on another attempt the best FEV1, those are to be used in order to determine the FVC percent. Again, Dr. Castle testified that the pulmonary function study done by Dr. Paul was not a valid study. (Respondent's Exhibit No. 2, pp. 37-38).

Dr. Castle testified that he also reviewed testing performed at Methodist Hospital on May 10, 2016, which was a valid study. This study was normal and he testified that it did not reveal any evidence of obstruction or restriction. (Respondent's Exhibit No. 2, p. 39). Dr. Castle testified that in this testing the lung volumes were normal and there was no evidence of a diffusion impairment. There was no evidence whatsoever of obstruction in the spirometry that was performed either. Dr. Castle testified that he also did not see anywhere in the medical records there ever having been a diagnosis of black lung, asthma, COPD or chronic bronchitis. Based upon this and his review of other records, he believed Petitioner was capable of heavy manual labor. (Respondent's Exhibit No. 2, p. 41).

Dr. Castle testified that he is familiar with the *AMA Guides to the Evaluation of Permanent Impairment, Sixth Edition*. He testified that if he applied Table 5-4 of the *Guides* to Petitioner's test results done at Methodist Hospital, he would fall in Class 0 impairment. He further testified that if he applied Table 5-5 to the testing done, Petitioner would fall in Class 0 impairment as far as asthma is concerned as well. (Respondent's Exhibit No. 2, p. 42).

Dr. Castle testified that studies have shown that as many as 50% of long term coal miners have pathological coal workers' pneumoconiosis that was not appreciated radiographically during their lives. (Respondent's Exhibit No. 2, p. 56). He believed that it is true that an individual can have the disease and have a negative chest x-ray. (Respondent's Exhibit No. 2, p. 55). Dr. Castle testified that the abnormality of coal workers' pneumoconiosis is essentially trapped coal dust in the part of the lung that ends up wrapped in scar tissue and can be accompanied by emphysema around it. The affected tissue itself cannot perform the function of normal healthy lung tissue. He 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. 60). Dr. Castle testified that to his knowledge, there was no cure for coal workers' pneumoconiosis. (Respondent's Exhibit No. 2, p. 70).

Medical records of Orthopedic Associates were admitted into evidence. Petitioner was seen by Dr. James Goris on August 27, 2013, for bilateral knee pain with the left worse than the right. Petitioner had previously undergone a left knee arthroscopic surgery in 1996. Updated films were taken in 2012 by his personal care physician and he occasionally took anti-inflammatories without relief of symptoms. He had also had injections without relief. Impression was osteoarthritis of the knees and surgery was recommended. (Respondent's Exhibit No. 5, pp. 18-20). Petitioner underwent a total left knee arthroplasty on September 23, 2013. (Respondent's Exhibit No. 5, p. 12). Petitioner returned for follow up on November 5, 2013, and it was determined that they would proceed with surgery on the right knee as well. (Respondent's Exhibit No. 5, pp. 9-10). A total right knee arthroplasty was performed by Dr. Goris on November 18, 2013.

(Respondent's Exhibit No. 5, p. 7). On February 10, 2014, Petitioner was able to return to work without restrictions. (Respondent's Exhibit No. 5, pp. 3-4).

Medical records of Primary Care Group were admitted into evidence. On September 15, 2006, Petitioner was seen by Dr. Winkleman to establish care. Physical examination of the chest showed the lungs were clear to auscultation. The only medication listed at that time was Prinivil. Review of systems respiratory revealed no cough or difficulty breathing. Current weight was 217 pounds. (Respondent's Exhibit No. 4, pp. 111-113). On May 16, 2007, Petitioner was seen for leg pain. Review of systems respiratory was negative for any cough or difficulty breathing. (Respondent's Exhibit No. 4, pp. 109-110). On September 12, 2008, Petitioner was seen for follow up of hypertension. Petitioner had been taking Coumadin. Review of systems respiratory revealed no difficulty breathing. Physical examination of the chest showed the lungs had no abnormality. Assessment was thrombus of the lower extremity. (Respondent's Exhibit No. 4, pp. 101-103). On January 19, 2009, Petitioner returned for leg pain. Petitioner had a medical history of phlebitis. Review of systems respiratory revealed no difficulty breathing. Physical examination of the chest remained normal. A Doppler study was ordered with a diagnosis of varicose veins of the lower extremities. (Respondent's Exhibit No. 4, pp. 97-98). On October 18, 2010, Petitioner returned again for follow up of hypertension. He denied any other symptoms and stated he was doing well. Review of systems respiratory revealed no difficulty breathing. Physical examination of the chest remained normal. (Respondent's Exhibit No. 4, pp. 91-93). On July 17, 2012, Petitioner was seen by Dr. Henson and related leg pain and swelling with an onset of one week prior. Review of systems respiratory remained negative for any difficulty breathing. Physical examination of the chest continued to be normal. Petitioner was started again on Lovenox and Coumadin. (Respondent's Exhibit No. 4, pp. 76-78).

He returned to Dr. Winkleman on July 20, 2012, for follow up of the leg complaints. Review of systems respiratory revealed no difficulty breathing. Assessment was DVT. (Respondent's Exhibit No. 4, pp. 74-75). On December 21, 2012, Petitioner had complaints of left elbow pain. Physical examination of the chest revealed no adventitious sounds. Petitioner was diagnosed with cellulitis. (Respondent's Exhibit No. 4, pp. 68-70). On September 18, 2013, Petitioner was seen for a preoperative evaluation prior to a total knee arthroplasty. At that time it was noted that Petitioner did not suffer from COPD. Physical examination of the chest remained normal. Petitioner's prescription for Proventil was changed to Lisinopril. (Respondent's Exhibit No. 4, pp. 63-65). On October 29, 2013, Petitioner followed up for hypertension. Review of systems respiratory continued to show that there was no difficulty breathing. Physical examination of the chest remained normal as well. (Respondent's Exhibit No. 4, pp. 58-60). This was also true of Petitioner's examination dates of November 25, 2013, and January 20, 2014. (Respondent's Exhibit No. 4, p. 51-57). On January 23, 2014, Petitioner was seen for a

recheck of his insomnia. Medications at that time included Lisinopril, Xarelto, Restoril, Cipro and Flomax. Review of systems respiratory was negative for difficulty breathing or sputum. It was indicated by his wife that he made unusual sounds when sleeping. Physical examination of the chest remained normal. (Respondent's Exhibit No. 4, pp. 48-50). Review of systems respiratory continued to reveal no difficulty breathing and physical examination of the chest remained normal on Petitioner's visit dates of January 27, 2014, February 11, 2014, and March 17, 2014, all of which were follow ups regarding his insomnia. (Respondent's Exhibit No. 4, pp. 36-44). On April 14, 2014, Petitioner was seen for a screening colonoscopy by Dr. Joyt. Review of systems respiratory remained negative for any cough or wheezing. Physical examination of the chest revealed the lungs were clear to auscultation. (Respondent's Exhibit No. 4, pp. 34-35). Petitioner followed up with Dr. Winkleman on July 8, 2014, for his hypertension. His blood pressure was well controlled with an ACE inhibitor. Review of systems respiratory revealed no difficulty breathing and physical examination of the chest remained normal. (Respondent's Exhibit No. 4, pp. 31-33). Petitioner's review of systems respiratory remained negative and physical examination of the chest remained normal on October 22, 2014. (Respondent's Exhibit No. 4, pp. 28-30). On November 13, 2015, Petitioner was marked as having never been a smoker. At that time he presented with lumbar spine pain. His medications included Lisinopril. Other problems listed for Petitioner included leg pain, hyperlipidemia, sleep apnea, upper respiratory infection, prosthesis, knee osteoarthritis, high blood pressure and periodic limb movement as well as an elevated PSA. Petitioner was also status post knee replacement, he suffered anxiety and had acute sciatica as well as otitis media. (Respondent's Exhibit No. 4, pp. 10-12).

On December 15, 2015, Petitioner was seen for hypertension follow up and stated that he was doing well. Review of systems respiratory revealed no abnormality. Physical examination of the chest also revealed no abnormality. (Respondent's Exhibit No. 4, pp. 6-8). On January 4, 2016, it was noted that Petitioner's MRI of the lumbar spine showed disc degeneration and bulging at multiple levels, causing spinal stenosis, which was worse at L2-3 and L3-4. Dr. Winkleman suggested an appointment with Pain Management to discuss options for injections and referral was made. (Respondent's Exhibit No. 4, p. 120). On March 15, 2016, Petitioner had a follow up for hypertension and hyperlipidemia. He was noted to be improving with his back pain after an epidural steroid injection. Petitioner had no difficulty breathing and physical examination of the chest showed breath sounds were normal. (Respondent's Exhibit No. 4, pp. 113-116). Review of systems respiratory on September 12, 2016, remained negative. Physical examination of the chest continued to show normal breath sounds. At that time, Petitioner was complaining of ear pain that had been present for four days. Petitioner received Amoxicillin and Cipro for the ear infection. (Respondent's Exhibit No. 4, pp. 107-109). On March 10, 2017, Petitioner was seen for transition in to care after having a colonoscopy consultation for history of colon polyps and family history of colon cancer. Review of systems respiratory showed no shortness of breath or wheezing. Physical examination of the chest showed

the lungs were clear to auscultation with no rhonchi. (Respondent's Exhibit No. 4, pp. 95-97). On July 11, 2017, Petitioner returned to the office for hyperlipidemia and hypertension. Petitioner did not have any shortness of breath. He was considering a total hip replacement due to hip pain. Review of systems respiratory was negative for any cough or shortness of breath. It was marked that Petitioner had never been a smoker. Oxygen saturation was 94% on room air. Physical examination of the chest showed normal effort with normal breath sounds and no wheezing. (Respondent's Exhibit No. 4, pp. 4-7).

On August 17, 2018, Petitioner was seen for another follow up. Review of systems respiratory remained negative for shortness of breath. It was noted that Petitioner was not in any respiratory distress and had no wheezing on physical examination. (Respondent's Exhibit No. 4, pp. 16-22). Review of systems respiratory remained negative and physical examination respiratory remained normal and negative on October 17, 2018, December 8, 2018, and February 18, 2019. (Respondent's Exhibit No. 4, pp. 27-45). On March 5, 2019, Petitioner had a complaint of a cough. He reported that he had been sick for two weeks and complained of cough with nasal congestion, as well as pain to the right side of the face and right ear. He also related having a sore throat and post nasal drip. Review of systems respiratory was positive for cough but negative for shortness of breath. Physical examination respiratory showed that respiratory effort and breath sounds were normal. There were no wheezes. Petitioner was diagnosed with acute maxillary sinusitis and prescribed Augmentin. (Respondent's Exhibit No. 4, pp. 46-51). As of March 22, 2019, Petitioner had no respiratory complaints and review of systems respiratory was negative for cough and shortness of breath. (Respondent's Exhibit No. 4, pp. 51-55). On April 12, 2019, review of systems respiratory remained negative for any cough or shortness of breath. (Respondent's Exhibit No. 4, pp. 58-61).

CONCLUSIONS OF LAW

Issue (c): Did an occupational disease occur that arose out of and in the course of Petitioner's employment with Respondent?

Issue (f): Is Petitioner's current condition of ill-being causally related to his occupational exposure?

The Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that he has an occupational disease arising out of and in the course of his employment.

The Arbitrator finds the x-ray interpretations by Dr. Castle and Dr. Meyer to be more credible than the interpretations by Dr. Paul and Dr. Smith. Dr. Paul is not a B-reader. Dr. Meyer testified that a specialized training course and examination must be

taken in order to become a B-reader. Dr. Paul does not have that training or certification. Dr. Paul's history of treating coal miners for coal mine-induced lung disease and interpreting chest x-rays of coal miners cannot be said to be the same as taking the B-reading course and passing the B-reading test. Dr. Paul did not know the date of the chest x-ray that he reviewed. Dr. Paul testified only that he believed the film was positive for coal workers' pneumoconiosis. Dr. Paul did not determine the profusion of the film. The Arbitrator finds it instructive to have testimony of a B-reader that explains what goes into a B-reading and, more specifically, a positive and/or negative B-reading. For these reasons, the Arbitrator finds Dr. Meyer's testimony helpful and more persuasive than the x-ray interpretation report of Dr. Smith. See *Slightom v. Tri County Coal*, LLC, 14 WC 015253, 19 IWC 0068 (February 1, 2019).

Furthermore, Dr. Meyer testified that the chest x-ray of January 19, 2016, was Quality 2 due to overexposure. Dr. Smith found the film to be a Quality 1, indicating that he did not take the overexposure into account in interpreting the film for pneumoconiosis.

Dr. Paul testified that if one wanted to know whether a specific exposure had caused impairment of a miner's lungs, he would need to have serial pulmonary function tests, pretests and post tests. Dr. Paul diagnosed Petitioner with asthma, as well as an obstructive defect. This appears to be based only upon Petitioner's history to Dr. Paul that he would sometimes get an upper respiratory infection in the winter, with associated cough and wheezing as well as his finding that Petitioner's chest exam revealed rales. Dr. Paul, however, did not review any medical records for Petitioner. Dr. Castle reviewed medical records pertaining to Petitioner's history, and testified that the history in the medical records did not support the history given to Dr. Paul. In virtually all office visits, Petitioner had normal respiratory exams and was without respiratory complaints. Further, Dr. Castle testified that the pulmonary function testing performed by Dr. Paul was invalid, failing to meet the American Thoracic Society standards and guidelines. The pulmonary function testing performed at Methodist Hospital on May 10, 2016, showed normal results, without any evidence of obstruction or restriction. The Arbitrator did not note the diagnosis of asthma or an obstruction or a restriction in the medical records which were admitted into evidence. The Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that he suffered from asthma or an obstruction or restriction.

Issue (o) Other: Whether Petitioner proved timely disablement pursuant to Sections 1: (e) and (f) of the Occupational Diseases Act?

The Arbitrator finds that Petitioner failed to prove a timely disablement pursuant to Sections 1(e) and 1(f) of the Occupational Diseases Act.

The Petitioner testified that he first noticed breathing problems at work while having to walk a lot underground. There was no evidence that any physician ever

restricted Petitioner from work due to a pulmonary condition. Petitioner was continuing to perform his job duties in the coal mine up until he decided to retire at age 62. He testified that at the time of his retirement he had told his wife he would retire when he turned 62, which was just a few days after his retirement date. Petitioner did not relate to Dr. Paul leaving the mine at the time he did on the recommendation of a physician or because of an inability to physically do his job. Dr. Castle testified that the pulmonary function testing performed by Dr. Paul was completely invalid. The testing performed at Methodist Hospital was normal and did not reveal an obstruction or restriction. Dr. Castle testified that Petitioner was capable of heavy manual labor based upon his ventilatory status. Dr. Castle further testified that if he applied the *AMA Guides* to Petitioner's test results, he would fall in Class 0 impairment.

Petitioner's claim for benefits is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☒ Reverse Accident	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MICHAEL MURRAY,

Petitioner,

20IWCC0428

vs. NO: 19 WC 18093

WILLIAMSON COUNTY SHERIFF'S DEPT.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causation, medical expenses and temporary total disability, and being advised of the facts and law, reverses the Decision of the Arbitrator on the issue of accident but attaches hereto the Decision of the Arbitrator for the Findings of Fact with the modifications noted below.

The Arbitrator found that Petitioner sustained an accident while working for Respondent when he fell down the stairs on May 30, 2019. Respondent argues that Petitioner fabricated this alleged accident because he had been disciplined earlier that day and was going to be suspended without pay for two days. After considering all of the evidence, the Commission finds that Petitioner failed to prove he sustained accidental injuries arising out of and in the course of his employment on May 30, 2019.

We initially make some modifications to the Arbitrator's Findings of Fact. First, the Arbitrator wrote:

> On cross-examination, Petitioner was questioned about the various areas of the anatomy noted in the Application. Other than the low back injury, Petitioner described those injuries as being strains/sprains which had totally resolved within two to three weeks following the accident. At that time, Petitioner's counsel made a statement that Petitioner was only 'seeking help' in regard to his low back. *Dec. 1.*

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We note that Petitioner's attorney did not use the phrase "seeking help." We find that Petitioner's attorney stipulated, which was confirmed by Petitioner, that the *only claim* Petitioner was making was for the low back. *T.53.*

Second, the Arbitrator wrote, "On May 30, 2019, Petitioner was also seen by Deborah Sullivan, a Nurse Practitioner." *Dec. 3.* However, Petitioner actually saw Ms. Sullivan on June 4, 2019.

Third, the Arbitrator's decision does not mention the June 3, 2019 visit with Dr. Buchman who noted no visible bruising or abnormality.

Fourth, the Arbitrator wrote, "Two days prior to the accident, May 28, 2019, Petitioner was informed he was going to be suspended without pay for two days, June 5 and June 6, 2019." *Dec. 1.* This statement is not accurate and makes it appear as though Petitioner was informed of his suspension two days before his accident. Petitioner testified that he did not remember the exact day that he got that notice. *T.45.* When Petitioner's attorney later showed him the Notice of Intent to Discipline that was dated May 28, 2019, Petitioner answered, "Yes, that's correct." *Id.* However, although that form indicates that it was created on May 28, 2019, Petitioner's signature on the bottom was dated May 30, 2019. *Rx3.* Furthermore, the May 30, 2019 memorandum by Lt. Owsley indicates that Petitioner was read the Notice of Intent to Discipline, Petitioner signed it, and he was given a copy on May 30, 2019. *Rx3.* This is consistent with Petitioner's cross-examination testimony that he was informed on May 30th that he would be undergoing two days suspension. *T.54.* The Commission finds that the evidence shows Petitioner was *not* aware of his suspension until May 30, 2019. He then allegedly sustained his accident later that same day.

We next turn to a review of the evidence which leads to our conclusion that Petitioner failed to prove accident. We find that Petitioner's medical records do not support his claim. Petitioner did not introduce his May 30, 2019 ambulance record into evidence. We note that such records are customarily considered significant evidence that one would normally use to support a claim of accident and the alleged mechanism of injury. Therefore, the Commission makes the permissible inference that the ambulance record contains information detrimental to Petitioner's claim. Petitioner also did not introduce the initial May 30th emergency room record. However, Respondent did introduce that record, which indicated no obvious trauma and normal range of motion of Petitioner's musculoskeletal system. Although the impression included "multiple contusions" it is not clear where these alleged contusions were and if they were actually seen by the provider or simply a diagnosis based on Petitioner's subjective complaints. Petitioner's only apparent exam findings were "tenderness to palpation," for which there was no documented objective basis. The impression of "multiple contusions" seems inconsistent with the finding of "no obvious trauma."

Petitioner's first chronological exhibit after the alleged date of accident was his June 1st report to Respondent indicating, "twisted my ankle missing a step and fell backwards down flight of stairs." *Px9.* Petitioner testified that he twisted his ankle "due to visibility" in the stairwell and fell backwards down the stairs. *T.40.* The Commission questions why the initial medical records do not indicate that Petitioner sustained an ankle injury.

Petitioner claims that he fell backwards down 10 to 15 steps. *T.59, Px3, Px4, Px5, Px9.* The Commission finds it extremely unlikely that Petitioner could fall backwards down a flight of 10 to

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15 steps without having any visible signs of trauma documented in any of the medical records. Interestingly, the May 30th emergency room record states "fell and slid down the stairs while on his back. He states he was able to hold his head up while sliding which caused the majority of his back to hit each stair going down." This could indicate that Petitioner may have slid down the stairs feet first but on his back, although he was able to hold his head up. Regardless, Petitioner's testimony and most of the subsequent medical records include some variation of Petitioner falling "backwards down the stairs." The Commission finds Petitioner's claimed mechanism of injury not credible.

The first *medical* record that Petitioner submitted into evidence was the June 3, 2019, note of Dr. Buchman. *Px3.* This record also indicates "no edema or deformity" and "no visible bruising [sic] or abnormality." However, at the end of page 1, it states, "Pain has worsened over the past few days as inflammation has built [sic: abrupt ending]"[.] But page 2 is completely missing from Petitioner's exhibit. We again make the permissible inference that the missing page contains information detrimental to Petitioner's claim.

The Arbitrator wrote, "In addition to the elevator call button not lighting when it was pressed by Petitioner, he also testified that he did not hear it moving. It was at that time he made the decision to use the stairs, again, not something that would be suspicious." *Dec. at 4.* However, we note that Petitioner was never asked if he had *ever* taken the stairs before. We find that, based on the evidence, it is likely that Petitioner had never taken those stairs before. Therefore, it is highly coincidental that Petitioner, who weighed 284 pounds, was 57-year old, and had previous knee surgeries would choose to walk down two flights of stairs in an allegedly dark stairwell for the very first time on the day that he was informed of his suspension.

One of the issues in this case is whether there was light in the stairwell from a crate propping the door open. The photos "Z" and "Z1," in *Px10,* show the exit door at the bottom of the stairwell being propped open by a milk crate. The Commission notes that these photos are in the authenticated record upside down. Clearly, the milk crate would not be propped at the top of the door. In any event, Petitioner testified that the milk crate was not in that door on the day he fell. *T.40.* However, Respondent's Chief Deputy, Scott McCabe, testified that the doors at both the top and the bottom of the staircases were propped open at the time of Petitioner's accident as an alternate means of exit in case of fire and also to allow more light into the stairwell. *T.76-78.* Chief Deputy McCabe also testified that if the door had been closed, a "large brass key" would have been needed to open the door. *Id.* The question then is how did Petitioner expect to be able to exit the stairwell if, according to Petitioner's own testimony, the door had not been propped open that day? Furthermore, there was no testimony about how the emergency personnel got to Petitioner and how he was ultimately removed from the stairwell. Petitioner's co-worker, Cassie Gossett testified that she took the elevator "up" that day but "when [Petitioner] fell I was working and could not go down stairs where he was." *T.19.* Although Ms. Gossett did not testify about the lighting conditions in the stairwell on the date of the alleged accident, she did testify that, in general, "you can see with the other lights on" and "you can see normal walking down the stairwell." *Id.*

The Commission finds that, although Petitioner may have been in that stairwell on the alleged date of accident and an ambulance was called in response to an alleged accident, he failed to prove that he sustained any accident at all.

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The Arbitrator also wrote, "While the initial medical record indicated there was 'No obvious trauma,' the diagnostic tests subsequently performed on [7/18/19], clearly indicated there was disc pathology in both the cervical and lumbar spine." *Dec. 4.* The Commission finds that these MRI findings a month and a half later do not support a claim of an alleged fall down 10 to 15 stairs *backwards* on May 30, 2019, considering there is no contemporaneous objective medical evidence of trauma.

The Arbitrator wrote:

> In spite of the fact Petitioner initially sustained injuries to multiple areas of the anatomy, at the time of trial, Petitioner was claiming that he had ongoing symptoms in regard to the low back and all of the other symptoms had resolved. If Petitioner was, in fact, attempting to perpetrate a fraud upon Respondent, it would seem that he would also, at a minimum, claim ongoing symptoms in respect to the cervical spine because of the findings of the diagnostic tests which revealed disc pathology in the cervical spine. *Dec. 4.*

The Commission finds that Petitioner's stipulation that he was limiting his claim to the low back does not make him more credible. Rather, it appears to be an attempt to deflect attention away from the lack of objective findings to any other body part after an alleged fall backwards down 10 to 15 stairs.

Petitioner testified that he would not throw himself down a flight of stairs and put himself through the pain he has over two days of pay (i.e., the suspension). *T.48-49.* However, that presumes that he actually did throw himself down the stairs and has any actual pain. The accident was not witnessed. The Commission does not doubt that Petitioner would not throw himself down a flight of stairs over two days of pay. However, that does not mean that he would not *claim* that he fell down the stairs over two days pay. Also, we find it likely that this was about much more than two days of lost pay. Petitioner had received multiple disciplinary warnings over the recent months prior to his alleged accident and very likely felt, justifiably, that his job was in jeopardy. *Rx3.* Would Petitioner fabricate a claim if he thought he would ultimately be fired? A May 30, 2019 memorandum from Lt. Owsley to Sheriff Bennie Vick about "Mike Murray Disciplinary Notification" states that at approximately 6:30 a.m. on May 30th, he and Chief Deputy Scott spoke with Petitioner:

> I then read to Mike [Petitioner] the entire Notice of Intent to Discipline form. I then explained to Mike that he would be suspended without pay for two(2) days and those days would be [6/5 and 6/6/19]. Mike then stated that he thought it would be best that he go ahead and resign. Mike stated that at his age he could see what was going on and that he was having trouble with the job. Mike appeared to be somewhat nervous. Myself and [McCabe] told Mike that we wanted to see him succeed and go home and think about his resignation and let me know before his shift that evening. Mike then signed and dated the Notice of Intent to discipline form. Mike was then given copies of both coaching forms along with a copy of the Notice of intent to discipline form.
>
> On Thursday, [5/30/19] at 9:05 AM I received a text message from Mike Murray the following is a transcript of that interaction:

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Mike: "Robert, I will be there tonight. I would like to get some additional training after the two days suspension and my vacation is past. If you think that will help. I will do my best to give it 100 percent."

Me: "Ok, sounds good. I will let Scott know."

Mike: "I am not willing to just give up but you surprised me this morning with what happened. I was not expecting that and am not will [sic] to just give up on all the training."

Me: "I appreciate it. We will get you some more training and get you where you need to be." *Rx3.*

The Commission finds that Petitioner was planning to resign when he was presented with his 2-day suspension on May 30, 2019. He was told to think about it, which he did and texted Lt. Owsley that he would accept the training and "give it 100 percent." Then, later that same day, he allegedly sustained this backwards fall down 10 to 15 steps, but had no visible signs of trauma. Based on a review of the entire record, the Commission finds that Petitioner failed to prove that he sustained an accident on May 30, 2019.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, issued October 28, 2019, is hereby reversed and all awards vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

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: JUL 3 1 2020

Maria Elena Portela
Maria E. Portela

Kathryn A. Doerries
Kathryn A. Doerries

SE/
O: 6/9/20
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DISSENT

I believe the Arbitrator's decision was well-reasoned and supported by the record, including Petitioner's credible testimony, and would affirm the Arbitrator's determination that Mr. Murray sustained accidental injuries arising out of and in the course of his employment on May 30, 2019 and that his current condition of ill-being with respect to his lumbar spine is causally related to same.

Petitioner credibly testified that he misstepped while descending a darkened stairwell to retrieve his lunch from his car. The fact that the lights were out in this stairwell was confirmed by both Chief Deputy McCabe and fellow dispatcher Cassie Gossett. Indeed, Chief Deputy McCabe

even acknowledged that one of the functions of using milk crates to prop open the doors was to allow more light into the stairwell. Likewise, building custodian Perry Hickey agreed that the stairway would be darker without the milk crate, as Petitioner alleged. Chief Deputy McCabe also confirmed Petitioner's claim that the call button light for the elevator on the third floor was not working at the time. As a result, it was entirely reasonable for Petitioner to decide to take the stairs instead of waiting for the elevator, especially since he had left his post and was presumably under pressure to retrieve his lunch box from his car and return to his dispatch station as soon as possible.

In addition, the histories contained in the medical records, as well as the employee report of injury, consistently reference an accident at work wherein Petitioner missed a step or twisted his ankle and fell down the stairs. I strongly disagree with my colleagues' decision to make what they call the permissible inference that the ambulance record contains information detrimental to Mr. Murray's claim simply because said records were not introduced into evidence by his attorney. I would point out that both parties could have submitted these records and that such an inference could have just as well been made about Respondent. Thus, the defense would not be entitled to the benefit of a negative inference. See *People v. Irby*, 237 Ill. App. 3d 38, 69, 602 N.E.2d 1349, 177 Ill. Dec. 177 (1992). In any event, this ambulance record would be but one piece of the puzzle, the majority of which supports Petitioner's claim that he suffered an on-the-job injury on the date in question.

Furthermore, I disagree with the majority's characterization of the medical records as inconsistent given that the emergency room reference to a diagnosis of "multiple contusions" is supposedly at odds with an earlier reference to "no obvious trauma." That same history also referenced the fact that Petitioner "... TRIED TO GRAB THE SIDE RAIL WHICH HELPED PREVENT HIM FROM FREE FALLING DOWN, AND EVENTUALLY FELL AND SLID DOWN THE STAIRS WHILE ON HIS BACK. HE STATES HE WAS ABLE TO HOLD HIS HEAD UP WHILE SLIDING WHICH CAUSED THE MAJORITY OF HIS BACK TO HIT EACH STAIR GOING DOWN." (Capitalized in original) (RX2). No doubt the reference to "multiple contusions" was a typical E.R. catch-all diagnosis, and the injury, as described in this document, was not one that would have necessarily manifested itself in the form of visible bruising, especially if he was able to lessen the impact by grabbing the rail. But it was the type of traumatic event that most assuredly could have and ultimately did cause and/or aggravate Petitioner's lumbar spine condition, including what turned out to include annular tears and disc protrusions. A fact made even more significant given that Petitioner had no prior history of low back complaints or treatment and was working full-duty without restrictions at the time of the accident.

I also fail to see how the fact that Petitioner had been disciplined and was set to serve a two-day suspension has any bearing on the compensability of this claim. The record shows that the reason for the disciplinary action was not because of some act of dishonesty or moral turpitude, but instead was due to his failure to follow established department protocols in the furtherance of his dispatch duties. Petitioner had acknowledged his deficiencies in this regard and accepted the consequences, including the aforementioned two-day suspension without pay and the promise of further training, and for all intents-and-purposes the matter had been resolved to everyone's satisfaction prior to the incident. To suggest that Petitioner then either "fabricated" the whole event (i.e. made it up) or else staged it because of his pending suspension makes no sense, particularly when one considers that he exhibited no signs or symptoms in his lower back prior to the incident

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and risked serious if not catastrophic injuries if he were to purposefully throw himself down the stairs.

Moreover, I believe that the preponderance of the evidence shows that the injury in question was the result of an employment risk – namely, a defect on Respondent's premises in the form of an inadequately illuminated stairwell. However, even if one were to view this scenario through the prism of a neutral risk analysis, the injury would still be compensable given that the darkened stairway represented a qualitative risk of injury that members of the general public were not exposed to, particularly in light of the fact that the stairwell where Petitioner fell was not open to the public.

Furthermore, the evidence shows that Petitioner's current condition of ill-being relative to his lumbar spine is causally related to the accident on May 30, 2019 based on the opinion of treating orthopedic surgeon Dr. Gornet as well as the chain of events which evidenced a previous condition of good health, an accident, and a subsequent injury resulting in disability. See *International Harvester v. Industrial Commission*, 93 Ill.2d 59, 63-64 (1982).

Therefore, I believe Petitioner sustained his burden of proving by a preponderance of the credible evidence that he sustained accidental injuries arising out of and in the course of his employment on May 30, 2019 and that his current condition of ill-being relative to his lumbar spine is causally related to said accident. For these reasons, I dissent from the majority opinion and would affirm the Arbitrator's decision.

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

MURRAY, MICHAEL
Employee/Petitioner

Case# **19WC018093**

WILLIAMSON COUNTY SHERIFF'S DEPT
Employer/Respondent

20IWCC0428

On 10/28/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.60% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0969 RICH RICH & COOKSEY PC
THOMAS C RICH
6 EXECUTIVE DR SUITE 3
FAIRVIEW HTS, IL 62208

2337 INMAN & FITZGIBBONS LTD
MICHAEL BANTZ
33 N DEARBORN ST SUITE 1825
CHICAGO, IL 60602

20 IWCC0428

STATE OF ILLINOIS)
)SS.
COUNTY OF MADISON)

- [ ] Injured Workers' Benefit Fund (§4(d))
- [ ] Rate Adjustment Fund (§8(g))
- [ ] Second Injury Fund (§8(e)18)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Michael Murray
Employee/Petitioner

Case # 19 WC 18093

v.

Consolidated cases: n/a

Williamson County Sheriff's Department
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Collinsville, on August 26, 2019. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] 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, May 30, 2019, Respondent was operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship did exist between Petitioner and Respondent.

On this date, Petitioner did sustain an accident that arose out of and in the course of employment.

Timely notice of this accident was given to Respondent.

Petitioner's current condition of ill-being is causally related to the accident.

In the year preceding the injury, Petitioner earned $32,344.00; the average weekly wage was $622.00.

On the date of accident, Petitioner was 57 years of age, married 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 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 authorize and pay for prospective medical treatment as recommended by Dr. Matthew Gornet.

Respondent shall pay Petitioner temporary total disability benefits of $414.67 per week for 12 3/7 weeks commencing May 31, 2019, through August 26, 2019, as provided in Section 8(b) of the Act.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

William R. Gallagher, Arbitrator
ICArbDec19(b)

October 21, 2019
Date

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged he sustained an accidental injury arising out of and in the course of his employment by Respondent on May 30, 2019. According to the Application, Petitioner "Fell down a Flight of Stairs" and sustained injuries to multiple areas of the anatomy including the "Bi-lateral Shoulders/Hips/Neck/Right Leg/Knee/Ankle/Back/BAW" (Arbitrator's Exhibit 2). However, during the cross-examination of Petitioner, Petitioner's counsel stipulated that, other than Petitioner's low back, all of the injuries to the other areas of the anatomy had resolved.

This case was tried in a 19(b) proceeding and Petitioner sought an order for payment of medical bills and temporary total disability benefits as well as prospective medical treatment. Respondent disputed liability on the basis of accident and causal relationship (Arbitrator's Exhibit 1). As noted herein, evidence was tendered regarding a disciplinary action that had been taken by Respondent against Petitioner. Two days prior to the accident, May 28, 2019, Petitioner was informed he was going to be suspended without pay for two days, June 5 and June 6, 2019. Respondent's position was that because of the aforementioned disciplinary action, Petitioner claimed he sustained a work-related accident on May 30, 2019, when, in fact, he did not.

Petitioner worked for Respondent as a dispatcher and had been employed by Respondent in that capacity for approximately one and one-half years. Petitioner's work station was located on the third floor of the Williamson County Courthouse. On May 30, 2019, Petitioner left his workstation to go to his vehicle to get his lunch which he had forgotten. Petitioner initially went to the elevator and pushed the button which he stated did not light. At that time, Petitioner decided to take the stairs and also said that he was not aware of any mechanical problem with the elevator, but that he did not hear the elevator moving so he decided to proceed and take the stairs. At that time, Petitioner had gone down several steps when he slipped and fell because of the lack of visibility.

On cross-examination, Petitioner was questioned about the various areas of the anatomy noted in the Application. Other than the low back injury, Petitioner described those injuries as being strains/sprains which had totally resolved within two to three weeks following the accident. At that time, Petitioner's counsel made a statement that Petitioner was only "seeking help" in regard to his low back.

Kimberly Murray, Petitioner's wife, testified for Petitioner at trial. She took several photographs of the stairwell where Petitioner sustained the fall which were received into evidence. She took the photographs on August 2, 2019. At the top of the stairwell, she testified there was only one fixture with one light bulb that was working. At the bottom of the stairwell, the door was held open with a milk crate and that opening was the only source of light (Petitioner's Exhibit 10; Z and Z1).

Respondent tendered into evidence various documents regarding the disciplinary action that had been taken. There were several instances in which Petitioner failed to meet performance standards or follow standard protocol. Specifically, there were instances in which Petitioner had made improper dispatches and had received coaching. Apparently, the most serious violation was

when Petitioner did not know the whereabouts of a deputy in the field. This was the basis of Petitioner being informed on May 28, 2019, that he was going to be suspended for two days without pay (Respondent's Exhibit 3).

On the same day of the accident, Petitioner met with Lieutenant Robert Owsley, his immediate supervisor, and Scott McCabe, the Chief Deputy. Petitioner was again informed he was going to be suspended without pay for two days. Petitioner initially stated he thought it would be best for him to just resign. Owsley and McCabe urged him to think about that and Petitioner subsequently changed his mind. Petitioner texted Owsley and noted he would get some additional training and would do his best to give it "100 percent" (Respondent's Exhibit 3).

Cassie Gossett testified for Petitioner at trial. Gossett was also a dispatcher employed by Respondent. Gossett identified photographs of the stairwell and agreed some of the lights were out, but said it was not darker than normal. Gossett said the door at the bottom was propped open with a crate which allowed light to enter. However, she did not know if the door was propped open on May 30, 2019, because she had used the elevator. She stated the elevators were working that day, but, there were days that they would be down.

Kevin Thomas testified for Petitioner at trial. Thomas worked for Respondent as a custodian and has done so for about six years. Thomas reviewed the photographs and stated the stairwell has lights, but they do not always work. He did not know if they were working on May 30, 2019, or not.

Perry Hickey testified for Petitioner at trial. Hickey also worked for Respondent as a custodian. Hickey reviewed the photographs and agreed the stairwell was dark. Further, Hickey stated the door to the outside was not an entrance for use by the public. He also stated the elevators were working on May 30, 2019.

Scott McCabe testified for Respondent at trial. McCabe has worked for Respondent for 19 years and has been the Chief Deputy for about one year. In regard to the light on the button to the elevator not coming on when pressed, McCabe said the light has not been working for quite some time. He also said that employees of Respondent who use the elevator on a regular basis were well aware of this. He also stated the doors to the stairwell were propped open primarily because of fire regulations and a large key would be used to unlock them if they were closed.

McCabe also testified about the disciplinary action taken in regard to Petitioner. McCabe confirmed Petitioner had issues with certain aspects of his job and had contemplated resigning. On cross-examination, McCabe agreed that none of Petitioner's conduct for which he was disciplined involved dishonesty, stealing, absenteeism or unprofessional/disrespectful behavior.

Petitioner sought medical treatment at Herrin Hospital the same day as the accident. According to the ER record, Petitioner fell down 10 to 12 stairs hitting his head and back. Petitioner was at the top of the stairs, missed a step, tried to grab the side rail and fell sliding down on his back. Petitioner held his head up which caused his back to strike each step as he went down. Petitioner complained of back, right shoulder and right hip pain, but denied having sustained a head injury (Respondent's Exhibit 2).

Petitioner complained primarily of right shoulder and right hip pain and, it was noted in the record, there was "No obvious trauma." CT scans of Petitioner's head, cervical spine, thoracic spine and lumbar spine were obtained. Others than some degenerative disc disease in the cervical spine, the CT scans were essentially normal (Respondent's Exhibit 2).

On May 30, 2019, Petitioner was also seen by Deborah Sullivan, a Nurse Practitioner. According to NP Sullivan's record, Petitioner was going down steps, missed the first step and fell 12 to 15 steps down. Petitioner did not hit his head, but had symptoms referable to his back and left shoulder. NP Sullivan opined Petitioner had cervicalgia, pain in the thoracic spine, a low back strain, neck strain and left rotator cuff strain. NP Sullivan imposed work restrictions and prescribed medication (Petitioner's Exhibit 4).

Petitioner was subsequently seen by Dr. Matthew Gornet, an orthopedic surgeon, on June 6, 2019. At that time, Petitioner informed Dr. Gornet of the accident of May 30, 2019. Petitioner complained primarily of pain referable to the cervical and lumbar spine. Dr. Gornet opined Petitioner's symptoms were consistent with a disc injury to both the cervical and lumbar spine. He opined Petitioner was temporarily totally disabled and his symptoms were related to the accident. He ordered physical therapy (Petitioner's Exhibit 5).

Petitioner was again seen by Dr. Gornet on July 18, 2019. He advised he had received about six weeks of physical therapy, but had not improved. Dr. Gornet ordered MRI scans of both the cervical and lumbar spine which were performed that same day (Petitioner's Exhibit 5).

According to the radiologist, the MRI of Petitioner's lumbar spine revealed an annular tear and protrusion at L5-S1 and foraminal annular tears at L4-L5 and L3-L4. According to the radiologist, the MRI of Petitioner's cervical spine revealed annular tears at C3-C4, C4-C5 and C6-C7 as well as a disc bulge at C5-C6 (Petitioner's Exhibit 6).

Dr. Gornet reviewed the MRI scans and his interpretation of them was consistent with that of the radiologist. He opined Petitioner had a disc injury at L5-S1 and recommended Petitioner undergo an epidural steroid injection at L5-S1 and medial branch blocks and facet rhizotomies at L4-L5 and L5-S1. He opined Petitioner also had cervical radiculopathy secondary to disc herniations at C4-C5 and C6-C7 as well as axial neck pain secondary to disc injuries at C3-C4, C4-C5 and C6-C7. However, Dr. Gornet did not make any recommendation for further treatment in regard to the cervical spine (Petitioner's Exhibit 5).

Petitioner was seen by Dr. Helen Blake on July 20, 2019. At that time, she administered an epidural steroid injection at L5-S1 (Petitioner's Exhibit 7).

At trial, Petitioner stated he was scheduled to be seen by Dr. Gornet on October 3, 2019. He wants to proceed with whatever treatment Dr. Gornet recommends in regard to his low back. As noted herein, Petitioner is only requesting treatment for his low back condition as the other conditions have resolved.

Conclusions of Law

In regard to disputed issue (C) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes Petitioner sustained an accidental injury arising out of and in the course of his employment by Respondent on May 30, 2019.

In support of this conclusion the Arbitrator notes the following:

Respondent's denial of this case is based upon its believe that, because of the disciplinary action that was being taken by Respondent against Petitioner, the accident of May 30, 2019, was a total fabrication that did not actually occur.

The fact that Petitioner simply forgot his lunch in his vehicle on the day of the accident is not suspicious.

In addition to the elevator call button not lighting when it was pressed by Petitioner, he also testified that he did not hear the elevator moving. It was at that time he made the decision to use the stairs, again, not something that would be suspicious.

The photographs of the stairwell and the testimony of various witnesses clearly demonstrated that the stairs were not well lit. This was certainly amplified by the fact the milk crate was used to prop the door open to permit light to enter.

While the initial medical record indicated there was "No obvious trauma," the diagnostic tests subsequently performed on July 18, 2019, clearly indicated there was disc pathology in both the cervical and lumbar spine.

In spite of the fact Petitioner initially sustained injuries to multiple areas of the anatomy, at the time of trial, Petitioner was claiming that he had ongoing symptoms in regard to the low back and all of the other very symptoms had resolved. If Petitioner was, in fact, attempting to perpetrate a fraud upon Respondent, it would seem that he would also, at a minimum, claim ongoing symptoms in respect to the cervical spine because of the findings of the diagnostic tests which revealed disc pathology in the cervical spine.

Based upon the preceding, the Arbitrator finds Petitioner did not fabricate having sustained an accident on May 30, 2019.

In regard to disputed issue (F) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes Petitioner's current condition of ill-being in regard to his low back is causally related to the accident of May 30, 2019.

In support of this conclusion the Arbitrator notes the following:

Dr. Gornet has opined that there is a causal relationship between Petitioner's low back condition and the accident. There is no medical evidence to the contrary.

In regard to disputed issue (J) Arbitrator makes the following conclusion of law:

The Arbitrator concludes that all of the medical treatment provided to Petitioner was reasonable and necessary and Respondent is liable for payment of the medical bills incurred therewith.

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibit 1, 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:

All of the medical treatment provided to Petitioner was reasonable and necessary and causally related to the accident, including the MRI of Petitioner's cervical spine which was performed on July 18, 2019, because Petitioner's neck still symptomatic at that time and the MRI was ordered by Dr. Gornet.

In regard to disputed issue (K) Arbitrator makes the following conclusion of law:

The Arbitrator concludes Petitioner is entitled to prospective medical treatment as recommended by Dr. Matthew Gornet.

In support of this conclusion the Arbitrator notes the following:

Dr. Gornet is scheduled to see Petitioner on October 2, 2019, and it is anticipated he will make treatment recommendations at that time.

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 12 4/7 weeks commencing May 31, 2019, through August, 26, 2019.

In support of this conclusion the Arbitrator notes the following:

Petitioner has been under the care of Dr. Gornet who has authorized him to be off work.

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

Illinois Workers' Compensation Commission,
Insurance Compliance Division,

Petitioner,

vs. No. 19WC023960

Shawn D. Stahly, Individually and as President of
Christian Home Improvement, LLC,

20IWCC0429

Respondent.

DECISION AND OPINION REGARDING INSURANCE COMPLIANCE

Petitioner, Illinois Workers' Compensation Commission (the Commission), Insurance Compliance Division, brought this action against Respondent by and through the office of the Illinois Attorney General alleging violations of section 4(a) of the Illinois Workers' Compensation Act (the Act). Proper and timely notice was given to all parties. An insurance compliance hearing on the merits was held before Commissioner Stephen Mathis on March 11, 2020, in Peoria, Illinois. Respondent did not appear at the hearing despite being properly served with notice of said hearing on February 25, 2020. (CX 1). After considering the entire record and being advised of the facts and law, the Commission finds that Respondent knowingly and willfully violated section 4(a) of the Act and shall pay a penalty of $500.00 per day for 291 days of non-compliance, equaling $145,500.00.

Petitioner alleges that Respondent, who was in a construction business and subject to section 3 of the Act requiring workers' compensations insurance, knowingly and willfully lacked workers' compensation insurance coverage for a period of 291 days, from July 19, 2017 through September 28, 2017, and from January 19, 2018 through August 27, 2018. During that time, an employee of Respondent sustained work-related injuries and filed a claim, *Myers v. Christian Home Improvement and Injured Workers' Benefit Fund*, 18 WC 09952. The case is pending on arbitration.

On March 11, 2020, Respondent did not appear for the insurance compliance hearing. Petitioner called as a witness Michael Cummins, a compliance investigator for the Commission. Investigator Cummins testified that in the course of his investigation, he determined that Respondent

was a home improvement business engaged in construction, demolition and interior redesign, and had more than one employee. Investigator Cummins further determined that Respondent was automatically subject to the provisions of sections 3 and 4 of the Act. Investigator Cummins's search of the insurance database maintained by the National Council on Compensation Insurance (NCCI) revealed that Respondent was uninsured from July 19, 2017 through September 28, 2017, and from January 19, 2018 through August 27, 2018. (PX 3). Investigator Cummins continued his investigation to determine whether Respondent was self-insured under the Act and received a certification from Maria Sarli-Dehlin of the Commission's Office of Self-Insurance Administration indicating there was no certificate of approval to self-insure issued by the Commission. (PX 4).

The Commission concludes that Respondent knowingly and willfully violated the insurance requirements of section 4(a) of the Act. Respondent did not appear to provide any defense for the fact that Respondent operated an extra hazardous business for 291 days without the mandated coverage. The Commission hereby assesses a penalty of $500.00 per day for 291 days, equaling $145,500.00.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent Shawn D. Stahly, Individually and as President of Christian Home Improvement, LLC, pay to the Illinois Workers' Compensation Commission the sum of $145,500.00 pursuant to section 4(d) of the Act and section 9100.90 of the Commission Rules. Pursuant to Commission Rule 9100.90(f), payment shall be made by certified check or money order made payable to the Illinois Workers' Compensation Commission. Payment shall be mailed or presented within 30 days after the final order of the Commission or the order of the court on review after final adjudication to:

Workers' Compensation Commission
Insurance Compliance Division
100 West Randolph Street, Suite 8-328
Chicago, Illinois 60601

Bond for the removal of this cause to the Circuit Court by 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: JUL 31 2020
SM/sk
44

Stephen Mathis

Douglas McCarthy

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

Maria Ruiz,

Petitioner,

vs. NO.15WC 28120

McDonald's,

Respondent.

20IWCC0430

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19b having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issue(s) of accident, medical expenses, causal connection, prospective medical care, temporary disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 29, 2019 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

20IWCC0430

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUL 31 2020
SJM/sj
07/08/2020
44

Stephen J. Mathis

Kathryn A. Doerries

Douglas D. McCarthy

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
AMENDED

RUIZ, MARIA
Employee/Petitioner

Case# **15WC028120**

McDONALD'S
Employer/Respondent

20IWCC0430

On 7/29/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.01% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

4069 LAW OFFICE OF JONATHAN SCHLACK
CHRISTOPHER BASSMAJI
200 N LASALLE ST SUITE 2830
CHICAGO, IL 60601

2461 NYHAN BAMBRICK KINZIE & LOWRY
BRIAN A RUDD
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

20IWCC0430

STATE OF ILLINOIS)
)SS.
COUNTY OF Lake)

- [ ] Injured Workers' Benefit Fund (§4(d))
- [ ] Rate Adjustment Fund (§8(g))
- [ ] Second Injury Fund (§8(e)18)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
AMENDED ARBITRATION DECISION

Maria Ruiz
Employee/Petitioner

v.

McDonald's
Employer/Respondent

Case # **15** WC **28120**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jessica Hegarty**, Arbitrator of the Commission, in the city of **Waukegan**, on **March 26, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD
L. [ ] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [x] Other **Prospective Medical Treatment, Petitioner exceeded choice of physician, 19(d) injurious practices**

FINDINGS

On **July 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.

Timely notice of this accident ***was*** given to Respondent.

Petitioner's current condition of ill-being ***is*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**11,487.32**; the average weekly wage was $**220.91**.

On the date of accident, Petitioner was **35** years of age, ***single*** with **2** dependent children.

Petitioner ***has*** received all reasonable and necessary medical services.

Respondent ***has not*** paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $**6380.00** 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

1. Petitioner is entitled to TTD benefits, July 30, 2015 through March 26, 2019, representing 190 and 6/7 weeks of TTD benefits. Petitioner is at the statutory minimum TTD rate of $220.91. Thus, this Arbitrator orders Respondent to pay $42,162.25 to Petitioner ($220.91 x 190 & 6/7 Weeks).

2. Respondent shall be given a credit of $6,380.00 for temporary total disability benefits that have been paid.

3. The Arbitrator finds Respondent is not liable for the following bills pursuant to the finding above:

$12,717.00:	Dr. Jain at Pinnacle Pain Management Specialists (April 20, 2016 - June 17, 2016 including a discogram of the lumbar spine).
$14,000.00:	Pinnacle Pain Management Specialists
$2,462.81 :	Pinnacle Interventional Pain Associates (*see* Pet. Ex. 18, at 2-5).
$963.00:	Dr. Girgis & Asso. (referral from Dr. Jain) (Pet. Ex. 19, at 3-4).
$262.00:	Suburban Radiologists (*see* Pet. Ex. 19, at 2 and 5).
$8,470.44:	Coast Management (equipment prescribed by Dr. Jain between May 26, 2016 and June 26, 2016) (*see* Pet. Ex. 20, at 2).
$16,675.00:	New Life Medical Center (January 16, 2016 - June 24, 2016) (*see* Pet. Ex. 16, at 2-3).

4. Respondent shall pay the following reasonable and necessary medical services, as provided in Sections 8(a) and 8.2 of the Act:

$7,201.00:	Dr. Abdellatif at ProClinics
$1,400.00:	Best Choice Rehab
$949.00:	Dr. Markarian at Orthopedic Associates of Naperville
$985.00:	Dr. Chunduri at Advanced Spine and Pain Specialists

$5,097.47:	Lakeshore Open MRI
$18,155.59:	Dr. Abdellatif at Summit Center for Health (aka DuPage Immediate Care)
$540.00:	DuPage Immediate Care Anesthesia
$5,597.41:	Advanced Spine Pain Clinics of Chicago
$4,000.00:	Imaging Centers of America
$4,820.00:	Dr. Vargas at River North Pain Management
$4,883.42:	Ashland Health, LLC.
$5,064.70:	Windy City RX
$225.00:	Lakeshore Surgery Center physician's charges
$275.00:	Lakeshore Surgery Center facility charges
$2,900.00:	Dr. Erickson - American Center For Spine & Neurosurgery
$1,500.00:	Lake County Neuromonitoring
$1,500.00:	Neurological Specialists LTD
$7,716.84:	EQMD
$2,400.00:	Edgebrook Open MRI -3-D MRI
$22,290.00	Windy City Medical Specialists

5. Respondent is liable for any and all outstanding medical charges to be incurred for prospective medical treatment recommended by Dr. Erickson, namely a hemilaminectomy of the lumbar spine at L5-S1 and all related treatment 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.

Susan C. Mgatt

Signature of Arbitrator
ICArbDec p. 2

7/26/19
Date

JUL 29 2019

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MARIA RUIZ,	)	**20 IWCC0430**
Petitioner,	)	
vs.	)	**No. 15 WC 28120**
MCDONALD'S,	)	
Respondent.	)	

AMENDED
ADDENDUM TO THE DECISION OF THE ARBITRATOR

This case was heard by the Arbitrator in the city of Waukegan, Illinois on March 26, 2019. After hearing the testimony and reviewing all of the evidence presented, the Arbitrator makes findings on the disputed issues below.

STATEMENT OF FACTS

Petitioner's Testimony

Petitioner testified through an interpreter that she began working part-time, 6-8 hour shifts, in the kitchen at the McDonald's located in Woodstock ("Respondent") around 2012 (Tr. Trans., at 8, 10). Her job duties included cooking meat, preparing salads and sandwiches and working on the assembly line and transporting packaged meat from a large freezer to the kitchen area.

On July 14, 2015, Petitioner was opening the kitchen for breakfast. Her duties included moving boxes and bags of meat from the big freezer to a smaller freezer, closer to the kitchen. She testified each box of meat weighed 50 lbs., "more or less" while the bags of meat weighed approximately 15-20 lbs. each. After lifting the items and loading them on a cart, she pushed the cart to the kitchen area, which, according to her testimony, required a lot of strength. On occasion, she had to lift the cart when it would get stuck (Id., at 10-11). When she reached the smaller freezer, Petitioner picked up a case containing quarter-pounder hamburger meat when the case "got caught on an iron" inside the small freezer. Petitioner testified, "I tried to get the case to place it better, and the case slipped and it pulled my arm and it cracked and my back hurt" (Id., 11).

Afterwards, Petitioner reported the incident to her manager, Emperatriz, who responded "Oh be careful" but didn't say anything else (Id., 12-13). Emperatriz did not fill out an accident report.

Petitioner took the next three days off of work. Despite pain in her back and arm, she returned to work for two days but the pain became too much so she went to a doctor (Id., at 13-14).

Petitioner consistently treated with various medical providers until November of 2016 when she became pregnant, at which time, her doctors advised her to discontinue treatment for the duration of the pregnancy (Id. 20). She commenced treating in July of 2017 after she gave birth (Id. 21).

Petitioner received benefits from Respondent from July of 2015 until February of 2016. (Id. 21). Although she is still employed by Respondent, she has not worked since July of 2015 due to medical restrictions (Id.).

Medical Records

On July 21, 2015, Petitioner presented to Aaron Schreiber, D.C. at the Spine and Joint Institute with a history of low back pain two days after intensive lifting at work on July 14, 2015 (Id.). (Pet. Ex. 17, at 2). Petitioner reportedly thought her complaints would diminish but when she returned to work on July 20, 2015, she felt a sharp stabbing pain and radiation down her left leg after lifting a box. Petitioner complained of "sciatica" in her left leg to her knee. She rated the pain at an 8/10 with constant, sharp numbness worsened with activity (Id.). Dr. Schreiber diagnosed Petitioner with sciatica, lumbago, displaced lumbar disc, pain in the shoulder joint, muscle spasms and weakness, difficulty walking, and nonallopathic lumbar lesion (Id., at 4). Dr. Schreiber recommended physical therapy for three times a week for 4-6 weeks and if she experienced no improvement, she would consult a specialist (Id.).

On July 30, 2015, Petitioner presented to Dr. Ossama Abdellatif at ProClinics pursuant to Dr. Schreiber's referral (Pet. Ex. 1, at 5). Dr. Abdellatif noted the Petitioner worked for McDonald's as a cook, prepping, lifting, and other various jobs when she suffered a work-related injury to her low back and right shoulder as she was coming out of a freezer with a box weighing approximately fifty (50) pounds (Id.). Petitioner was maintaining balance of the boxes with her right upper extremity and had repeatedly lifted boxes (Id.). Dr. Abdellatif noted Petitioner tried to return to work but, due to the increase in pain in her right shoulder and low back, sought medical care (Id.). On physical examination, tenderness in the lumbar spine and right shoulder were noted (Id.). The doctor diagnosed Petitioner with lumbar radiculopathy, lumbar facet si/syndrome, myofacia pain, right shoulder pain, and thoracic radiculopathy (Id., at 6). Dr. Abdellatif recommended an MRI of the lumbar spine, right shoulder, and thoracic spine, EMG of the lower extremities, orthopedic consult for the right shoulder and a trigger point injection for the myofascial pain (Id.). Petitioner was to undergo physical therapy and was prescribed medications (Id.). Petitioner was to remain off-work (Id., at 4-6).

Petitioner underwent the above-recommended EMG at Midwest Neurodiagnostic Specialists on July 30, 2015 that revealed radiculitis affecting L4-S1 bilaterally (Id., at 9-10).

On August 11, 2015, Petitioner presented to Best Choice Rehab for initial evaluation (Pet. Ex. 2, at 3). The treatment plan consisted of electric muscle stimulation, ultrasound, soft tissue mobilization, gait training, therapeutic exercise, ice compression, and continued treatment with Dr. Abdellatif (Id., at 4).

On August 13, 2015, Petitioner underwent MRIs of the thoracic spine, lumbar spine, and right shoulder at Imaging Centers of America as recommended by Dr. Abdellatif (Pet. Ex. 5, at 3-7).

- The MRI of the lumbar spine revealed a subligamentous posterior disk herniation with an extruded nucleus pulposus measuring 5-6 mm noted to indent the ventral and left side of the thecal sac with left sided spinal stenosis and left lateral recess narrowing seen, exacerbated by facet arthrosis and ligamentum flavum hypertrophy at L5-S1 (Id., at 5). A 2-3 mm posterior disk protrusion also noted to indent the thecal sac with mild bilateral neuroforaminal narrowing seen, exacerbated by some ligamentum flavum hypertrophy (Id.).

- The MRI of the right shoulder revealed rotator cuff tendonitis and/or bursitis involving the distal supraspinatus tendon (Id., at 6-7).

- The MRI of the thoracic spine was unremarkable (Id., at 3).

On September 3, 2015, Petitioner underwent a series of lumbar spine and right shoulder injections per Dr. Abdellatif's recommendation at Summit Center for Health a.k.a. DuPage Immediate Care (Pet. Ex. 4, at 13-19).

On September 17, 2015, Petitioner attended an IME with Dr. Frank Phillips at Midwest Orthopaedics at Rush regarding her lumbar spine (*see* Resp. Ex. 3). After examining Petitioner, reviewing the medical records and the Employer's First Report of Injury (Resp. Ex. 8), Dr. Phillips noted the Petitioner "did in fact sustain an L5-S1 herniated disk in the injury in question." The doctor further noted Petitioner had a positive straight leg raise and that her objective findings and subjective complaints correlated with the MRI findings. Dr. Phillips opined that Petitioner's current condition related to the July 14, 2015 injury and that the treatment to date had been reasonable and necessary. He recommended Petitioner undergo a lumbar therapy program and receive epidural injections. If Petitioner failed to respond to this treatment, Dr. Phillips opined that "she might ultimately be a candidate for discectomy surgery." Dr. Phillips noted the Petitioner was not at MMI and should be restricted to sedentary capacity.

On September 25, 2015, Petitioner presented for initial consult with Dr. Gregory Markarian at Orthopedic Associates of Naperville regarding her right shoulder and left knee pursuant to the recommendation of Dr. Abdellatif (Pet. Ex. 3, at 3). Dr. Markarian noted the Petitioner worked at McDonald's in the kitchen assembly area where she suffered a work-related injury to her right shoulder and left knee on July 14, 2015 while lifting a 75 lb. box of frozen meat. She experienced an acute onset of right shoulder pain when her right shoulder was eccentrically loaded and twisted her left knee (Id.). On exam of the right shoulder, the doctor noted tenderness with positive apprehension and relocation and positive O'Brien's. Exam of the left knee indicated tenderness along the medial joint line with positive McMurray and Steinman's tests. Dr. Markarian recommended the Petitioner undergo MRI arthrogram of the right shoulder and MRI of the left knee (Id., at 3-4).

On October 5, 2015, Petitioner underwent a right shoulder contrast injection for arthrogram under fluoroscopic guidance by Dr. Krishna Chunduri at Lakeshore Surgery Center as recommended by Dr. Markarian followed by a right shoulder MR arthrogram at Lakeshore Open MRI by Dr. Kuritza (Pet. Ex. 7, at 3; Pet. Ex. 6, at 3). The MR arthrogram revealed "no evidence of a full thickness rotator cuff tendon tear" (Id.).

On October 13, 2015, Petitioner underwent MRI of the left knee at Lakeshore Open MRI by Dr. Kuritza (as recommended by Dr. Markarian) that revealed small joint effusion, subtle horizontal irregularity of the intrasubstance portion of the posterior horn of the medial meniscus (probably a small intrasubstance tear), and mild peripatellar soft tissue swelling (presumably post-traumatic soft tissue bruising) (Id., at 4-5).

On October 21, 2015, Petitioner presented to Dr. Axel Vargas at River North Pain Management per Dr. Schreiber's referral (Pet. Ex. 8, at 3). Dr. Vargas noted the Petitioner sustained a work-related injury on July 14, 2015 while lifting heavy boxes of frozen meat. Following the incident, Petitioner had low back and lower extremity pain with radiation along with right shoulder pain (Id.). Petitioner briefly returned to work but her pain was too much (Id.). Dr. Vargas diagnosed Petitioner with lumbosacral discogenic radiculopathy and pain syndrome, lumbar facet pain syndrome, and right shoulder internal derangement (Id., at 6). The doctor recommended lumbar injections, continued medication, a lumbar brace and continuation of physical therapy (Id., at 8). Petitioner was to remain off-work (Id.).

On November 2, 2015, Petitioner presented to Dr. Thomas Poepping at Windy City Medical Specialists for initial consult of her right shoulder (Pet. Ex. 11, at 3). Dr. Poepping noted the Petitioner sustained a work-related injury on July 14, 2015 while working at McDonald's when she was pushing a cart with a fifty (50) pound box of meat on it (Id.). The Petitioner injured herself while lifting the jammed cart with the heavy box on it causing severe low back and right shoulder pain (Id.). On exam of the right shoulder, the doctor noted positive Neer and Hawkins. Petitioner was diagnosed with right shoulder impingement for which an injection was administered (Id.).

On November 9, 2015, Dr. Markarian noted Petitioner presented for follow up with respect to her knee (Pet. Ex. 3). The doctor noted, "she is here for x-rays. Her MRI is not available for review" (Id.). The doctor noted the left knee x-ray showed no arthritis while the right shoulder x-ray noted a normal acromiohumeral interval.

The doctor noted once the MRI results are obtained, a treatment plan will follow (Id.) This is the last record for this treating doctor.

On November 10, 2015, Petitioner attended her last physical therapy session at Best Choice Rehab (Pet. Ex. 2, at 2, 13-14).

On November 30. 2015, Petitioner followed up with Dr. Poepping who noted the right shoulder was much improved after the injection. On January 11, 2016, Petitioner reported to Dr. Poepping that her shoulder was pain free. She was released from care with respect to the right shoulder (Id., at 5).

On November 6, 2015 and November 20, 2015, Petitioner underwent bilateral L4-L5 and L5-S1 transforaminal epidural steroid injections and selective nerve root blocks by Dr. Vargas at Lakeshore Surgery Center (Pet. Ex. 12, at 6-27).

Petitioner attended an IME on November 17, 2015 with Dr. Brian Forsythe at Midwest Orthopaedics at Rush regarding the right shoulder and left knee (*see* Resp. Ex. 4). Dr. Forsythe noted the Petitioner sustained a work injury on July 14, 2015 while lifting a 40-50 lb. box of meat. Petitioner was diagnosed with a resolved right shoulder strain and left knee referred pain, possibly from the lumbar spine. Dr. Forsythe opined that Petitioner's "current complaints are related to the work incident of July 14, 2015" and that treatment to date had been reasonable and medically necessary. Dr. Forsythe opined the Petitioner was at MMI and could return to work full duty.

On December 2, 2015, Dr. Vargas noted Petitioner's complaints of persistent lower back pain with associated lower extremity radicular symptoms, focalized weakness and "frank" paresthesia. The doctor noted Petitioner's treatment thus far consisting of physical therapy, "around-the-clock" intake of muscle relaxants, neuromodulators, non-opiate analgesics and NSAID's (Pet. Ex. 8, at 9). Based on Petitioner's negative clinical progression, the doctor recommended Petitioner consult with a neurosurgeon, undergo a lumbar discogram followed by at CT scan and continue with the orthopedic treater (Id., at 10). Petitioner was to continue medications and remain off-work (Id., at 10-12). This is the last treating record by Dr. Vargas contained in the record.

Petitioner attended a repeat IME with Dr. Phillips on January 8, 2016 regarding her lumbar spine (*see* Resp. Ex. 5). The diagnosis of an L5-S1 herniated disk remained the same. Dr. Phillips opined Petitioner's subjective complaints correlated with the objective findings and that treatment to date had been reasonable and medically necessary. Dr. Phillips believed a discectomy had been recommended for Petitioner and thought surgical recommendation was reasonable. Dr. Phillips further opined that Petitioner was not at MMI and could return to work in a sedentary capacity.

On January 13, 2016, Petitioner presented to Dr. Robert Erickson, a neurosurgeon, at The American Center for Spine & Neurosurgery (Pet. Ex. 13, at 4). Dr. Erickson noted the Petitioner sustained a work-related injury on July 14, 2015 at McDonald's while loading frozen meat onto a cart and having to lift the cart, which was stuck (Id., at 4-5). After reviewing the diagnostic studies and completing a physical examination, Dr. Erickson opined the Petitioner was an "excellent candidate for hemilaminectomy at L5-S1 on the left side for treatment of the stenosis resulting from the disc herniation" (Id., at 5). Dr. Erickson noted the Petitioner was interested in pursuing surgery as soon as possible and that the surgery was a "consequence of the injury, which occurred on July 14, 2015" (Id.).

On January 18, 2016, Petitioner presented to New Life Medical Center for a physical therapy evaluation (Pet. Ex. 16, at 10). It was noted the Petitioner sustained a work-related injury at McDonald's on July 14, 2015 while lifting heavy boxes (Id.). As a result, Petitioner had right shoulder, lumbar spine, and left leg pain (Id.). Petitioner was diagnosed with lumbar disc herniation, low back pain, lumbar radiculopathy, and muscle spasm (Id., at 11). Petitioner was recommended to continue therapy to decrease pain and increase range of motion

and remain off work pending surgery (Id., at 11-14; 16). Petitioner treated at New Life Medical Center through June 24, 2016 and remained off-work Id., at 15-81).

On February 18, 2016, Petitioner underwent a Clinical Evoked Potential Lower Extremities test with Dr. Chhabria at Lake County Neuromonitoring as recommended by Dr. Erickson (Pet. Ex. 14, at 3). The test revealed evidence of the L5 Left 0.8/Right 0.8 and S1 Left 0.9/Right 0.8 (Id.).

Petitioner followed up with Dr. Erickson on February 24, 2016, June 29, 2016, August 10, 2016, September 7, 2016, July 5, 2017, July 26, 2017, and October 12, 2017 (Pet. Ex. 13, at 6-12). During these visits, Petitioner's diagnoses remained the same, and Dr. Erickson continued to recommend Petitioner undergo surgery (Id.). Dr. Erickson noted several times that he had yet to receive authorization for the procedure (Id.). Further, Dr. Erickson noted, treatment was delayed from the end of 2016 through July of 2017 due to Petitioner giving birth in May of 2017 (Id., at 11).

On April 20, 2016, Petitioner presented for initial evaluation with Dr. Neeraj Jain at Pinnacle Pain Management Specialists (Pet. Ex. 18, 6). Dr. Jain noted a history of a work related injury on July 14, 2015 while lifting heavy boxes at work causing her to feel pain and cracking on her back and pain in her right shoulder (Id.). Petitioner was diagnosed with lumbar facet syndrome and lumbar radiculopathy (Id., at 7). Petitioner was recommended to undergo a discogram (Id.).

On May 11, 2016, Petitioner underwent the discogram recommended by Dr. Jain (Pet. Ex. 18, at 9-11). The discogram revealed discogenic pain at L5-S1 with control levels at L2-L3, L3-L4, and L4-L5 (Id., at 11). Also on May 11, 2016, Petitioner underwent a post-discogram lumbar CT with Dr. Hrabski at Drs Girgis & Associates (Pet. Ex. 19, at 3-4). The study demonstrated disc space narrowing at L5-S1 with degenerated nucleus pulposus with contrast tracking along the annulus (Id., at 4).

Petitioner followed up with Dr. Jain on May 25, 2016 and June 17, 2016 (Pet. Ex. 18, at 12-14). Petitioner's diagnoses remained the same (Id.). Petitioner was to continue physical therapy and treatment with Dr. Erickson given the positive L5-S1 discogram (Id.).

On July 11, 2017, Petitioner underwent a 3-Dimensional Reconstruction MRI of the Lumbar Spine and a normal MRI of the Lumbar Spine at Edgebrook Radiology as recommended by Dr. Erickson (Pet. Ex. 22, at 3-4). At L5-S1, the was a 3-4 mm broad based posterior disk herniation with an extruded nucleus pulposus with generalized spinal stenosis and bilateral neuroforaminal narrowing, greater on the left (Id., at 4). At L4-L5, there was a 2 mm posterior annular disk bulge, which indents the thecal sac with bilateral neuroforaminal narrowing (Id.).

Petitioner attended another repeat IME with Dr. Phillips on December 1, 2017 regarding the lumbar spine (*see* Resp. Ex. 6). Dr. Phillips was concerned because he stated "there is no evidence of any active treatment for her lumbar spine after the 2016 IME for a period of almost 9 months" and that this meant Petitioner's symptoms were not severe and constant. He also noted that Petitioner gave birth at the end of 2016. Due to the alleged gap in treatment from January 8, 2016 to the end of 2016, Dr. Phillips stated Petitioner was no longer a surgical candidate. Dr. Phillips stated that Petitioner still had an L5-S1 disk herniation and that she no longer had radicular pains. Dr. Phillips saw the surveillance video, which showed Petitioner ambulating with less difficulty. Dr. Phillips concluded by opining that Petitioner was at MMI and should undergo an FCE, and any restrictions given by the FCE would be related to the 2015 accident.

On January 17, 2018, Petitioner followed up with Dr. Erickson for reevaluation and review of Dr. Phillips' IME reports (Pet. Ex. 13, at 14). Dr. Erickson again opined that Petitioner was an excellent candidate for hemilaminectomy of the lumbar spine, noting such is supported by neurophysiological testing, imaging studies, and continued back pain with associated leg pain (Id.).

On February 20, 2018, Petitioner followed up with Dr. Erickson, and her diagnoses and treatment plan remained the same while awaiting approval for the recommended surgery (Pet. Ex. 13, at 15). Also on February 28, 2018, Petitioner underwent an SSEP with Dr. Kranzler at Neurosurgical Specialists LTD as recommended by Dr. Erickson, which revealed a delay at S1 on the left and is compatible with S1 radiculopathy on the left (Id., at 3-10).

On October 9, 2018, Dr. Erickson authored a narrative report in which he opined Petitioner was indeed injured on July 14, 2015 at work when a cart became stuck in the freezer causing injuries to her right shoulder and lumbar spine (Pet. Ex. 13, at 16). Dr. Erickson further stated that with respect to the surveillance video that is common for patients with sciatica relative to nerve compression are able to walk for a number of minutes at a time before requiring rest for leg and back pain (Id.). Dr. Erickson opined the videotape does not speak to whether or not Petitioner would receive significant improvement with treatment of her ongoing sciatica (Id.). Dr. Erickson noted the objective evidence, including the MRI scans and single nerve root neurophysiological testing, indicate significant lateral recess stenosis at L5-S1 (Id.). Dr. Erickson opined that Petitioner would need single nerve root testing during surgery to make sure there is no contribution from the disc protrusion at L4-L5 (Id.). Dr. Erickson concluded noting that Petitioner would achieve significant benefit with the proposed surgical treatments (Id.).

Petitioner's most recent visit with Dr. Erickson was on February 20, 2019 (Pet. Ex. 13, at 18). Petitioner's diagnoses remained the same, and Dr. Erickson again recommended Petitioner undergo hemilaminectomy at L5-S1 with the approach undertaken from the left side (Id.). Dr. Erickson noted the surgery had yet to be approved (Id.). Dr. Erickson concluded noting, "At this late date, conservative treatment will not reverse her current situation" (Id.).

Petitioner testified that as of the day of trial, she remains under the care of Dr. Erickson and wants to proceed with the surgery recommended by Dr. Erickson (Tr. Trans, at 19-20). Petitioner testified she continues to have pain in her lumbar spine, which is constant and severe (Id., at 25-26). Her pain continues to affect activities of daily living and her children (Id., at 26). She has been off-work from July of 2015 to the present and has not worked anywhere else since that time (Id., at 21). Petitioner testified she has not had any new accidents or incidents since July 14, 2015 (Id., at 24). Prior to July 14, 2015, Petitioner testified she did not experience any pain in her left leg, lumbar spine or right shoulder (Id., at 25). Further, prior to July 14, 2015, she never sought medical treatment for her left leg, lumbar spine or right shoulder (Id.).

Respondent's witness, Kenneth Reinke, conducted surveillance which the Arbitrator reviewed (*see* Resp. Ex. 7.)

Respondent produced Karen Mignogna who has been employed by Respondent for 33 years. According to her testimony, she is Director of Operations/Supervisor of four restaurants for which she is in charge of all injury claims (Tr. Trans., at 68-69). In 2015 and 2016, Petitioner was "either directly or indirectly" under Mignogna's supervision (Id., at 69). Mignogna testified about an in-person conversation she had with Petitioner in the dining room of Petitioner's workplace on July 22, 2015 with Luis Rico present as a translator (Id., at 69-70). Mignogna testified the Petitioner gave her a doctor's note stating she had been injured and needed time off work (Id., at 71). Mignogna testified she completed Respondent's Exhibit 8 on July 22, 2015, a form entitled "Employer's First Report of Injury or Illness" except for the signature which was signed by general manager, Luis Rico (Id.). This form states Petitioner claimed to have been injured "carrying stock". Mignogma testified the "stock" consisted of "a case of meat, a case of nuggets, bags of food" on July 18, 2015 (Id., at 72).

Mignogna next testified regarding Respondent's Exhibit 9, a "Supervisor's Injury Report" also completed by Mignogna on July 22, 2015 after her conversation with Petitioner (Id., at 73-74). On this form, in response to the question "Where did the injury occur?" Ms. Mignogna wrote "N/A" because Petitioner allegedly did not provide Mignogna with any information regarding where the accident occurred (Id., at 74-75). Mignogna testified she did ask Petitioner that question (Id., 75). Mignogna testified she questioned the legitimacy of

Petitioner's alleged injury because "there was no incident to report" and the doctor said Petitioner's pain was due to work. Petitioner told Mignogna the doctor said her back injury was from continually lifting heavy items (Id.).

Mignogna testified the Petitioner worked at the store after the alleged accident, on November 18, 2016, "I believe that's the day when Maria was working and said she didn't want to work anymore and was going to call a doctor to get a doctor's note that she didn't want to work anymore" (Id., at 77).

CONCLUSIONS OF LAW

In support of the Arbitrator's decision relating to (C), whether an accident occurred that arose out of and in the course of Petitioner's employment by Respondent and (F), whether Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator finds:

Petitioner testified and the medical records reflect that she had no complaints or treatment to her left leg, lumbar spine or right shoulder before the alleged accident date.

She was 35-years-old at the time of the alleged accident.

Respondent's IME doctors, Dr. Phillips and Dr. Forsythe, opined the Petitioner sustained a work-related injury on July 14, 2015 and hers subjective complaints correlated to her objective findings (*see* Resp. Exs. 3, 4, 5, and 6). Dr. Forsythe opined the Petitioner's right shoulder and left knee complaints were causally related to the July 14, 2015 accident. At all three visits, Dr. Phillips opined the Petitioner's lumbar spine condition was causally related to the July 14, 2015 accident.

Petitioner's treating neurosurgeon, Dr. Erickson opined the Petitioner sustained work-related injuries on July 14, 2015 to her right shoulder and lumbar spine based on the objective evidence including the MRI scans and single nerve root neurophysiological testing that indicate Petitioner has significant lateral recess stenosis at L5-S1 that is causally related to the work accident.

The Arbitrator adopts the opinion of treating neurosurgeon, Dr. Erickson.

Regarding Petitioner's credibility, the Arbitrator found Petitioner an exceedingly credible witness whose demeanor at the hearing appeared honest, trustworthy, calm and confident.

On cross-exam, Respondent questioned Petitioner's veracity on a number of issues including the histories reported to various treaters, the date of the accident, the weight of the box of meat she was carrying, provider referrals, her pregnancy, and the amount of time her case took to proceed to hearing. Petitioner withstood the cross-exam, maintained her composure and answered Respondent's questions with a demeanor that was quite matter-of-fact, as if she was simply telling the truth.

After examining the evidence submitted by the parties, the Arbitrator concludes the Petitioner's testimony was consistent and corroborated by the preponderance of the evidence contained in the record.

Regarding Ms. Mignogna, the Arbitrator did not find her testimony credible. Ms. Mignogna completed Respondent's Exhibit 9, The Supervisor's Injury Report, on July 22, 2015 *after* helping Mr. Rico complete Respondent's Exhibit 8 and *after* Petitioner produced a doctor's note (Tr. Trans., at 92). According to the records in evidence, the only doctor the Petitioner saw prior to July 22, 2015, was Dr. Schreiber on July 21, 2015 (Pet. Ex. 17). A review of that note indicates Petitioner reported a history of "low back pain 2 days after intensive lifting at work on 7/14/15" at McDonalds (Id.). The note further reflects Petitioner reported she thought the pain would go away but when she went back to work on 7/20/15, while lifting a box she felt a

sudden sharp stabbing pain and radiation down her left leg (Id.). Assuming Petitioner's Exhibit 17 is the same note the Petitioner gave to Ms. Mignogna before Ms. Mignogna completed Respondent's Exhibit 9, the Ms. Mignogna had many facts at her disposal to include in her report. Even if Ms. Mignogna were only to reference Respondent's Exhibit 8 (which she helped complete) when filling out Respondent's Exhibit 9, she failed to use the same basic information contained in Resp. Exhibit 8.

It is illogical that on July 21, 2015, Petitioner reported to Dr. Schreiber a July 14, 2015 date of injury and then tell Ms. Mignogna on July 22, 2015 that the date of injury is July 18, 2015.

In addition, Ms. Mignogna, during the course of her investigation, did not speak to Emperatriz, the manager on shift on the accident date (Tr. Trans., at 88).

Further, there were functioning cameras in the area where Petitioner was injured (Tr. Trans., at 88-89). Ms. Mignogna testified she did not check the tapes, claiming she was unable to because there was no date of accident. The Arbitrator does not find this testimony credible considering she listed July 18, 2015 as the date of injury in one of her reports. Assuming the medical record tendered to Ms. Mignogna by Petitioner is Petitioner's Exhibit 17, the date of injury is listed as July 14, 2015. Nonetheless, Ms. Mignogna did not review surveillance tape from either date.

The Arbitrator places far more weight on the testimony of Petitioner and the treating medical records that consistently corroborate Petitioner's testimony as to the date of accident and the mechanism of injury.

Regarding the surveillance footage of Petitioner, Mr. Reinke testified the Petitioner may have been carrying a bag of ice, but on cross examination admitted he was not sure exactly what it was and that he could not confirm if it was a bag of ice. Petitioner testified she had thin blouses in the bag (Tr. Trans., at 107). The rest of the video shows Petitioner walking and driving, which as Dr. Erickson opined is normal for a patient with sciatica to be able to walk for short period of time. Another portion of the video shows Petitioner at the grocery store with another woman, whom Petitioner testified is the Godmother of her child, who loaded all of the bags and groceries in to the car while Petitioner sat inside the car.

The Arbitrator finds Petitioner sustained her burden with respect to accident and causal connection regarding injuries to her left leg, lumbar spine and right shoulder as a result of the occurrence on July 14, 2015 that arose out of and in the course of her employment with Respondent.

In support of the Arbitrator's decision relating to (O), whether Petitioner exceeded her choice of physicians, this Arbitrator finds:

Section 8 (a) of the Workers' Compensation Act states that an employer shall provide and pay... all necessary medical, surgical and hospital services thereafter incurred, limited, however to that which is reasonably required to cure or relieve the effects of the accidental injury.
The Arbitrator finds that the Petitioner's first choice of doctor/provider was Chiropractor Schreiber. The following treatment providers are part of this first referral "chain":

Dr. Abdellatif
Dr. Hassan (aka Dr. Abdellatif per Petitioner's testimony)
Best Choice Rehab,
Dr. Halwaji (EMG)
Dr. Markarian
Dr. Krishna Chunduri at Lakeshore Surgery Center
Dr. Kuritza and Lakeshore Open MRI
Dr. Axel Vargas
Dr. Erickson (neurosurgery consult per Dr. Vargas).

The Arbitrator also finds Dr. Thomas Poepping at Windy City Medical Specialists is part of the first referral chain. Although the medical records in the record do not reference a referral. Petitioner credibly testified she was referred to Dr. Poepping by either Dr. Markarian or Dr. Vargas.

Petitioner's second choice of provider is A New Life Medical Center where she presented for a physical therapy evaluation on January 18, 2016 and continued treatment until June 24, 2016. Dr. Erickson, with whom Petitioner had initially consulted 5 days prior, made no such referral nor did Dr. Vargas, with whom Petitioner had last treated with on December 2, 2015.

Finally, the Arbitrator finds Dr. Neeraj Jain at Pinnacle Pain Management constitutes Petitioner's third choice of doctors as no evidence indicates Petitioner sought such consult pursuant to any of her providers in the first or second chain.

In support of the Arbitrator's decision relating to (J), whether medical treatment rendered was reasonable and necessary, the Arbitrator finds:

Section 8(a) allows Petitioner to submit medical bills for reasonable, necessary, and related medical services from employees first choice of medical provider and any subsequent provider to whom she is referred for medical care and also Petitioner's second choice of provider and subsequent chain of referrals.
The Arbitrator finds the preponderance of evidence including the treating medical records, the IME reports of Dr. Phillips of September 17, 2015 and January 2016, the IME report of Dr. Brian Forsythe of November 17, 2015 along with the credible testimony of Petitioner have established that the medical bills issued by the providers in the first two referral chains were reasonable and necessary.
Respondent shall pay the following reasonable and necessary medical services, as provided in Sections 8(a) and 8.2 of the Act:

$7,201.00:	Dr. Abdellatif at ProClinics (July 30, 2015 - October 1, 2015) Included in this bill is the EMG conducted by Dr. Halwaji on July 30, 2015 (*see* Pet. Ex. 1, at 2-3).
$1,400.00:	Best Choice Rehab (August 11, 2015 - November 10, 2015) in the amount Of (*see* Pet. Ex. 2, at 2).
$949.00:	Dr. Markarian at Orthopedic Associates of Naperville from September 25, 2015 through October 7, 2015 (*see* Pet. Ex. 3, at 2).
$985.00:	Right shoulder contrast injection for arthrogram on October 5, 2015 administered by Dr. Chunduri at Advanced Spine and Pain Specialists (*see* Pet. Ex. 7, at 2)
$5,097.47:	Right shoulder arthrogram performed on October 5, 2015 and an MRI of the left knee on October 13, 2015 at Lakeshore Open MRI resulting in outstanding charges of $5,097.47 (*see* Pet. Ex. 6, at 2).
$18,155.59:	Petitioner underwent a series of injections to her right shoulder and lumbar spine with Dr. Abdellatif at Summit Center for Health (aka DuPage Immediate Care) on September 3, 2015.
$540.00:	DuPage Immediate Care Anesthesia
$5,597.41:	Advanced Spine Pain Clinics of Chicago (*see* Pet. Ex. 4, at 2-4).
$4,000.00:	Imaging Centers of America for MRIs of the thoracic spine, lumbar spine, and right shoulder on August 13, 2015 (*see* Pet. Ex. 5, at 2).
$4,820.00:	Dr. Vargas at River North Pain Management (October 21, 2015 - December 2, 2015) (*see* Pet. Ex. 8, at 2).
$4,883.42:	Ashland Health, LLC, medication and creams during the course of treatment (*see* Pet. Ex. 9, at 2).
$5,064.70:	Windy City RX (*see* Pet. Ex. 10, at 2).
$225.00:	Lakeshore Surgery Center physician's charges, Dr. Axel Vargas, injections to the lumbar spine on November 6, 2015

$275.00:	Lakeshore Surgery Center facility charges in the amount of $275.00 (*see* Pet. Ex. 12, at 2-3).
$2,900.00:	Dr. Erickson - American Center For Spine & Neurosurgery (January 13, 2016 through February 20, 2019) (*see* Pet. Ex. 13, at 2-3).
$1,500.00:	Lake County Neuromonitoring - Clinical Evoked Potential Lower Extremities test (*see* Pet. Ex. 14, at 2).
$1,500.00:	SSEP at Neurological Specialists LTD on February 28, 2018. There are currently outstanding charges for Neurological Specialists LTD in the amount of $1,500.00 (*see* Pet. Ex. 23, at 2).
$7,716.84:	EQMD - medication prescribed by Dr. Erickson (*see* Pet. Ex. 15, at 2 and 4).
$2,400.00:	Edgebrook Open MRI -3-D MRI (July 11, 2017) as recommended by Dr. Erickson (*see* Pet. Ex. 22, at 2).
$22,290.00	Windy City Medical Specialists (*see* Pet. Ex. 21, at 2-3)

The Arbitrator finds Respondent is not liable for the following bills pursuant to the Arbitrator's finding above (issue "O"):

$12,717.00:	Dr. Jain at Pinnacle Pain Management Specialists (April 20, 2016 - June 17, 2016 including a discogram of the lumbar spine).
$14,000.00:	Pinnacle Pain Management Specialists
$2,462.81 :	Pinnacle Interventional Pain Associates (*see* Pet. Ex. 18, at 2-5).
$963.00:	Dr. Girgis & Asso. (referral from Dr. Jain) (Pet. Ex. 19, at 3-4).
$262.00:	Suburban Radiologists (*see* Pet. Ex. 19, at 2 and 5).
$8,470.44:	Coast Management (equipment prescribed by Dr. Jain between May 26, 2016 and June 26, 2016) (*see* Pet. Ex. 20, at 2).

The Arbitrator does not find Petitioner's treatment at New Life Medical Center for physical therapy was reasonable and necessary as indicated by the December 2, 2015 note in which Dr. Vargas referred Petitioner for a neurosurgical consult noting her clinical progress had not improve despite physical therapy, "around-the-clock" intake of muscle relaxants, neuromodulators, non-opiate analgesics and NSAID's (Pet. Ex. 8, at 9). Once Petitioner consulted with neurosurgeon, Dr. Erickson, he did not recommend Petitioner begin physical therapy, he recommended some testing before recommending surgery.

The Petitioner has not sustained her burden in proving that treatment at New Life Medical Center was reasonable and necessary. Therefore, Respondent is not liable for the following bill:

$16,675.00:	New Life Medical Center (January 16, 2016 - June 24, 2016) (*see* Pet. Ex. 16, at 2-3).

In support of the Arbitrator's decision relating to (K), whether the Petitioner is entitled to Temporary Benefits pursuant to 19(b) of the Act, this Arbitrator finds the following:

As the medical records reflect and as Petitioner testified, she has yet to undergo surgery due to lack of authorization, and remains off work pursuant to the orders of her treating neurosurgeon, Dr. Erickson. Although the IME physician, Dr. Phillips opined the Petitioner could return to work with a 15 lb. restriction, the Arbitrator finds the recommendation ill-advised given that Dr. Phillips also agreed the Petitioner was indeed a candidate to undergo lumbar spine surgery.

The Arbitrator adopts the opinion of treating neurosurgeon, Dr. Erickson and finds the preponderance of evidence, including the credible testimony of Petitioner, the treating medical records, and the IME reports, supports a finding in favor of Petitioner on this issue.

Petitioner is entitled to TTD benefits from July 30, 2015 through March 26, 2019 representing 190 and 6/7 weeks of TTD benefits.

The parties agree that the average weekly wage is $220.91. Petitioner is single with two dependent children. Therefore, Petitioner is at the statutory minimum TTD rate of $220.91. Thus, this Arbitrator orders Respondent to pay $42,162.25 to Petitioner ($220.91 x 190 & 6/7 Weeks). Per the parties stipulation, Respondent is entitled to a credit for TTD in the amount of $6,380.00 (Arb. 1).

In support of the Arbitrator's decision relating to (O), whether the prospective medical treatment recommended is reasonable and necessary, this Arbitrator finds the following:

Section 8 (a) of the Workers' Compensation Act states that an employer shall provide and pay... all necessary medical, surgical and hospital services thereafter incurred, limited, however to that which is reasonably required to cure or relieve the effects of the accidental injury...

Respondent's argument that prospective surgery with Dr. Erickson is not warranted rests on their IME, Dr. Phillips who examined Petitioner three times. In Petitioner's initial IME visit with Dr. Phillips, he opined that if conservative care were to continue to fail, Petitioner might be a surgical candidate. In Petitioner's second IME visit with Dr. Phillips, he opined that Petitioner is indeed a surgical candidate for the prospective surgery which he deemed reasonable. In Petitioner's third IME visit with Dr. Phillips, he retracted his surgical recommendation due to an alleged gap in treatment from January 8, 2016 to the end of 2016 as well as surveillance video showing Petitioner ambulate.

Based on a preponderance of the evidence, the Arbitrator finds Dr. Phillips' retraction of his surgical recommendation is not justified.

Conservative treatment including physical therapy, medication, and injections have failed to garner appreciable improvement as noted by Dr. Vargas and Dr. Erickson.

Dr. Erickson opined the Petitioner was an excellent candidate for hemilaminectomy of the lumbar spine. The doctor noted his recommendation is supported by the neurophysiological testing and imaging studies which correlate to Petitioner's continued complaints of back with associated leg pain.

Dr. Erickson addressed Dr. Phillips' review of the surveillance video, pointing out that Petitioner is able to walk for about 30 minutes before needing to rest due to back and leg pain. Dr. Erickson pointed out Petitioner's pregnancy necessitated a gap in treatment. Dr. Erickson lastly addressed Dr. Phillips' opinion that Petitioner's problem was non-radicular in nature noting her complaints of pain radiating down to her left foot correlated to the neurophysiological testing and MRI findings. Although Petitioner experienced slight improvement, she still had severe back pain with positive findings. Dr. Erickson noted there was "no rationale reason to withhold definitive surgical treatment" from the Petitioner whom he characterized as "straightforward".

As Dr. Erickson noted, on Petitioner's last visit before the hearing, "At this late date, conservative treatment will not reverse her current situation."

Based on a preponderance of evidence, including the credible testimony of Petitioner, the treating medical records and the opinions of Dr. Erickson, the Arbitrator finds the proposed surgery, namely a hemilaminectomy of the lumbar spine, reasonable and necessary. Respondent is liable for any and all outstanding medical charges to be incurred for this prospective medical treatment and all related treatment pursuant to the fee schedule.

STATE OF ILLINOIS)
) SS.
COUNTY OF CHAMPAIGN)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Katie Harvey,

Petitioner,

vs. No. 12 WC 17980

Country Financial,

20IWCC0431

Respondent.

DECISION AND OPINION ON REVIEW UNDER SECTION 8(a)

A petition for review under section 8(a) having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issues of medical expenses and prospective medical care, and being advised of the facts and law, grants the 8(a) petition for the reasons set forth below.

On June 7, 2011, Petitioner sustained severe work-related traumatic injuries, including spinal injuries and paralysis. On March 20, 2013, the parties entered into a settlement agreement keeping Petitioner's section 8(a) rights open.[1] Subsequently, the parties executed additional stipulations and releases, which continued to keep section 8(a) rights open.

On December 24, 2019, Petitioner filed a section 8(a) petition seeking payment of past and prospective physical therapy. On March 13, 2020, Commissioner Deborah Simpson held a hearing on behalf of Panel B. Petitioner, who was a crop adjuster at the time of the accident, testified on direct examination that she was injured in a motor vehicle collision during work-related travel. Respondent-owned van, in which Petitioner was a passenger, was rear-ended by a semi truck. Petitioner sustained traumatic brain injury and multiple fractures of the thoracic and lumbar spine, and was hospitalized for several months, followed by inpatient rehabilitation. The injuries left Petitioner partially paraplegic and dependent on a wheelchair. Currently, Petitioner lives in a house with only her 10-year-old

[1]Except for vocational rehabilitation.

daughter. Petitioner drives a handicapped equipped van.

In May of 2019, Respondent stopped paying for Petitioner's physical therapy. Petitioner was able to get 12 additional sessions through Medicare before Medicare too stopped paying for physical therapy. Petitioner's last physical therapy session was on June 20, 2019. The therapy was three times a week, focusing on hip stretching. Petitioner explained that she suffers from contractures at the hips, "where the muscle has been so tight for so long that it's starting to harden and then it just gets to where it doesn't want to move at all." Petitioner described the typical physical therapy session: "I lay on my back and they help stretch out my legs because I can't lay out completely flat from the scar contractures at my hips, and they have to do it a certain way because I have a lot of tone and spasticity in my lower back and legs from the brain damage and spinal cord damage, and if I try stretching too fast my legs cramp up and they stick out straight and I can't do anything with them which hurts *** pretty bad." Petitioner affirmed she could not do the stretching on her own.

Petitioner credits physical therapy with keeping her able to stand and walk a little with the aid of a walker. After physical therapy stopped, Petitioner lost the ability to walk or stand because of tightening contractures and decreased strength. It is now more difficult for Petitioner to do house chores, and she has to rely more on her 10-year-old daughter. Before, when Petitioner's wheelchair would get stuck on gravel or grass, Petitioner was able to stand up and get it unstuck. Now, Petitioner's daughter has to pull Petitioner in the wheelchair to help get it unstuck. Petitioner also suffers from a lot more pain and spasms. She cannot lie flat when she is trying to sleep. The stretching Petitioner tries to do on her own does not work.

On cross-examination, Petitioner clarified she had greater function and pain control due to a combination of physical therapy and an implanted Baclofen pump. Petitioner acknowledged not attending physical therapy for periods of time due to depression and psychological problems. Petitioner's treatment also included Botox injections (before the implantation of the Baclofen pump) and chiropractic treatment. Petitioner understood that Respondent and Medicare stopped paying for physical therapy because her condition was not improving. On redirect examination, Petitioner testified she needs ongoing physical therapy (in addition to Baclofen) to maintain function and pain control. Petitioner affirmed there is no one to help her with activities of daily living, except her daughter.

Dr. Sanjiv Jain, Petitioner's treating physician, testified by evidence deposition on December 2, 2019. Dr. Jain is board certified in physical medicine and rehabilitation, and hospice and palliative medicine. Dr. Jain has treated Petitioner since the accident. Dr. Jain explained that Petitioner's partial paralysis is due to spinal cord injuries at the thoracic level. Petitioner is confined to a wheelchair for the most part. However, she had some ability to walk with assistance. Petitioner's many problems include "significant spasticity issues and contractures. This has resulted in pain. It's resulted in her inability to transfer, stand, and ambulate effectively on a regular basis, so the therapy was designed to intervene to maintain and as possible improve her range of motion, decrease her tone and spasticity, decrease her pain." Dr. Jain continued: "With a spinal cord injury you have a reflex arc that causes the limb to become spastic or have increased tone, and it begins to contract, and with her spinal cord injury and her fractures she had developed significant tone and spasticity that required a skilled therapist to be able to stretch those limbs and do it in a way that she could tolerate and not overstretch her in a way that would rip the muscles, so she required both the range of motion and the stretching as well as with that a work on strengthening the muscles to be able to maintain the ability to transfer and to work on

the limited ambulation that she could do." Without physical therapy, "[t]he contractures would get worse. Her ability to transfer and in particular ambulate would become more limited, more likely, and in her case in particular she develops more pain and more limitations."

Petitioner last saw Dr. Jain on July 9, 2019, after going without physical therapy for two weeks. She complained of decreased range of motion, increased spasticity, and difficulty with transfers. Dr. Jain noted that during previous periods when physical therapy was not consistent, Petitioner "had clear declines in her level of independence, her ability to interact with her child, and do things in her home environment as independently." Dr. Jain opined the present worsening of Petitioner's condition is due to not having ongoing physical therapy. Dr. Jain affirmed Petitioner needs ongoing physical therapy (along with her medications and intrathecal pump) for the foreseeable future in order to maintain her range of motion, pain control, ability to transfer, and do some limited standing and walking. Dr. Jain was particularly concerned that Petitioner's ability to transfer, stand and ambulate would be lost. Her pain level would likely increase, her sleep would be less comfortable, and she might need surgery to attempt to regain the lost motion.

On cross-examination, Dr. Jain clarified that Petitioner benefited from both physical therapy and chiropractic treatment, as they targeted different areas. Petitioner's condition improved at times and regressed at times. Dr. Jain affirmed Petitioner requires physical therapy for the foreseeable future. Any home exercises would be in addition to physical therapy.

Dr. Charles Carnel, a physical medicine and rehabilitation specialist and Respondent's main utilization reviewer, testified by evidence deposition on December 17, 2019. Dr. Carnel performed a utilization review at the request of Claims Eval, issuing a report on July 18, 2019. Dr. Carnel opined that ongoing physical therapy is not medically necessary because there was no "documentation of an end point or when there was a plan to *** re-evaluate the patient." In Dr. Carnel's view, the aim of physical therapy in patients with spinal cord injury and paraplegia is to help them try to recover as much function as possible and develop adaptive techniques. In Petitioner's case, she "had largely reached *** a plateau with regards to strength, spasticity, and range of motion." Dr. Carnel expected patients such as Petitioner to "transition to self-management." Dr. Carnel relied on "some general guidelines *** from the official disability guidelines with regards to *** the general amount of *** therapy that may be provided for someone with myelopathy or spinal cord compression and *** regarding those types of treatments." Dr. Carnel thought Petitioner's physical therapy had been excessive, adding: "[T]o justify ongoing treatment *** the patient needs to be clinically assessed from time to time to determine whether or not *** additional therapy is necessary rather than just saying or leaving things open-ended at *** three visits per week *** indefinitely;" "progress has to be evaluated and validated." Dr. Carnel reiterated: "[I]n general, the goal of physical therapy is for the patient to learn a home management or self-management program."

On cross-examination, Dr. Carnel was "not familiar" with any difficulties Petitioner had with home exercises. Dr. Carnel acknowledged that on July 9, 2019, Dr. Jain prescribed ongoing physical therapy because of increased spasticity. Dr. Carnel further acknowledged that Dr. Jain also documented a decreased range of motion and difficulty with movement and transfers after Petitioner went without physical therapy for two weeks. Dr. Carnel criticized Dr. Jain for not providing "modified Ashworth scores, range of motion, or *** other thorough documentation *** that really quantifies those changes." In all, Dr. Carnel spent an hour to an hour and a half reviewing Petitioner's medical records and preparing his utilization review report.

20IWCC0431

Dr. Michael Chen, another utilization reviewer, testified by evidence deposition on February 6, 2020. Dr. Chen, a physical medicine and rehabilitation specialist, issued a report on June 4, 2019, at the request of Claims Eval. Dr. Chen was asked to review a request for six more weeks of physical therapy. Dr. Chen recommended non-certifying additional physical therapy, explaining: "[The claimant] had 61 visits, and it did not appear that she was progressing significantly. She had not reached any of her long-term goals at the end of 61 visits. And because there was not much progression in the last several visits, non-certification was concluded." Dr. Chen believed the goal of physical therapy was to "maximize function *** after her Baclofen pump implant to maximize physical therapy based on decreased spasticity." Dr. Chen relied on disability guidelines for spinal cord injury. Dr. Chen opined that Petitioner had apparently reached maximum medical improvement—"[I]t does not appear that she would continue to improve with continued physical therapy."

On cross-examination, Dr. Chen did not know what happened to Petitioner after physical therapy was discontinued, specifically whether she suffered an increase in spasticity or contractures. Dr. Chen testified the majority of his utilization review report was prepared by someone else in advance of his evaluation and tendered to him for review and signature. Dr. Chen did not know the name(s) or qualifications of the Claims Eval staff who prepared the report. Dr. Chen did not recall whether he made any changes to the prepared report. Upon further questioning, Dr. Chen admitted signing the report that was sent to him. Dr. Chen did not recall whether he independently checked the disability guidelines referenced in the report. Dr. Chen spent "a little over an hour" reviewing the medical records.

Having carefully considered the entire record, the Commission gives greater weight to the opinions of Dr. Jain and finds that Petitioner is entitled to past and prospective physical therapy to maintain her function and manage her pain. Such an award of ongoing medical and palliative care is within the Commission's statutory authority. See *Gordon v. Tri-County Personnel*, 98 WC 30323, 2010 Ill. Wrk. Comp. LEXIS 1017, aff'd, *Tri-County Personnel Mgmt. v. Ill. Workers' Comp. Comm'n*, 2012 IL App (3d) 110609WC-U.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay outstanding physical therapy bills in evidence, pursuant to §§8(a) and 8.2 of the Act. To the extent Medicare has paid any of the physical therapy bills, Respondent shall hold Petitioner harmless from any claims for reimbursement by Medicare.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall provide prospective physical therapy prescribed by Dr. Jain, 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.

20 IWCC0431

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: JUL 31 2020
SM/sk
44

Stephen Mathis

L. Elizabeth Coppoletti

Douglas McCarthy

STATE OF ILLINOIS)
) SS.
COUNTY OF CHAMPAIGN)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

James Pruitt,

Petitioner,

vs. NO. 19WC008054

Clifford Jacobs Forging

Respondent.

20IWCC0432

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19b having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, causal connection, prospective medical care, temporary disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 17, 2020 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

20 IWCC0432

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUL 31 2020
SJM/sj
o-7/21/2020
44

Stephen J. Mathis

L. Elizabeth Coppoletti

Douglas D. McCarthy

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

PRUITT, JAMES
Employee/Petitioner

Case# **19WC008054**

CLIFFORD JACOBS FORGING
Employer/Respondent

20IWCC0432

On 1/17/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.53% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

1580 BECKER SCHROADER & CHAPMAN
TODD J SCHROADER
3673 HWY 111 PO BOX 488
GRANITE CITY, IL 62040

0481 MACIOROWSKI SACKMANN & ULRICH
ROBERT MACIOROWSKI
105 W ADAMS ST SUITE 2200
CHICAGO, IL 60603

20 IWCC0432

STATE OF ILLINOIS)
)SS.
COUNTY OF CHAMPAIGN)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

JAMES PRUITT
Employee/Petitioner

v.

CLIFFORD JACOBS FORGING
Employer/Respondent

Case # 19 WC 008054

Consolidated cases: Urbana

An *Application for Adjustment 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 **Urbana**, on October 17, 2019. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ 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, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship *did* exist between Petitioner and Respondent.

On this date, Petitioner *did* sustain an accident that arose out of and in the course of employment.

Timely notice of this accident *was* given to Respondent.

Petitioner's current condition of ill-being *is* causally related to the accident.

In the year preceding the injury, Petitioner earned $69,190.68; the average weekly wage was $1,330.59.

On the date of accident, Petitioner was 53 years of age, **married** with 0 children under 18.

Respondent *has not* paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $ for TTD, $ for TPD, $ for maintenance, and $ for other benefits, for a total credit of $.

Respondent is entitled to a credit of $ under Section 8(j) of the Act.

ORDER

1. The Arbitrator finds that Petitioner's accident arose out of and in the course of his employment with Respondent.
2. The Arbitrator finds that Petitioner's current condition of ill-being is casually related to the injury.
3. The Arbitrator finds Petitioner is entitled to prospective medical care as outlined by Dr. Seidl.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

1/14/20
Date

JAN 17 2020

ICArbDec19(b)

STATE OF ILLINOIS)
) SS
COUNTY OF CHAMPAIGN)

20 IWCC0432

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATOR DECISION

JAMES PRUITT
Employee/Petitioner
v.
CLIFFORD JACOBS FORGING
Employer/Respondent

Case # 19 WC 008054

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner reported a repetitive injury while working as an operator/helper and an inactive hammer operator with Respondent. Petitioner reported repetitive work pouring dye into the machine and the pulling and pushing of the metals was causing right shoulder pain located in the right elbow. (PX 1 at 1).

Petitioner testified he was an operator/helper and an inactive hammer man. Petitioner further testified he can operate any hammer in the forging shop. Petitioner further stated hammers range from 25,000 down to 1,250 pounds and are 40 to 50 feet tall. Petitioner described that metal is heated to 2,400 degrees or lower depending on what the job requires, and a gigantic hammer is used to mold the metal. Petitioner testified he makes forgings for Caterpillar for heavy equipment. Petitioner testified during this process on September 11, 2018, he complained of right elbow pain and the company sent him to SafeWorks to treat his right elbow pain. SafeWorks referred him to Dr. Seidl at Safeworks. Dr. Seidl eventually recommended surgery. Petitioner noted at that point the company did not approve surgery and sent him to Dr. Michael Vender in Chicago. After that visit, he was informed his surgery would not be approved and he was returned to full duty. Petitioner testified that he still has a lot of pain into the elbow and into the joint itself. Sometimes it is hard for him to grip things. Petitioner was adamant that he wanted to return to Dr. Seidl and would like to have his arm fixed.

Petitioner testified the video depicts a helper carrying a part on a fork. The fork in the video is approximately 15 to 20 feet long. There are two people in the front of the fork and one person in the back. Petitioner testified in the back of the fork position, you have to go in and push down and then carry the part. Petitioner further testified that there is lot of pressure on your arms as this fork, essentially is a counterbalance. Petitioner stated that he would be on the back of the fork himself if any piece of metal on the front of the fork was under 400 pounds. The two people located in the front of the fork worked the hoist and guided the metal.

Again, Petitioner is counter-balancing all the weight at the front of the fork. Petitioner described his movements as going to the hammer with the hoist operator and the push/pull men go in, if the operator needs help lifting it, we will take the corner of one of the forks and help lift it up so the operator can put his prybar under it. Then we will slide underneath a bit, I'll push down, and the hoist operator knows to come up that way. Petitioner testified that he pretty much has all the weight when he is pushing down on the fork. Petitioner has had occasion when he is pushing down on the fork with an

inexperienced hoist operator where it lifted him up, meaning the counterbalance was not enough even with his weight. When his arm is straight it is because he is pushing down, then when he goes to move in to take the pieces out of the hammer, his arm comes into his body, into his arm itself. Petitioner states that sometimes his arm is in a lot of time during these operations.

Petitioner also works as a hammer operator of which there is no video. Petitioner described waiting for the manipulator driver to bring in a hot piece of metal, by the time you should have your forks in your hands or your tongs in your hands. The tongs weigh anywhere from 10 to 15 pounds and they can be three foot to four foot to five foot tall. The tongs are utilized to reach in to squeeze, pull and flip metal. Petitioner described reaching with his arms away from his body then squeezing the tongs and then pulling towards his body with his arms bent at least a 90-degree angle if not more and flipping the metal over. Petitioner stated he could do this part of the job, 28 pieces to 2 and 3 and 400 pieces. As the operator, he pulls it in, lines it up, hits it with a hammer, one blow. Petitioner noted that sometimes it hurts pretty good to squeeze the tongs.

Petitioner then described while working the hammer, he has to throw graphite oil in reaching into the hammer. This process is performed by dipping a mop with a steel rod 3 to 4 feet long into a graphite oil bucket. After dipping the mop into the bucket, Petitioner would then utilize an underhanded toss to fling graphite oil into the hammer. Depending on the process, he may have to repeat that three times, sometimes 30 times per piece. On an average, you could do anywhere from 150 to 200 pieces per shift, if not more. Petitioner confirmed the job description in Respondents Exhibit 5 was accurate in that he would have to use a pry bar to push or pull more than 60 pounds. When asked how that would make his right arm feel, he stated that he goes home hurting every night.

Petitioner testified he worked for Clifford Jacobs for 23 years and holds the same jobs that he has described over the course of that 23 years. Petitioner estimated that for 75 percent of the time he was on the helper job and 25 percent of the time on the operator job. Petitioner estimated the weight of the fork around 50-60 pounds. Petitioner stated there was more to the job than what the 53 second video revealed. Petitioner indicated when the forging or part is taken out of the press, placed on a table and flipped it over if it needs to be flipped over. Petitioner was always moving something throughout the day. Petitioner commented the only time he generally gets a rest is when they are cooling the dial, most of the time he had the fork in his hand waiting for the hammer operator to finish the piece then he would take it and go. Petitioner felt on an average it takes 2 to 3 minutes to finish a part. As soon as the part is done, he would take the part to the press, which takes less than a minute to trim, then at that time you are ready for the next piece. After the piece is done being trimmed and retrieved out of the trim box, if it requires to turn it over, you turn it over or you take it to the next trimmer. If it requires to be punched, you take it to him, then you walk back. From start to finish, it is usually 5 minutes per part. Petitioner noted, again, with the hammer operator position, you stand there with the tongs waiting for your manipulator driver to bring the piece into the hammer. You upset the piece and you grab the piece and you flip it over, center it, and then hit it the first blow, let the scale blower do what needs to be done, and by that time I am putting the tongs down, grabbing my pry bar. Petitioner tries to get the piece out within five minutes so he can go on to the next piece where this process is repeated all day.

Petitioner's Exhibit 9 indicated a job description for the job title "Hammerman" which included keeping tools and tongs in the proper place, utilizing steam hammer presses, pipe wrench, adjustable wrench, tongs and sledgehammer. (PX 9 at 1). The physical demands, when associated with the performance of the functions of this job, push and/or lift on pry bar in order to move over 60 pounds. (PX 9 at 1). Respondent did not provide a written job description for the job title operator/helper.

TREATMENT AT SAFEWORKS

Petitioner was initially seen at SafeWorks Illinois Occupational Health Services at the behest of Respondent. The working diagnosis was unspecified sprain of the right elbow, initial encounter; lateral epicondylitis, right elbow. (PX 1 at 3). Methylprednisolone was dispensed and Petitioner was placed on restrictive duty effective 9/11/2018. (PX 3, 4). Petitioner's pain diagram noted a pain in the right elbow. (PX 1 at 5). Petitioner was given a diagnosis of unspecified sprain of right elbow, initial encounter; lateral epicondylitis right elbow and was put on modified duty from 9/11/18 to 10/2/18; Right Arm: No use of right arm. (PX 1 at 17).

Petitioner returned to SafeWorks Illinois with noted problems of aching, pain to be severe to moderate, pain accompanied by numbness. (PX 1 at 18). X-Rays were performed which showed some arthritic changes, no acute fracture. (PX 1 at 19). Petitioner was placed on restricted duty from 10/2/18 through 10/16/18, no use of the right arm (PX 1 at ??) Petitioner described the problem as repetitive work pouring dye into the machine and the pulling and pushing of the metals was causing right shoulder pain. (PX 1 at 22). Petitioner's pain diagram revealed right elbow, not shoulder, problems. (PX 1 at 21). On the October 2, 2018 visit, Petitioner was referred from SafeWorks to Dr. Robert Seidl. The referral was signed off by Dr. Fletcher. (PX 1 at 24).

Petitioner returned to SafeWorks on October 16, 2018 wherein he complained of primary problem in the right elbow. (PX 1 at 25). On October 16, 2019, Dr. Seidl performed an injection. (PX 1 at 26). Petitioner was placed on modified duty, effective 10/16/18 through 11/6/18, no use of right arm. (PX 1 at 31). Petitioner returned to SafeWorks on November 6, 2018 herein they recommended modified duty from 11/6/18 through 11/12/18, no use of the right arm. (PX 1 at 37). On November 12, 2018, Petitioner returned to SafeWorks noting that his problem was improved by physical therapy with a pain level still at 6. (PX 1 at 38). It was noted that Petitioner was to follow-up with Dr. Seidl on December 4, 2018. (PX 1 at 39). SafeWorks recommended Petitioner stop PT and start work conditioning on November 13, 2018. (PX 1 at 40). Petitioner was still placed on modified duty, no use of the right arm from 11/12/18 through 11/28/18. (PX 1 at 40). On November 28, 2018, Petitioner noted that he was having increasing pain, with the pain level at a 7 and that he was beginning to have numbness and warm to touch on the right index and small finger. (PX 1 at 44). Petitioner was placed on modified duty on 11/28/18 through 12/4/18 with a follow up appointment with Dr. Seidl on December 4, 2018. (PX 1 at 46). Petitioner was also instructed to stop work conditioning on November 13, 2018. Dr. Fletcher ordered an MRI on the right elbow without contrast. (PX 1 at 48).

Petitioner was placed on modified duty from 11/28/2018 through 12/12/18 of no use of the right arm. (PX 1 at 51). On December 12, 2018, Petitioner was seen in SafeWorks and was told to follow-up after his EMG and MRI. SafeWorks noted that Petitioner had conduction testing done that showed moderate to severe cubital tunnel in the right arm, mild to moderate radial tunnel. (PX 1 at 58). Petitioner was placed on modified duty and no use of right arm December 12, 2018 through December 21, 2018. (PX 1 at 62). Petitioner was seen by SafeWorks on December 21, 2018 where the recommended after care instructions were Celebrex 200 mg. Work restrictions continue until surgery, Lyrica elbow pad, set up surgery with Dr. Seidl and GR ice compression. (PX 1 at 67).

TREATMENT BY DR. SEIDL

Petitioner was referred to Dr. Robert Kenneth Seidl, a Board-Certified Orthopedic Surgeon, by Safeworks on October 16, 2018. (PX 8 at 4). In the initial examination by Dr. Seidl, he noted Petitioner had elbow form aching in the context of a work injury, work related was checked as "yes". (PX 2 at 2). Dr. Seidl noted an initial history of repetitive motion at work and he has gradual pain, no specific injury,

states the pain along the inner and outer sides of the elbow as well as into the hands. (PX 8 at 4, 5). Dr. Seidl noted the Petitioner had an EMG by Dr. Trudeau which did show both ulnar neuropathy as well as radial tunnel on that extremity. (PX 8 at 5). Dr. Seidl performed an examination which revealed symptoms over the ulnar nerve or the elbow. Petitioner also had symptoms of lateral epicondylitis which is pain with resistance of the extension of the digits two and three, consistent with acute or chronic degeneration of the extensor mass at the elbow. He also had some pain over the radial tunnel. (PX 8 at 5). Dr. Seidl recommended an injection and carried that out on the initial visit. The injection was for lateral epicondylitis. Dr. Seidl documented that Dr. Trudeau was a referral by Dr. Fletcher. He also stated that Dr. Fletcher referred Petitioner to Dr. Seidl as well. (PX 8 at 8). Dr. Seidl made a recommendation of cubital tunnel release and interior transposition of the ulnar nerve as well as an exploration and decompression of the osseous nerve in the radial tunnel as well as the treatment of the lateral epicondylitis if the injection did not work. (PX 8 at 9). Dr. Seidl confirmed in his records that this was a work-related condition. (PX 8 at 8). Dr. Seidl also responded to his opinion on causation or aggravation that he believed that based upon history the patient gave him in his notes that he has in the chart, his repetitive activities at work likely contributed in some part to his complaints. (PX 8-11). Dr. Seidl stated that since it had been some time that Petitioner had seen him, Dr. Seidl would like to see him again and if he still had symptoms, then determine if he still needs surgery. (PX 8 at 12)

Dr. Seidl, when cross-examined, noted that when asked about whether he reviewed any job description, he noted at the time of the visit, again, I often either have through communication with Fletcher in the office, since we are both in the same office, or with patients specifically in the EMR, it is not listed but usually we have a description at that time. I can't recall specifically but we usually have it. (PX 8 at 13).

An MRI of the right elbow revealed a focal moderate chondromalacia subchondral fluid lateral aspect distal ulna at the capitellum. Severe chondromalacia with subchondral fluid central aspect distal articular surface humerus. Severe spurring coronoid process ulna. Small elbow joint effusion. Severe thickening, irregularity and intermediate signal intensity, common extensor tendon with severe bone irregularity at the humeral insertion with marginal spurring and small bone fragments within the proximal aspect of the tendon. Partial tear along the medial aspect, common extensor tendon measuring 6 mm superior to inferior 2.6 mm transverse and 10 mm AP diameter beginning 8 mm distal to the humeral insertion and extending distally. Mild bicipitoradial bursitis. The remainder of the study was unremarkable. (PX 4 at 2).

TREATMENT BY DR. TRUDDEAU

Petitioner was seen by Dr. Edward Trudeau for a nerve conduction velocity study and EMG. Dr. Trudeau noted that Petitioner was an operator and helper and has to use the upper extremities a great deal and also noted, he is left-handed, but he still has to use that right upper extremity a great deal. (PX 5 at 2). Dr. Trudeau found Petitioner had ulnar neuropathy at the right elbow (cubital tunnel syndrome), moderately severe electroneurophysiologic testing terms, consistent with the quite correct clinical assessment of Dr. Fletcher as well as James Blatzer, P.A.-C, the excellent physician assistant working with Dr. Fletcher. In addition, this gentleman has posterior interosseous neuropathy in the right dorsal proximal forearm (PINS/radial tunnel syndrome), mild to moderate in electroneurophysiologic testing terms. (PX 5 at 5). Dr. Trudeau felt Petitioner may also have both medial and lateral epicondylitis regions at the right elbow. (PX 5 at 6).

RESPONDENT SECTION 12 DR. VENDER

The deposition of Dr. Michael Vender was taken on August 30, 2019. Dr. Vender agreed that he felt there was an ulnar neuropathy at the level of the elbow. Dr. Vender, in his report, noted there was no hyperflexion of the arm at any point in the video. However, in his deposition, he agreed there was hyperflexion within the video. (RX 7 at 18, 19). Dr. Vender agreed that the video was only a minute long and he did not know how many hours were in a shift nor did he know how many breaks were taken during a day, nor did he know whether there was overtime. (RX 7 at 20). Again, Dr. Vender felt that with a work-related condition that you needed force with hyperflexion with forceful use indicating force was something that if performed over and over again would cause fatigue. (RX 7 at 20). Dr. Vender noted that carrying a 50-pound box would be forceful and that you need force with how often something is done. It was a combination of how often it is done and how heavy the weight. (RX 7 at 21). Dr. Vender was surprised whenever he noted the fork lifted Mr. Pruitt off his feet at times. (RX 7 at 24). Dr. Vender agreed that Dr. Fletcher was the company doctor for Clifford and Jacobs. (RX 7 at 27).

The impression of an additional nerve conduction study done by Scott Heller, M.D. revealed a mild to moderate bilateral ulnar neuropathies across the elbow, more noteworthy on the right, without active denervation within bilateral proximal and/or distal ulnar innervated muscles. Mild to moderate bilateral median neuropathies at wrist, more noteworthy on left, without active denervation with bilateral distal medial innervated muscles. Probably mild sensory polyneuropathy involving upper extremities, predominantly of axonal character (Mr. Pruitt has two-year history of non-insulin dependent diabetes mellitus). The reason for the referral was a 4-month history of numbness and tingling involving right 4th and 5th digits, associated with right medial elbow and right proximal dorsal forearm pain and right-hand weakness without neck or radicular pain following repetitive activities operating a drop forging hammer. (PX 6 at 2).

SUMMARY

After Petitioner's accident, he was referred by the company to Dr. Fletcher. Dr. Fletcher's office, Safeworks, initiated medical care for Petitioner. All medical bills for Dr. Fletcher have been paid by Respondent. Further, Dr. Fletcher directed and referred Petitioner to Dr. Seidl, an orthopedic surgeon who sees patients at Safeworks. Petitioner was seen at Dr. Fletcher's SafeWorks location by Dr. Seidl, the orthopedic surgeon who has recommended surgery. All of Dr. Seidl's medical bills have been paid by Respondent. Treatment and medical care were provided solely by Respondent's doctors up until Dr. Seidl recommended surgery. At that point, Respondent sought out an additional doctor's opinion and retained Dr. Michael Vender in Arlington Heights, Illinois in the Chicago area. Respondent provided a 53 second video that purported to be Petitioner's entire job. Through testimony, it was discovered that Petitioner works both as a hammerman, for which there was a job description provided and on the fork. There was no video provided for the job of hammerman. It is also noted that throughout the treatment provided by Dr. Seidl, all of the reports generated marked this case as work related. Petitioner's testimony was unrebutted and indicated quite a bit of forceful activity as well as repetitive activity throughout the course of his two different jobs.

Dr. Vender returned Petitioner to full duty, wherein Petitioner noted the pain continued in his right elbow and never stopped. Petitioner testified the pain has continued the same as it was before he saw Dr. Vender. Petitioner testified that he is always gripping the fork to ensure the safety of his co-workers. Petitioner stated if he lets go of the fork, it could hurt the two men in front of him, they could be burned. Petitioner testified he is gripping the back of the fork, very tightly and pushing down because he did not want the piece to go anywhere. Petitioner noted if you were to let go of the fork with no piece in it, it would still fall forward so during the time that there is no metal in it, he is still gripping the fork.

The Arbitrator finds the following:

Issue C: Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?

The Arbitrator finds the accident arose out of and in the course Petitioner's employment with Respondent. The Arbitrator finds that Petitioner's activities were repetitive by his testimony that he had hyperflexion in the course of his duties as well as forced gripping which aggravated his condition. Petitioner's treating doctor, Dr. Seidl, indicated that his repetitive activities at work likely contributed in some part to his complaints. It should be noted that Dr. Seidl was a referral from Dr. Fletcher. It is undisputed that Petitioner was sent to Dr. Fletcher by Respondent. The video contained in Respondent's Exhibit 6 was less than a minute long and did not reveal an accurate portrayal of the operator/helper job duties. Furthermore, there was no job description of the Operator/Helper job. Additionally, there was no video of the Hammerman job.

Issue F: Is Petitioner's current condition of ill-being causally related to the injury?

The Arbitrator finds that Petitioner's current condition of ill-being is casually related to the injury. The Arbitrator basis his findings from the unrebutted testimony of Petitioner as well as the testimony of Dr. Seidl, his treating physician. The Arbitrator further finds Petitioner did experience hyperflexion within the video which was acknowledged by Dr. Vender, Respondent's Section 12 physician. The Arbitrator further gives more weight to the testimony of Dr. Seidl who was not only the Petitioner's treating physician but was also a referral by Dr. Fletcher. Petitioner was sent to Dr. Fletcher by 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?

The Arbitrator finds the following medical bills are reasonable and related to the accident of September 9, 2018.

ATI Physical Therapy	$508.58

Respondent shall pay, reasonable and necessary medical services, pursuant to the medical fee schedule, of $508.48 to ATI Physical Therapy, as provided in Sections 8(a) and 8.2 of the Act. All other medical bills related to the treatment of Petitioner by Safeworks, Dr. Trudeau, Dr. Seidl and all other diagnostic tests have already been paid by Respondent.

Issue K: Is Petitioner entitled to any prospective medical care?

The Arbitrator finds Petitioner is entitled to prospective medical care. Dr. Seidl recommended a cubital tunnel release and interior transposition of the ulnar nerve as well as an exploration and decompression of the osseous nerve in the radial tunnel as well as the treatment of the lateral epicondylitis if the injection did not work. Further, Dr. Seidl noted he would need to see the Petitioner again to determine whether the surgery was still needed. If Petitioner's condition remained the same, then the above-surgery would be recommended. The Arbitrator approves the return visit to Dr. Seidl as well as approval for the recommended cubital tunnel release and interior transposition of the ulnar nerve as well as an exploration and decompression of the osseous nerve in

the radial tunnel as well as the treatment of the lateral epicondylitis should that be Dr. Seidl's recommendation after the office visit.

Ed Lee

Arbitrator Edward Lee

11/14/20

Dated