STATE OF ILLINOIS)
) SS
COUNTY OF WILLIAMSON)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

NICHOLAS OLIZ,

Petitioner,

No. 15 WC 30841
20IWCC0287

GWEN HUNT D/B/A PK'S,

Respondent.

ORDER

This matter comes before the Commission on Petitioner's Petition to Correct Clerical Error pursuant to Section 19(f) of the Act. The Commission having been fully advised in the premises finds the following:

The Commission finds that said Decision should be recalled for the correction of a clerical/computational error.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Commission Decision dated May 18, 2020, is hereby recalled pursuant to Section 19(f) of the Act. Respondent does not object to Petitioner's Petition. The parties should return their original decisions to Commissioner K. Doerries.

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

Kathryn A. Doerries

DATED: JUN 4 - 2020
o- 3/10/20
KAD/jsf

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)	☐ Reverse Choose reason	☐ Second Injury Fund (§8(e)18)
WILLIAMSON		☐ PTD/Fatal denied
	☒ Modify Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

NICHOLAS OLIZ,

Petitioner,

vs.

NO: 15 WC 30841
20 IWCC 0287

GWEN HUNT D/B/A PK's,

Respondent.

CORRECTED DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, wage rate/benefit rates, temporary total disability, medical expenses, and permanent partial disability and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

- Petitioner was a 48-year-old employee of Respondent, for about six years. He described his job as a bartender in Carbondale, Illinois. Breaking up disputes at Respondent's facility was part of Petitioner's responsibilities as a bartender. Petitioner reported that he was paid $8.25 per hour, plus tips, and he worked 15 to 40 hours per week.

- Respondent presented a wage statement for the year prior to the accident reflecting wages paid of $11,451.07, (RX 2). Petitioner offered tax returns 2012 and 2013, wherein, he did not report any tips and did not pay taxes regarding tips received, (PX 2). Petitioner also presented calendar's documenting his tips for those years, (PX 3). Petitioner testified that shortly before the hearing, he had filed amended returns for those years to reflect the tips, but had not yet paid the taxes in that regard.

- Petitioner had an undisputed accident in the early hours of April 30, 2013 when he

intervened in an altercation and injured his left shoulder. Petitioner subsequently underwent treatment with Dr. Golz, an orthopedic, and Dr. Thalman, a chiropractor. Petitioner underwent MRI's on June 4, 2013 and June 24, 2013 with impressions of subacromial impingement and tendinosis. There were no tears noted; there was thinning of the tendon with mild bursal surface fraying. Petitioner was diagnosed with left shoulder pain/strain, and adhesive capsulitis. Dr. Golz, and Respondent's Section 12 examiner, Dr. Paletta agree with the radiologist interpretation that there were no rotator cuff tears on either of those MRI's.

- Petitioner saw Dr. Paletta for a Section 12 examination for Respondent on September 23, 2013 and he opined in his November 1, 2013 correspondence that Petitioner should continue the physical therapy and he recommended an injection to the glenohumeral joint and a Medrol dose pack and NSAIDS. Therapy was emphasized on restoring range of motion of the shoulder, rotator cuff and periscapular strengthening per impingement protocol. He further opined Petitioner would reach maximum medical improvement in 6-12 weeks if there was a positive response to the injection and post injection therapy. He then did not believe there was indication for ongoing or implementation of manipulative chiropractic care. (RX 1).

- Petitioner had treatment with Dr. Thalman between April 30, 2013 and February 19, 2014, for chiropractic manipulative therapy of about 88 visits. (PX 4).

- Petitioner had 12 therapy visits at NovaCare Rehabilitation between January 8, 2014 and March 19, 2014 for diagnosis of shoulder joint pain, joint stiffness, and lack of coordination and was discharged due to no approval for continued therapy. When discharged, they noted Petitioner was progressing with shoulder range of motion and advancing with scapular stabilization program. (PX 6).

- Petitioner continued to treat with Dr. Golz who administered a subacromial injection July 13, 2013 and the October 30, 2013 visit noted it had provided significant improvement. At that time ROM was better and strength and pain levels were about the same. Overhead activities were an issue and he complained of aching discomfort. Petitioner continued to work full duty with modifications, which was still uncomfortable. Dr. Golz did not think there was any significant adhesive capsulitis but still believed the biggest problem was rotator cuff tendinitis. X-rays then indicated some early AC arthritis, some slight narrowing of the acromiohumeral distance and subclavical spurring, but no significant glenohumeral arthrosis. Continued therapy and a Medrol dose pack was prescribed along with pain medication and home exercises. (PX 5).

- Dr. Golz noted December 11, 2013 that the injection had significantly helped with motion. He then believed the rotator cuff tendinitis was improving slowly with conservative care. Therapy and home exercise were continued. The Medrol was not refilled. The restrictions were continued.

- Dr. Golz saw Petitioner March 5, 2014. At that time no further therapy had been approved

and Petitioner was doing home exercises and working full duty. Home exercise was again emphasized as well as protective mechanics. Petitioner was taking over-the-counter anti-inflammatory medication and Petitioner requested another injection. Dr. Golz believed another injection was reasonable to decrease inflammation to allow better exercise and help the symptoms. Further therapy was prescribed. Employment status was not then addressed.

- On May 14, 2014, Dr. Golz noted Petitioner was working full duty and had graduated from therapy and Petitioner continued advance to home exercises. Petitioner then reported was 90% better then prior to treatment especially with ROM, though he felt strength was diminished and with occasional pain. The doctor noted near full AROM of the shoulder being more fluid with good abduction strength. He noted some patient complaints of mild tenderness over the anterolateral aspect of the shoulder but there was no significant crepitus or AC joint signs, no instability, no labral signs and the long head of the biceps appeared intact. Dr. Golz assessed that presentation was most compatible with biceps tendinitis. He planned another ultra-sound guided injection to the bicipital groove and encouraged Petitioner to be more diligent with use of Naprosyn and home exercises and continue protective mechanics. No medications were prescribed.

- The ultrasound guided injection on September 8, 2014 was to address the left shoulder pain. At the time of the injection, the ultrasound impression noted no evidence of a full-thickness tear of the bicipital tendon; a small linear tear was noted. Therapy was continued after the injection. (PX 5).

- Dr. Golz saw Petitioner October 15, 2014. He noted the small linear tear found on ultrasound and noted that the injection provided complete and lasting relief of the anterior pain. He also noted Petitioner had recently moved furniture. He discontinued use of the Naprosyn. Petitioner had noted that moving furniture and weather changes had aggravated the shoulder pain. Pain was then noted more localized laterally, per Petitioner the pain now in the 'other tendon'. Petitioner felt his shoulder was cocked forward. The doctor noted ROM still restricted slightly and overhead motion was slow and uncomfortable. Dr. Golz noted good abduction strength and negative supraspinatus test and long head of biceps was non-tender. Dr. Golz had explained the natural course of rotator cuff tendinitis. It was then too soon for another injection. He thought there may be benefit to steroids due to inflammatory exacerbation of the symptoms and Petitioner was again placed on Naprosyn. Employment status was not addressed.

- Dr. Golz's notes of December 31, 2014 noted a telephone call from Petitioner noting that the steroid injection had helped but he was then having increased pain and difficulty performing his job and Petitioner requested a high definition MRI. (PX 5).

- Dr. Golz saw Petitioner January 7, 2015 and Petitioner indicated the steroid dose pack helped while he was on it and he had been doubling up on the Naprosyn due to ongoing soreness and shoulder stiffness. Petitioner felt his condition was then worse with daily complaints and losing ROM and strength. Dr. Golz noted some loss of motion and abduction strength loss and tenderness anterolateral. The long head of the biceps was okay and there were no AC joint signs and no instability. Dr. Golz noted Petitioner slow and

guarded and uncomfortable motion into and from overhead. He then recommended an MRI to access labral pathology and recommended continued home exercises and protective mechanics. Employment status was not discussed.

- Petitioner had the left shoulder MRI January 21, 2015 for left shoulder pain, possible rotator cuff tear. The impression was a full thickness supraspinatus tendon tear, tendinopathy versus partial tear involving the infraspinatus tendon; superior labral tear; questionable mild thickening along the inferior glenohumeral ligament, possibly due to previous injury; component of adhesive capsulitis not excluded. (PX 7).

- Dr. Golz saw Petitioner February 18, 2015 and Petitioner indicated the shoulder was getting worse and he had persistent, achy discomfort and his arm was weak. Petitioner noted trouble lifting and trouble working overhead, and he had loss of range of motion and nocturnal complaints; he could not lie on his left shoulder. He was working with modifications. Dr. Golz noted overhead motion was guarded and slow and less range of motion and abduction weakness and positive supraspinatus weakness. The long head biceps appeared to be intact and there were no AC signs. An MR arthrogram of January 21, 2015 noted a full thickness tear of the rotator cuff with no retraction and no atrophy and the long head of the biceps appeared intact; some signal changes along the superior labrum. Dr. Golz then recommended a left shoulder arthroscopy due to Petitioner's failure to respond to conservative care and persistent functional limitation. Work status was not addressed.

- Petitioner underwent 19 sessions of physical therapy at the Orthopedic Institute of Southern Illinois between March 24, 2014 and February 24, 2015. The discharge summary noted Petitioner had reached maximal level and also noted anterior/lateral pain which was worse because he had to move furniture. (PX 5).

- Petitioner decided on having the surgery in the phone call of March 19, 2015. Surgery was ultimately denied by workers' compensation insurance April 7, 2015.

- Dr. Golz saw Petitioner April 12, 2015 and noted the shoulder becoming progressively worse and more bothersome with functional limitation. He was taking non-steroidal medication with some relief and he continued the home exercises. On exam, Dr. Golz noted limited ROM and overhead motion guarded and slow. Abduction strength was found weak and Petitioner with a positive supraspinatus test but no instability and no AC joint signs and the biceps was intact. Petitioner was to continue conservative care. Dr. Golz there noted the initial MRI showed some rotator cuff tendinitis and the 'second' MRI showed a full thickness rotator cuff tear and he recommended surgery given the failed conservative treatment and he recommended to continue protective mechanics and home exercise and medications pending Petitioner's decision on surgery. Work status was not addressed.
  (Of NOTE-Dr. Golz reference to the 'second' MRI showing the tear appears to be a misstatement, as Petitioner had two MRI's in June 2013 that did not reveal any tears and the January 2015 was the next MRI and that did reveal the full thickness tear.).

- Petitioner saw Dr. Paletta for a 2nd Section 12 examination April 8, 2015. Petitioner then

had subjective complaints noted of pain more laterally and posteriorly, particularly with lowering his arm. Petitioner was still taking Naprosyn daily, the amount depending on his level of discomfort. On examination, Dr. Paletta noted normal right shoulder and the left shoulder revealed no asymmetry, muscle atrophy or deformity. He noted painful arc of motion with guarding with forward motion. He noted some weakness with rotator cuff strength testing and some pain with resisting manual testing with normal rotational strength and slightly decreased supraspinatus strength with pain complaints with resisted strength testing and normal strength. Dr. Paletta noted positive impingement signs with no instability to load and shift testing. Dr. Paletta's impression was that Petitioner had a focal full thickness rotator cuff tear supraspinatus, left shoulder and possible superior labral tear. (RX 3).

- Dr. Paletta noted Petitioner's continued complaints of worsening shoulder pain and noted weakness found on examination that was not present in the prior exam. He reviewed the MRI and stated that it demonstrated a focal full thickness tear of the supraspinatus, a different finding than on prior MRI studies. He stated that the treatment had been reasonable and necessary. He noted the prior studies in 2013 did not demonstrate evidence of a full thickness tear. In 2013 he noted there was some tendinopathy and slight tendon thickening with no retraction or defect or full thickness tear of the rotator cuff. He noted the MR arthrogram clearly showed thinning of the tendon which was a dramatic change from the prior study. He stated now Petitioner had a full thickness tear previously not seen.

- Dr. Paletta opined that Petitioner's diagnosis was not causally related to the April 2013 incident. He noted Petitioner had two MRI's within two months of the injury and neither showed any evidence of a full thickness rotator cuff tear involving the supraspinatus, and multiple physicians reviewed those studies. He noted the MR arthrogram clearly showed the thinning of the tendon with a focal full thickness tear which was a dramatic change from previous study; now he has a full thickness rotator cuff tear.

- Dr. Paletta agreed with Dr. Golz's recommendation to consider surgery to repair the rotator cuff but he did not agree that it was related to the incident in 2013 as MRI's done within two months of the incident showed no evidence of a tear. Dr. Paletta did not think further diagnostic testing was needed. Dr. Paletta stated 19 months had passed between the initial MRI scan showing no tears and the MR arthrogram that then demonstrated a rotator cuff tear. He stated that while Petitioner denied any intervening trauma or injury, clearly something occurred during that timeframe that resulted in a full thickness rotator cuff tear. He again indicated that the need for surgery was not related to the work accident. Dr. Paletta reiterated his opinion from his prior examination that Petitioner was at maximum medical improvement regarding the work related shoulder injury.

- Petitioner then had an MRI July 27, 2016 that revealed a partial supraspinatus tendon tear, hypertrophy of the AC joint with inferior spurring resulting in impingement. There was indication of possible fraying within the posterior labrum posteriorly, mild thickening along the inferior glenohumeral ligament possibly associated with adhesive capsulitis. (PX 7).

- Dr. Golz again saw Petitioner July 28, 2016 with the left shoulder static and Petitioner was still considering surgery. A light duty restriction was imposed with no overhead heavy lifting. Surgery was being planned for the end of the year.

- The August 3, 2016 Dr. Golz record indicated Petitioner was unresponsive to conservative care and assessment was left shoulder rotator cuff tear and surgery was again discussed. Work status was not addressed.

- The September 9, 2016 operative report of Dr. Golz noted the left shoulder arthroscopic surgery and debridement, subacromial decompression and mini open rotator cuff repair.

- Petitioner was seen for post-operative visits December 14, 2016 and into January 2017 with Robert Deaton, CNP (at Orthopedic Institute of Southern Illinois; with Dr. Golz) who noted healing and no infection and therapy was ordered. Progression of recovery was slow but satisfactory. Employment status was not addressed.

- Petitioner requested a work release (to perform work as a stagehand) April 12, 2017 and Dr. Golz allowed Petitioner to work within pain tolerance. (PX 5). Petitioner had a follow up visit and Dr. Golz noted slow, gradual improvement with good strength.

- On September 27, 2017, Robert Deaton, CNP, noted 4/10 pain which was dull, achy, and aggravated by daily activities and the weather. An MRI was then recommended. Petitioner had an MRI at Cedar Court Imaging December 13, 2017. The impression was moderate supraspinatus tendinopathy with an insertional tear, high grade, possible full thickness tear. There was mild to moderate infraspinatus tendinopathy with no tear, and degenerative changes of the shoulder with spurs. (PX 5). On December 20, 2017, Mr. Deaton, CNP, noted the left shoulder showed normal ROM and strength and a right shoulder rotator cuff surgery was recommended to address a rotator cuff tear.

The Commission, herein, affirms and adopts the decision of the Arbitrator as to causal connection, average weekly wage/benefit rates, temporary total disability, and medical expenses.

> §8.1(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.

The Commission affirms and adopts the weight the Arbitrator gave as to factors §8.1(b) (i) through

(iv). As Petitioner reached MMI at the time of Dr. Golz October 15, 2014 exam, temporary total disability and medical expenses are denied thereafter. Petitioner suffered a left shoulder injury, strain, and resulting adhesive capsulitis April 30, 2013. The weight of the evidence shows that as a result of that injury Petitioner received conservative treatment, including physical therapy and injections, and anti-inflammatory medications. The MRI's performed shortly after the injury did not reveal any tears.

Petitioner saw Dr. Paletta for a Section 12 examination for Respondent on September 23, 2013 and he opined in his November 1, 2013 correspondence that Petitioner should continue the physical therapy and he recommended an injection to the glenohumeral joint and a Medrol dose pack and NSAIDS. Therapy was emphasized on restoring range of motion of the shoulder, rotator cuff and periscapular strengthening per impingement protocol. He further opined Petitioner would reach maximum medical improvement in 6-12 weeks if there was a positive response to the injection and post injection therapy.

The ultrasound guided injection on September 8, 2014 was to address the left shoulder pain. At the time of the injection, the ultrasound impression noted no evidence of a full-thickness tear of the bicipital tendon; a small linear tear was noted.

Dr. Golz saw Petitioner October 15, 2014. He noted the small linear tear found on ultrasound and noted that the injection provided complete and lasting relief of the anterior pain. He also noted Petitioner had recently moved furniture. He discontinued use of the Naprosyn. Petitioner had noted that moving furniture and weather changes had aggravated the shoulder pain. Pain was then noted more localized laterally, per Petitioner the pain was now in the 'other tendon'.

Petitioner had therapy at the Orthopedic Institute of Southern Illinois between March 24, 2014 and February 24, 2015. The discharge summary noted Petitioner had reached maximal level and also noted anterior/lateral pain which was worse because he had to move furniture.

Dr. Golz ordered an MRI of the left shoulder, dated January 21, 2015, for left shoulder pain, possible rotator cuff tear. The impression of the MRI then was a full thickness supraspinatus tendon tear, tendinopathy versus partial tear involving the infraspinatus tendon; superior labral tear; questionable mild thickening along the inferior glenohumeral ligament, possibly due to previous injury; component of adhesive capsulitis not excluded.

Dr. Golz April 12, 2015 visit notes indicated the 'initial' MRI showed some rotator cuff tendinitis and the 'second' MRI showed a full thickness rotator cuff tear. It appears that was clearly a misstatement as Petitioner had two MRI's June 4, 2013 and June 24, 2013 which revealed no tears. The next MRI ('second') was done January 21, 2015 and that did reveal the full thickness supraspinatus tear.

The evidence clearly shows that Petitioner had the injection that had provided complete and lasting of the anterior pain (positive response) at the October 15, 2014 visit (MMI) and Petitioner then noted the aggravation of shoulder pain after moving furniture and weather changes. The therapy discharge notes also noted Petitioner had reached maximum level of improvement until it worsened from moving furniture. While the Commission agrees Petitioner is entitled to a

loss of 7.5% loss of use of his person as a whole as result of the injury, the Commission assigns greater weight to §8.1(b) (v) given the evidence of disability corroborated by the treating medical records that there was no full thickness supraspinatus tear as result of the April 30, 2013 accident. Petitioner had recovered from the left shoulder injury, strain, and resulting adhesive capsulitis within 6-12 weeks of the successful ultrasound injection as indicated by Dr. Paletta, prior to discovery of the rotator cuff tear in January 2015. The Commission, herein, affirms the permanent partial disability award of 7.5% loss of Petitioner's person as a whole as result of the injury.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of **$220.00** per week (min. rate) for a period of 37.5 weeks, as provided in §8(d)(2) of the Act, for the reason that the injuries sustained caused the 7.5% loss of Petitioner's person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is entitled to a credit of $13,132.35 for medical expenses paid under §8(a) of the Act. No medical expenses awarded after October 15, 2014.

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 $21,500.00. 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: JUN 4 – 2020
o-3/10/20

KD/jsf

Kathryn A. Doerries

Maria E. Portela

DISSENT

I find that the evidence supports that Petitioner's current condition of ill-being is causally related to his undisputed April 30, 2013 accident, and that the alleged intervening accident did not break the chain of causal connection.

In *PAR Elec. v. Ill. Workers' Comp. Comm'n*, 2018 IL APP (3d) 170656WC, the court addressed the issue of intervening accident. The Court stated:

> To obtain compensation under the Act, an employee must establish by a preponderance of the evidence a causal connection between a work-related injury and the employee's condition of ill-being. *Vogel*, 354 Ill. App. 3d at 786. Every natural consequence that flows from a work-related injury is compensable under the Act unless the chain of causation is broken by an independent intervening accident. *National Freight Industries*, 2013 IL App (5th) 120043WC, 993 N.E.2d 473, 373 Ill. Dec. 167, *Vogel*, 354 Ill. App. 3d at 786; *Teska*, 266 Ill. App. 3d at 742. Under an independent intervening cause analysis, compensability for an ultimate injury or disability is based upon a finding that the employee's condition was caused by an event that would not have occurred "but for" the original injury. *International Harvester Co.*, 46 Ill. 2d at 245. Thus, when an employee's condition is weakened by a work-related accident, a subsequent accident, whether work related or not, that aggravates the condition does not break the causal chain. See *Lee v. Industrial Comm'n*, 167 Ill. 2d 77, 87, 656 N.E.2d 1084, 212 Ill. Dec. 250 (1995); *Vogel*, 354 Ill. App. 3d at 787; *Lasley Construction Co. v. Industrial Comm'n*, 274 Ill. App. 3d 890, 893, 655 N.E.2d 5, 211 Ill. Dec. 345 (1995). "For an employer to be relieved of liability by virtue of an intervening cause, the intervening cause must completely break the causal chain between the original work-related injury and the ensuing condition." *Global Products*, 392 Ill. App. 3d at 411. As long as there is a "but for" relationship between the work-related injury and subsequent condition of ill-being, the first [***39] employer remains liable. *Global Products*, 392 Ill. App. 3d at 412.

The majority found the opinion from Respondent's Section 12 examiner persuasive. Dr. Paletta opined that Petitioner's rotator cuff tear was not causally related to his April 30, 2013 accident as the original MRIs did not demonstrate any evidence of a full thickness rotator cuff tear. I disagree with the majority and would adopt Dr. Robert Golz's opinion that the tear apparent on the second MRI [January 21, 2015] was likely a progression of his initial injury and was better delineated with the arthrogram study.

The MRIs from June 2013 were performed without contrast. The June 4, 2013 MRI noted that a partial rotator cuff tear could not be excluded. The June 24, 2013 MRI revealed no tear but found thinning of the supraspinatus tending along with mild bursal surface fraying. It was not until the January 21, 2015 that an MRI with contrast was performed and a full thickness supraspinatus tendon tear was identified.

The majority finds that Petitioner sustained an intervening accident on October 15, 2014 which caused the full thickness supraspinatus tendon tear. I disagree. The October 15, 2014 record indicates that Petitioner recently "moved some furniture, went off Naprosyn and with this and the weather changes he now has aggravated his shoulder pain." His examination, however, revealed that he still had slightly restricted range of motion and overhead motion was a little uncomfortable. There is no evidence as to the severity of this event.

Leading up to the October 15, 2014 visit, Petitioner consistently treated with Dr. Golz and his shoulder complaints were well documented in the record. While some of the records note some improvement following the injections, the vast majority of the records confirm that Petitioner consistently complained of shoulder discomfort and range of motion issues. His complaints after October 15, 2014 continued and were consistent with his complaints prior to this alleged intervening accident.

Based upon the above, and pursuant to the reasoning in *Par Electric*, I would find that this alleged incident does not constitute an intervening accident sufficient to break the chain of causal connection.

As I would find causal connection, I would affirm the Arbitrator's finding of an AWW of $220.21. I would award Petitioner all reasonable and necessary medical expenses, TTD from September 23, 2015 through April 12, 2017, and award Petitioner 15% MAW.

D. Douglas McCarthy

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

OLIZ, NICHOLAS
Employee/Petitioner

Case# **15WC030841**

GWEN HUNT D/B/A PK'S
Employer/Respondent

20IWCC0287

On 7/16/2019, 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 2.01% 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:

5983 CARAWAY FISHER & BROOMBAUGH PC
DANIEL G BROOMBAUGH
9423 W MAIN ST
BELLEVILLE, IL 62223

0000 JELLIFFE DOERGE & PHELPS PC
KELLY PHELPS
108 E WALNUT ST PO BOX 406
HARRISBURG, IL 62946

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

NICHOLAS OLIZ
Employee/Petitioner

v.

GWEN HUNT d/b/a PK's
Employer/Respondent

Case # 15 WC 030841

Consolidated cases: _____

20IWCC0287

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Ed Lee**, Arbitrator of the Commission, in the city of **Herrin, Illinois**, on **05/14/2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **04/30/2013**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**11,451.07**; the average weekly wage was $**220.21**.

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 $**0.00** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**13,232.35** for other benefits, for a total credit of $**13,232.35**.

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

ORDER

Respondent shall be given credit of $13,232.35 for medical benefits paid under Sections 8(a) and 8.2 of the Act.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, to the following: 1) Dr. Thalman, dates of service 04/30/2013 through 02/09/2014; 2) Dr. Golz/Orthopaedic Institute of Southern Illinois, dates of service 06/09/2013 through 10/15/2014; 3) Cedar Court Imaging, date of service 06/24/2013; and 4) Novacare Rehabilitation, dates of service 01/08/2014 through 02/14/2014, as provided in Sections 8(a) and 8.2 of the Act.
Respondent shall be given a credit for any for medical benefits that have been paid, as provided in Section 8(j) of the Act.

TTD benefits are denied.

Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 7.5% loss of use of person-as-a-whole pursuant to §8(d)(2) of the Act.

RULES REGARDING APPEALS Unless a party 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

7/13/19
Date

JUL 16 2019

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

NICHOLAS OLIZ,	)	
	)	
Petitioner,	)	
	)	
vs.	)	15-WC-030841
	)	
GWEN HUNT d/b/a PK's,	)	
	)	**20IWCC0287**
Respondent.	)	

MEMORANDUM OF DECISION OF ARBITRATOR

EVIDENCE PRESENTED AT ARBITRATION

Respondent is a bar in Carbondale, Illinois. Petitioner was a bartender for respondent. (T. 9). He was paid $8.25 per hour, plus tips, and worked 15 to 40 hours per week. (T. 9-11).

In the early morning hours of April 30, 2013, petitioner sustained an accidental injury to his left shoulder that arose of out and in the course of his employment when he attempted to break up or prevent a fight at the bar. (T. 21-23).

Petitioner first sought treatment for his left shoulder injury on April 30, 2013, at Thalman Chiropractic. (PX 4). Petitioner gave Dr. Thalman a history of his accident. He was complaining of pain in his left shoulder. Dr. Thalman performed a physical examination. Dr. Thalman's assessment was acute strain/sprain of the left shoulder, suspect biceps and supraspinatus tear. Dr. Thalman performed treatment consisting of ultrasound, cryotherapy, and interferential current. Petitioner was given work restrictions of light work.

Respondent accommodated petitioner's light work restrictions and petitioner continued to work after the accident.

Petitioner continued to receive chiropractic treatment from Dr. Thalman. Dr. Thalman ordered an MRI that was performed on June 4, 2013. (PX 4). That MRI was interpreted as showing subacromial impingement with tendonosis. (PX 4). Dr. Thalman reviewed the MRI report and felt that it was inconclusive and suboptimal. (PX 4). On June 12, 2013, Dr. Thalman referred petitioner to Dr. Robert Golz for examination. Dr. Golz is an orthopedic surgeon with the Orthopaedic Institute of Southern Illinois. After the referral to Dr. Golz, petitioner continued to treat with Dr. Thalman until February 19, 2014. (PX 4).

Petitioner was examined by Dr. Golz on June 19, 2013. (PX 5). He gave Dr. Golz a history of his work accident. He was complaining of left shoulder pain. Dr. Golz performed a physical examination. Dr. Golz's impression was left rotator cuff tendonitis versus tear. Dr. Golz was okay with petitioner continuing therapy with Dr. Thalman. Petitioner was to continue working with the same restrictions previously set by Dr. Thalman. Dr. Golz recommended a repeat MRI. Petitioner was to return for follow-up examination after the repeat MRI was completed.

The repeat MRI was performed on June 24, 2013. That MRI was interpreted as showing supraspinatus tendinopathy, no tear. (PX 7).

Petitioner returned to Dr. Golz's office on July 10, 2013. (PX 5). Dr. Golz reviewed the repeat MRI and also the MRI done on June 4, 2013. Dr. Golz's impression was supraspinatus tendinopathy with no tear. Dr. Golz injected petitioner's subacromial space. Dr. Golz recommended that petitioner continue therapy with Dr. Thalman. Petitioner was to continue to work with his previous restrictions. Petitioner was released from Dr. Golz's care to return as needed.

On September 23, 2013, petitioner was examined by Dr. George Paletta pursuant to Section 12 of the Act. (RX 1). Dr. Paletta took a history from petitioner, which included his work accident. Dr. Paletta reviewed petitioner's treatment records, performed a physical examination, and obtained and reviewed x-rays of petitioner's left shoulder. The MRI scans of June 4, 2013, and June 13, 2013, were available for Dr. Paletta's review. Dr. Paletta reviewed and compared the MRIs. He interpreted the MRI of 6-4-13 as showing some rotator cuff tendonopathy with no evidence of a tear. He interpreted the MRI of 6-13-13 as showing supraspinatus tendonopathy with no evidence of a partial thickness or full thickness tear. Dr. Paletta's impression was resolving adhesive capsulitis secondary to initial shoulder strain. Dr. Paletta opined that the adhesive capsulitis and shoulder strain were related to his work accident. He also opined that there was no evidence of a labral tear or rotator cuff tear that required surgical treatment. Dr. Paletta recommended an intraarticular injection in conjunction with a Medrol dose pack followed by some over the counter anti-inflammatories. He also recommended a focused physical therapy program emphasizing rotator cuff strengthening. Finally, Dr. Paletta said that petitioner could continue to work full duty, without restriction. He expected petitioner to achieve maximum medical improvement within 6 to 12 weeks after the intraarticular injection.

Petitioner returned to Dr. Golz's office on October 30, 2013. (PX 5). He was still complaining of aching discomfort in his shoulder and difficulty with overhead activity. Dr. Golz read Dr. Paletta's report for his examination of 9-23-14 and thought that his recommendation for an intraarticular injection was reasonable. Therefore, Dr. Golz performed that injection at this visit. Dr. Golz recommended therapy. Petitioner insisted that his therapy be done with Dr.

Thalman. Dr. Golz wrote out formal therapy orders for Dr. Thalman. Petitioner was to continue to work full duty.

Petitioner continued to treat with Dr. Golz. He was seen by Dr. Golz on December 11, 2013, and told to continue therapy for 6 weeks with a goal of home exercises. (PX 5).

Dr. Golz saw petitioner on March 5, 2014. (PX 5). Petitioner had obtained some therapy at Novacare Rehabilitation since he last saw Dr. Golz. That therapy began on January 8, 2014, and ended on March 19, 2014. (PX 6). Dr. Golz discussed the natural history of rotator cuff and bicipital tendinitis with petitioner. Dr. Golz also performed a subacromial injection.

Petitioner returned to see Dr. Golz on May 14, 2014. (PX 5). Dr. Golz thought he was progressing satisfactorily with conservative treatment for his rotator cuff tendinitis. Petitioner reported that he was experiencing similar symptoms in his right shoulder. Dr. Golz continued the treatment plan and told petitioner to return for a recheck in 3 months.

On August 20, 2014, petitioner was next seen by Dr. Golz. (PX 5). At this visit, Dr. Golz noted that petitioner had 2 MRIs of the left shoulder which both showed some rotator cuff tendinitis but no tear. Petitioner also reported that he had experienced recent exacerbations of soreness and pain following activities such as pulling a starter cord for a motor and cleaning up the bar. Dr. Golz performed a physical examination and felt that petitioner's presentation was most compatible with biceps tendinitis and suggested an ultrasound guided injection of the bicipital groove. Petitioner was to return for recheck after the injection.

The ultrasound guided injection of the bicipital tendon sheath was performed on September 8, 2014. (PX 5).

On September 17, 2014, petitioner was seen by Dr. J.T. Davis of the Orthopaedic Institute of Southern Illinois for bilateral knee pain. (PX 5). There was no treatment noted for his left shoulder.

Petitioner returned to Dr. Golz on October 15, 2014. (PX 5). This was petitioner's first visit after the ultrasound guided injection of the bicipital groove. Petitioner reported that the injection gave him complete and lasting relief of his anterior pain but he recently moved some furniture, went off his Naprosyn, and with the weather changes, he had aggravated his shoulder pain. Dr. Golz told petitioner to continue his home exercises and protective mechanics. He was to return for recheck in 6 days.

Petitioner did not return to see Dr. Golz again until January 7, 2015. (PX 5). His left shoulder pain was worse. Dr. Golz reviewed the last MRI from June

2013 and felt is showed some signal changes in the rotator cuff but no obvious tear. Dr. Golz ordered a new MRI.

On January 21, 2015, petitioner had another MRI of his left shoulder performed. (PX 5). The radiologist interpreted it as showing a full thickness supraspinatus tendon tear.

Dr. Golz next examined petitioner on February 18, 2015. (PX 5). Dr. Golz reviewed the recent MRI. He interpreted it as showing a full thickness tear of the rotator cuff. He recommended surgery to repair the tear.

On April 8, 2015, petitioner was again examined by Dr. Paletta pursuant to Section 12 of the Act. (RX 3). Another history was obtained from petitioner. Dr. Paletta also reviewed records of petitioner's treatment and performed a physical examination. Dr. Paletta obtained x-rays of petitioner's left shoulder. Dr. Paletta also reviewed the MRI scan of 1-25-15 and compared it to the prior MRIs done in June 2013. Dr. Paletta opined that both MRIs in June 2013 did not demonstrate any evidence of a full thickness rotator cuff tear. However, the 1-25-15 MRI did show evidence of a full thickness rotator cuff tear. Dr. Paletta noted in his report for this examination that several physicians, including Dr. Golz, radiologists, and him, reviewed the June 2013 MRIs and none interpreted them as showing a full thickness tear. Those MRIs were done within 2 months of petitioner's work accident. Dr. Paletta opined that the full thickness rotator cuff tear demonstrated on the 1-25-15 MRI was not related to petitioner's work accident in April 2013.

Petitioner returned to Dr. Golz on April 22, 2015. (PX 5). Dr. Golz examined petitioner but most of the visit was centered around causation of the left rotator cuff tear. Dr. Golz's office note for this visit states that petitioner denied any complaints prior to his injury on April 30, 2013. Petitioner also denied that he suffered any subsequent injury. Based on these representations by petitioner, Dr. Golz thought that the rotator cuff tear now present on the most recent MRI was a progression of his initial injury and better delineated with the recent MRI arthrogram. Dr. Golz again recommended surgery to report the rotator cuff tear.

Dr. Golz examined petitioner on July 28, 2015. (PX 5). He was still complaining of left shoulder pain.

Petitioner claims he was fired by respondent on September 23, 2015. (T. 35).

Petitioner was next seen by Dr. Golz approximately 1 year later on July 19, 2016. (PX 5). He was still experiencing left shoulder pain. Dr. Golz ordered a repeat MRI arthrogram.

On August 3, 2016, petitioner was seen by Dr. Golz. (PX 5). The repeat MRI arthrogram had been performed and it again showed the full thickness tear of the supraspinatus tendon. Dr. Golz recommended surgery and petitioner agreed.

Petitioner returned to Dr. Golz's office on August 23, 2016. (PX 5). He had questions regarding his scheduled shoulder surgery. His questions were answered by a nurse practitioner, Robert Deaton.

Dr. Golz performed surgery on petitioner on September 19, 2016. (PX 5). The procedure was left shoulder arthroscopy with debridement, subacromial decompression, and mini open rotator cuff repair. The post-operative diagnoses were left rotator cuff tear and advance AC joint arthrosis.

Petitioner began a course of physical therapy after his surgery. His therapy was performed at Memorial Hospital of Carbondale. (PX 8). He began therapy on September 21, 2016, and completed it on February 8, 2017.

Petitioner had a post-operative appointment with Dr. Golz on October 4, 2016. (PX 5). He was doing well and told to continue with physical therapy and to return in 4 weeks. This office note is silent as to any work restrictions.

Petitioner was seen at Dr. Golz's office for post-operative appointments on October 26, 2016; December 14, 2016; and January 25, 2017. (PX 5). He was progressing slowly but satisfactory. Petitioner was told to continue with therapy. These office notes are silent as to any work restrictions.

On March 29, 2017, petitioner was examined by Dr. Golz. (PX 5). Petitioner was done with therapy. Dr. Golz told petitioner to gradually start to advance his activities and return to the office in 3 months. Again, this office note is silent as to any work restrictions.

Contained in Dr. Golz's records is a nurse's note dated April 12, 2017, stating that petitioner was going to do stage hand work and requested a work release note. (PX 5). The note further states that petitioner could overhead lift and was able to go back to work. Dr. Golz advised petitioner to let pain be his guide and do activities within his pain tolerance.

Petitioner was next examined by Dr. Golz on June 28, 2017. (PX 5). His left shoulder was doing better but his right shoulder was painful. Petitioner was to return for an examination 1 year post surgery.

On September 27, 2017, petitioner was seen at Dr. Golz's office. (PX 5). He was still experiencing pain in his left shoulder. His right shoulder was also painful. There was a concern noted for possible rotator cuff tear of the right shoulder so an MRI was ordered for it.

Petitioner was seen at Dr. Golz's office on December 13, 2017, complaining of bilateral knee pain. (PX 5).

On December 20, 2017, petitioner returned to Dr. Golz's office to follow up for his knee pain. (PX 5). However, petitioner had undergone a right shoulder MRI on December 14, 2017, and he was there to discuss the findings of that test too. The right shoulder MRI demonstrated moderate supraspinatus tendinopathy with an insertional tear. Surgery for the right rotator cuff tear was discussed with petitioner but declined. He was to follow up as needed.

Petitioner returned to Dr. Golz's office on April 11, 2018, for bilateral knee osteoarthritis. (PX 5).

Petitioner testified that he has a little less strength in his left shoulder. (T. 37). He also testified he has some restricted range of motion in his left shoulder. (T. 37-38).

CONCLUSIONS OF LAW

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

The weight of the evidence shows that petitioner suffered a left shoulder strain and resulting adhesive capsulitis as a result of his accident on April 30, 2013. Petitioner failed to meet his burden of proof that the left rotator cuff tear was causally related to his accident on April 30, 2013.

Petitioner had 2 MRIs of his left shoulder done in June 2013. The first MRI was on June 4, 2013. The second was on June 24, 2013. Both of these MRIs were within 2 months of petitioner's accident. These MRIs were reviewed by several doctors – Dr. Golz, Dr. Paletta, the radiologists – and none of them interpreted them as showing a rotator cuff tear. The MRI done on January 21, 2015, however, showed a rotator cuff tear. These diagnostic tests establish that the rotator cuff tear present on the January 2015 MRI was not caused by petitioner's accident on April 30, 2013.

Dr. Paletta's causation opinion set forth in his IME report of April 8, 2015, corroborates that petitioner's rotator cuff tear was not causally related to his accident on April 30, 2013.

Dr. Golz's causation opinion set forth in his office note of April 22, 2015, is not as persuasive as Dr. Paletta's causation opinion. Dr. Golz's opinion is predicated on petitioner's representation to him that he did not have any symptoms before his accident and that he did not have any subsequent injury. For reasons set forth below, the Arbitrator does not find petitioner credible.

The evidence establishes that after the ultrasound guided injection on September 8, 2014, petitioner suffered an intervening incident that caused the left rotator cuff tear. ***See* National Freight Industries v. Illinois Workers' Compensation Com'n, 2013 IL App (5th) 120043WC.** Dr. Golz' office note for October 15, 2014, states that petitioner reported complete and lasting relief of his left shoulder pain after the ultrasound guided injection of his bicipital groove. Petitioner admitted to Dr. Golz at this office visit, however, that his pain recently returned after he aggravated his left shoulder moving furniture. Petitioner reported to Dr. Golz at his next visit on January 7, 2015, that his left shoulder was worse. Shortly thereafter, the January 2015 MRI showed the rotator cuff tear that was not present on the June 2013 MRIs. Hence, by October 15, 2014, there was a change in petitioner's symptoms and a change in the pathology of his left shoulder that was confirmed by diagnostic tests, i.e., MRIs.

The Arbitrator also notes that petitioner developed right shoulder pain and a right rotator cuff tear without any noted trauma.

Based on the foregoing, the Arbitrator finds that petitioner suffered a left shoulder strain and resulting adhesive capsulitis as a result of his accident on April 30, 2013. That injury was resolved after the ultrasound guided injection of his bicipital groove on September 8, 2014. The left rotator cuff tear is not causally related to his accident on April 30, 2013.

Issue G: What were petitioner's earnings?

Petitioner claims that his earnings during the year preceding his injury were $43,913.00. He claims an average weekly wage of $844.48. Petitioner testified that respondent paid him $8.25 per hour, plus tips, and that he worked 15 to 40 hours per week.

Respondent offered into evidence a wage statement showing that during the year preceding his injury, petitioner was paid $11,451.07. (RX 4). Respondent claims an average weekly wage of $220.21.

There is a difference of $32,461.93 between petitioner's and respondent's claimed earnings during the year preceding his injury. Petitioner claims this difference is the tips he received while working for respondent. In support of his claim, petitioner offered into evidence amended U.S. tax returns for 2012 and 2013. (PX 2). Petitioner also offered into evidence calendars documenting his tips. (PX 3).

The Arbitrator finds that petitioner failed to meet his burden of proof regarding his earnings. Petitioner did not report on his tax returns the tips he received in 2012 or 2013. Therefore, he did not pay taxes on those tips. Petitioner claims he did file amended returns reporting his tips in 2012 and 2013

but he did not do this until April 17, 2019, 1 month before this arbitration. Petitioner testified, however, that he still has not paid taxes for any tips received in 2012 or 2013. (T. 16).

Based on the foregoing, the Arbitrator does not find petitioner's testimony and evidence regarding his earnings credible. The only reliable evidence regarding earnings is respondent's wage statement showing earnings of $11,451.07, and an average weekly wage of $220.21. Therefore, the Arbitrator finds that petitioner's earnings during the year preceding his injury was $11,451.07, and the average weekly wage, calculated to Section 10 of the Act, was $220.21.

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?

Based on the Arbitrator's causation finding above, petitioner is awarded the following medical expenses set forth in petitioner's exhibit 9, subject to the fee schedule and any credits due respondent:

1. Dr. Thalman, dates of service 04/30/2013 through 02/09/2014;
2. Dr. Golz/Orthopaedic Institute of Southern Illinois, dates of service 06/09/2013 through 10/15/2014;
3. Cedar Court Imaging, date of service 06/24/2013; and
4. Novacare Rehabilitation, dates of service 01/08/2014 through 02/14/2014.

All other medical expenses are denied in light of the arbitrator's causation finding.

Issue K: What temporary total disability benefits are in dispute?

Petitioner claims to be entitled to TTD benefits from 09/23/2015 through 04/12/2017. Based on the Arbitrator's causation finding above, the Arbitrator finds that petitioner is not entitled to TTD benefits for this time period. Therefore, petitioner's claim for TTD benefits is denied.

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

Pursuant to the 5 factors set forth in Section 8.1b(b) of the Act, as for subsection (i), the Arbitrator notes that no permanent partial disability report or opinion was submitted into evidence. Therefore, the Arbitrator gives no weight to this factor.

As for subsection (ii), the Arbitrator notes that petitioner was employed as a bartender at the time of the accident and that he is able to return to work in his prior capacity. The Arbitrator gives little weight to this factor.

As for subsection (iii), petitioner was 48 years old at the time of the accident. The Arbitrator gives little weight to this factor.

As for subsection (iv), petitioner's future earnings capacity, the was no evidence that petitioner has suffered a diminishment in his future earnings capacity as a result of said accident. The Arbitrator gives little weight to this factor.

Finally, as to subsection (v), evidence of disability corroborated by the medical records, the Arbitrator finds that petitioner suffered a left shoulder strain and resulting adhesive capsulitis as a result of his accident on April 30, 2013. This injury was treated conservatively with therapy, injections, and anti-inflammatory medication. Petitioner was not restricted from working after his accident. Petitioner achieved maximum medical improvement after an ultrasound guided injection of his bicipital groove on September 8, 2014.

Based on the foregoing factors, the Arbitrator finds that petitioner has sustained permanent partial disability to the extent of 7.5% loss of use of the person-as-a-whole, or 37.5 weeks of permanent partial disability, pursuant to Section 8(d)(2) of the Act.

Issue N: Is respondent due any credit?

The parties stipulated that respondent is entitled to a credit of $13,232.35 in medical benefits paid. Therefore, the Arbitrator finds that respondent is entitled to a credit of $13,232.35 in medical benefits paid.

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

STEVEN FORNEAR,

Petitioner,

vs. NO: 12 WC 20476

ILLINOIS DEPARTMENT OF CORRECTIONS,

Respondent.

20IWCC0301

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, temporary disability, and permanent disability, and being advised of the facts and law, affirms the finding that Petitioner failed to prove his condition of ill-being is causally related to a repetitive trauma accidental injury manifesting on April 26, 2012, but applies different reasoning to reach its conclusion.

As a preliminary matter, the Commission makes the following corrections:

1 - The caption on the Arbitrator's decision identifies "Menard C.C." as Respondent. The Commission observes Petitioner worked at Tamms Correctional Center, but more importantly, the Application for Adjustment of Claim names "Illinois Department of Corrections" as the respondent. The Commission corrects the caption to reflect "Illinois Department of Corrections" as Respondent;

2 – The Commission corrects the decision to reflect Petitioner was 44 years old on the date of accident and 51 on the trial date.

20IWCC0301

Conclusions of Law

The Arbitrator's decision reflects Petitioner alleged bilateral hip injuries stemming "from repetitive walking and standing." This is incorrect. Review of the record reveals the activity Petitioner associated with his symptoms was climbing and descending several flights of stairs multiple times per shift while wearing a heavy-duty belt. Given the Arbitrator's decision misconstrues Petitioner's accident theory, we provide a separate analysis to conform to the evidence adduced at trial.

An injury "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." *Sisbro, Inc. v. Industrial Commission*, 207 Ill. 2d 193, 203, 797 N.E. 2d 665 (2003). To determine whether a claimant's injury arose out of his employment, "we must first determine the type of risk to which he was exposed." *Baldwin v. Illinois Workers' Compensation Commission*, 409 Ill. App. 3d 472, 478, 949 N.E.2d 1151 (2011). There are three categories of risk to which an employee may be exposed: (1) risks that are distinctly associated with one's employment, (2) risks that are personal to the employee, such as idiopathic falls, and (3) neutral risks that have no particular employment or personal characteristics, such as those to which the general public is commonly exposed. *Springfield Urban League v. Illinois Workers' Compensation Commission*, 2013 IL App (4th) 120219WC, ¶27, 990 N.E.2d 284. Injuries resulting from a neutral risk generally do not arise out of the employment and are compensable under the Act only where the employee was exposed to the risk to a greater degree than the general public. *Illinois Institute of Technology Research Institute v. Industrial Commission*, 314 Ill. App. 3d 149, 163, 731 N.E.2d 795 (2000). Such an increased risk may be either qualitative, such as some aspect of the employment which contributes to the risk, or quantitative, such as when the employee is exposed to a common risk more frequently than the general public. *Metropolitan Water Reclamation District of Greater Chicago v. Illinois Workers' Compensation Commission*, 407 Ill. App. 3d 1010, 1014, 944 N.E.2d 800 (2011). Traversing stairs is a neutral risk. *Baldwin*, 409 Ill. App. 3d at 478. Therefore, it is incumbent upon Petitioner to establish the stair climbing occasioned by his work duties was quantitatively or qualitatively different. The Commission acknowledges the record demonstrates Petitioner repeatedly traversed multiple flights of stairs throughout his shift and did so while wearing a 12-pound duty belt. However, the Commission finds that, even concluding Petitioner was exposed to a neutral risk to a greater degree than the general public, his claim nonetheless fails because he failed to meet his burden of proof on causation.

To come within the workers' compensation statute, an employee need only prove that some act or phase of employment was a causative factor of a resulting injury. The sole limitation to this general rule is that where it is shown the employee's health has so deteriorated that any normal daily activity is an overexertion, or where it is shown that the activity engaged in presented risks no greater than those to which the general public is exposed, compensation will be denied. *Sisbro, Inc.*, 207 Ill. 2d at 208. Although medical testimony as to causation is not necessarily required, where the question is one within the knowledge of experts only and not within the common knowledge of laypersons, expert testimony is necessary to show that claimant's work activities caused the condition complained of. *Interlake Steel Co. v. Industrial Commission*, 136 Ill. App. 3d 740, 483 N.E.2d 979 (1985). In cases predicated on the repetitive

trauma concept, the claimant generally relies on medical testimony establishing a causal connection between the work performed and the claimant's disability. *Nunn v. Industrial Commission*, 157 Ill. App. 3d 470, 477, 510 N.E.2d 502 (1987). Cases involving aggravation of a preexisting condition concern primarily medical questions and not legal ones (*Long v. Industrial Commission*, 76 Ill. 2d 561, 565, 394 N.E. 2d 1192 (1979)); this is especially true in repetitive trauma cases. *Id.*

Here, the only causation opinion in the record was provided by Dr. Johnston, Respondent's Section 12 examiner, who opined Petitioner's condition of ill-being was attributable to Petitioner's anatomy. Dr. Johnston explained greater trochanteric bursitis is primarily related to tight iliotibial bands, a condition which was not related to or caused by Petitioner's work duties. RX4, p. 14. Dr. Johnston further explained that while Petitioner experienced symptoms while at work, the underlying condition was such that it was equally affected by any physical activity involving the lower extremities (RX4, p. 14), *i.e.*, his hips had "so deteriorated that any normal daily activity is an overexertion." *Sisbro*. The Commission finds Dr. Johnston's opinion is credible. We further find Dr. Johnston's opinion is corroborated by the fact that although Petitioner has been off work since 2012 and is seven years removed from repetitive stair climbing, Petitioner still claims to have incapacitating pain that significantly inhibits his activities of daily living.

Based on the above, the Commission finds Petitioner failed to prove by the preponderance of the credible evidence that his condition of ill-being is causally related to a repetitive trauma injury manifesting on April 26, 2012.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 16, 2019, as modified above, is hereby affirmed.

Pursuant to Section 19(f)(1), this decision is not subject to judicial review.

DATED: JUN 4 - 2020

L. Elizabeth Coppoletti

L. Elizabeth Coppoletti

LEC/mck

D: 4/28/2020

Stephen J. Mathis

Stephen Mathis

43

DISSENT

I dissent from the Majority's decision to affirm and adopt the Arbitrator's finding that Petitioner did not suffer an injury that arose out of and in the course of his employment with Respondent on April 26, 2012. The main activity that Petitioner associated his bilateral hip complaints was traversing numerous flights of stairs on a frequent basis throughout his work

shift. Petitioner had worked for Respondent for more than 15 years as a correctional officer.

Petitioner specifically testified:

> If I was on midnight shift, you had six flights of stairs at 11:00, six flights at 11:15, six flights of stairs at 11:30, and depending when you cleaned your showers, you had six more then and at 12:00. You had to go around every 30 minutes . . . And, initially, we had four officers per pod. And by the time we left, when I was really hurting is when we got short. And like I said, I've counted up I had done 36 flights of stairs before midnight, and that's just starting shift. (T.10-11).

Petitioner further testified to wearing a heavy duty equipment belt which held "a radio, which is one of the fairly heavier ones, it's a Motorola flashport, and I generally had two sets of handcuffs and two sets of keys, which doesn't sound heavy, because people think of keys, they're not thinking of those big..." (T.12). Petitioner's testimony with respect to his hip pain and having to climb flights of stairs and wear a heavy duty equipment belt during work was consistent with the evidence in the arbitration record, including the medical records and Respondent's evidence.

Traversing stairs is a neutral risk. *See Vill. of Villa Park v. Ill. Workers' Comp. Comm'n*, 2013 IL App (2d) 130038WC, ¶ 20. Neutral risks – risks that have no particular employment characteristics – generally do not arise out of the employment and are compensable under the Act only where the employee was exposed to the risk to a greater degree than the general public. (Citation omitted). Such an increased risk may be either qualitative, such as some aspect of the employment which contributes to the risk, or quantitative, such as when the employee is exposed to a common risk more frequently than the general public. *McAllister v. Ill. Workers' Comp. Comm'n*, 2019 IL App (1st) 162747WC, ¶ 28.

I find Petitioner's act of climbing stairs a neutral risk that was increased both qualitatively and quantitatively. Petitioner was exposed to a qualitative increased risk when performing his patrolling duties, which required Petitioner to traverse numerous flights of stairs while wearing his equipment belt. Petitioner was also exposed to a quantitative increased risk. It is undisputed that Petitioner was required to climb flights of stairs on a frequent basis during his work shift. As such, Petitioner was exposed to the risk to a greater degree than the general public, and I therefore find his injury compensable under the Act.

With respect to causation, it is well-settled that a work-related injury need not be the sole or principal causative factor, as long as it was a causative factor in the resulting condition of ill-being. *Sisbro, Inc. v. Indus. Comm'n*, 207 Ill. 2d 193, 205 (2003). Thus, even if a claimant had a pre-existing condition which made him more vulnerable to injury, recovery for an accidental injury will not be denied as long as he can show that his employment was also a causative factor. *Id.* at 205. In this claim, Respondent's Section 12 examiner, Dr. Richard Johnston, did not believe that Petitioner's tight iliotibial bands were caused by Petitioner's job duties. However, he did agree that Petitioner's job duties could aggravate the tight bands on both hips. (RX4, pgs. 13-14). Therefore, I find that Petitioner's employment was a causative factor in the resulting

condition of ill-being to Petitioner's hips.

Dr. Johnston diagnosed Petitioner with bilateral trochanteric bursitis. Noting Petitioner's diagnosis, his treatment history by way of pain medication, physical therapy, and injections to both hips, as well as the evidence of disability as corroborated by the medical records, I would award Petitioner five-percent (5%) loss of use of each leg.

In light of the foregoing, I respectfully dissent from the Majority's decision.

D. Douglas McCarthy

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

FORNEAR, STEVEN
Employee/Petitioner

Case# **12WC020476**

MENARD C C
Employer/Respondent

20IWCC0301

On 7/16/2019, 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 2.01% 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:

1167 WOMICK LAW FIRM CHTD
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501 RUSHING DR PO BOX 1187
HERRIN, IL 62948

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

0558 ASSISTANT ATTORNEY GENERAL
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ATTORNEY GENERAL
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1350 CENTRAL MANAGEMENT SERVICES
BUREAU OF RISK MANAGEMENT
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

JUL 16 2019

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

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

STEVEN FORNEAR
Employee/Petitioner

v.

MENARD C.C.
Employer/Respondent

Case # **12** WC **20476**

Consolidated cases: _____

20IWCC0301

An *Application for Adjustment 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 **5/15/19**. 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 **4/26/12** Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner *did 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 $**59,483.84**; the average weekly wage was $**1143.92**

On the date of accident, Petitioner was **55** years of age, *married* with **0** dependent children.

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

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

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

Respondent is entitled to a credit of $**any benefits paid through group** under Section 8(j) of the Act.

ORDER

The Arbitrator finds that Petitioner did not suffer a work accident on April 26, 2012 that arouse out of his employment. Petitioner alleges injures to his bilateral hips from repetitive walking and standing. The Commission has held that the mere act of repetitive standing or repetitive walking does not constitutes an accident as contemplated under the Workers' Compensation Act. Cady v. State of Illinois Menard C.C., 12 IL. W.C. 10991, 13 IWCC 981, 2103 WL 6516490.

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

7/15/19
Date

JUL 16 2019

Steven Fornear v. Tamms C.C., 12 WC 204076

The Arbitrator makes the following findings of fact:

This is a decision on a repetitive walking/standing claim. The issues in dispute are accident, causation and medical care.

The petitioner, a 59-year-old employee from the Tamms Correctional Center, alleges accidental injuries to his bilateral hips stemming from repetitive trauma with an effective date of loss of April, 26, 2012. (Arb. Ex. 2) The Petitioner worked for Respondent for more than 15 years as a correctional officer.

Petitioner testified that standing on concrete floors aggravated his hip and caused pain.

On June, 13, 2012, Petitioner filed his Application for Adjustment of Claim in this matter.

Petitioner has treated at St. Francis Medical Center, Orthopedic Institute of Southern Illinois, Community Health and Emergency Services for his condition. (Px. 1, 2 and 3)

Petitioner first saw Dr. C. David Wood at the Orthopedic Institute of Southern Illinois on August 9, 2010 for his bilateral hip pain. (Px. 2) At this visit, Petitioner completed a health history which stated that this was not a workers' compensation claim and that his hip pain was the result of no know injury and that the pain got worse over time. (Id.)

Petitioner was diagnosed as having bilateral trochanteric bursitis. (Id.) He received corticosteroids injections in his bilateral hips and physical therapy. (Id.) Petitioner continued to treat with Dr. Wood until 2017. (Id.) Petitioner has received injections in his hips over the years. In 2012 and 2015 endoscopic surgery was offered to explore the area, which Petitioner has declined.

The records of Petitioner' treating physician are devoid of any causation opinion linking Petitioner's bilateral hip condition to his work duties. (Px. 1, 2, and 3)

Respondent had Petitioner examined by Dr. Richard Johnston pursuant to Section 12. (Rx. 2, 3) Dr. Johnston testified via deposition and stated that the Petitioner's work for the State of Illinois did not cause Petitioner's bilateral hip condition. (Rx. 4 at 14) Dr. Johnston testified that Petitioner's walking at work would aggravate the symptoms in Petitioner's bilateral hips.

Dr. Johnston is a board certified orthopedic surgeon. (Id., pg. 5) He treats mostly hip and knee conditions in his practice. (Id.) Dr. Johnston testified that Petitioner could work full duty.

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

A claimant must prove by the preponderance of credible evidence all elements of the claim in order to receive compensation under the Act. Orisini v. Industrial Commission, 117 Ill. 2d 38, 44-45, 509 N.E.2d 1005, 109 Ill. Dec. 166 (1987). In cases involving the repetitive trauma concept, the petitioner must show the injury arose out of and in the course of his employment and was not the result of a normal degenerative aging process. Peoria County Bellwood Nursing Home v. Industrial Commission, 115 Ill. 2d 524, 505 N.E.2d 1026, 106 Ill. Dec.235 (1987).

Simply performing work over a period of years is not legally sufficient to prove that work is repetitive enough to cause an increased to the petitioner. Id.

The Arbitrator also notes a claimant fails to prove a causal relationship through repetitive trauma where the medical opinion upon which they have relied is based upon incorrect or incomplete information about the claimant's job duties. See, e.g., Lon Dale Beasley v. Decatur Public School #61, 03 IIC 301; Jerry Wiser v. American Steel Foundries. 02 HC 310; Vicki Staley v. BroMenn Lind Medical Hills Internists, 99 IIC 539.

The Commission has determined a claimant fails to prove causation from repetitive trauma when the treating physician testified repetitive motions caused the injuries but failed to detail what repetitive motions the petitioner engaged in and the frequency of the motions. Gambrel v. Mulay Plastics, 97 IIC 238.

Additionally, in cases involving a repetitive trauma theory, the claimant generally relies on medical testimony to establish a causal connection between the claimant's work and the claimed disability. See, e.g., *Peoria County Bellwood,* 115 Ill.2d 524 (1987); *Quaker Oats Co.* v. *Industrial Commission,* 414 Ill.2d 326 (1953). When the question is one specifically within the purview of experts, expert medical testimony is mandatory to show claimant's work activities caused the condition of which the employee complains. See, e.g., *Nunn v. Industrial Commission*, 157 Ill. App. 3d 470, 478 (4th Dist. 1987). The causation of compression neuropathy via repetitive has been deemed to fall in the area requiring such expert testimony. *Johnson v. Industrial Commission*, 89 Ill. 2d 438 (1982).

The right to recover benefits cannot rest upon speculation or conjecture. *County of Cook v. Industrial Commission*, 68 Ill. 2d 24 (1977).

The Commission decision Clay v. Hill Correctional Center, 12 I.W.C.C. 0152, is instructive to this case. In Clay, the Commission noted that testimony of locking and unlocking hundreds of doors was unpersuasive testimony to show that those job duties aggravate carpal tunnel syndrome when there is no mention of the force required to do

these activities. (Id.) Likewise, in this case there is no testimony about the force to perform any of the activities listed by Petitioner.

The Arbitrator also notes he testimony of Dr. Johnston that Petitioner's condition is not related or caused by his works duties. Petitioner's treating doctor records do not contain any causation opnion.

Dr. Johnston explained that Petitioner's smoking habit exacerbated the condition. (Rx. 4, pg. 17)

For the above reasons, Petitioner's claim fails.

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

Based upon the above, paragraph F is moot.

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

Based upon the above, paragraph J is moot.

Therefore, the Arbitrator concludes that:

1. Petitioner failed to prove an accident that arose out of his employment.
2. Benefits are denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DALE FLYNN,

Petitioner,

vs.

NO: 16 WC 32539
17 WC 23547 (cons.)

ILLINOIS DEPARTMENT OF TRANSPORTATION,

Respondent.

20IWCC0302

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 20, 2019 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $951.85 per week for a period of 37 5/7 weeks, representing June 3, 2016 through October 2, 2016; February 4, 2017 through June 8, 2017; and July 25, 2017 through August 20, 2017, those being the periods of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay reasonable and necessary medical services related to the right knee from May 19, 2016 through August 17, 2017, pursuant to Section 8(a) and subject to Section 8.2 of the Act.

20IWCC0302

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $775.18 per week for a period of 43 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused a 20% loss of use of the right leg.

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

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

Pursuant to Section 19(f)(1), this decision is not subject to judicial review.

DATED: JUN 4 – 2020

L. Elizabeth Coppoletti

LEC/ck

O: 5/19/2020

43

L. Elizabeth Coppoletti

Stephen Mathis

D. Douglas McCarthy

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

FLYNN, DALE
Employee/Petitioner

Case# **16WC032539**

17WC023547

IDOT
Employer/Respondent

20IWCC0302

On 2/20/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

2333 WOODRUFF JOHNSON & EVANS
JAY JOHNSON
4234 MERIDIAN PKWY SUITE 134
AURORA, IL 60504

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

4138 ASSISTANT ATTORNEY GENERAL
WARREN A WILKE
500 S SECOND ST
SPRINGFIELD, IL 62706

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

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

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

FEB 20 2019

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

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

DALE FLYNN,
Employee/Petitioner

v.

IDOT,
Employer/Respondent

Case # **16** WC **32539**

Consolidated cases: **17 WC 23547**

20IWCC0302

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Maureen Pulia**, Arbitrator of the Commission, in the city of **Springfield**, on **1/24/19**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **5/19/16 and 2/1/17**, 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 5/19/16 ad 2/1/17, 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 as it relates to his right knee ***is*** causally related to the accident on 2/1/17. Petitioner's current condition of ill-being as it relates to his right knee from 5/19/16 through 1/31/17 is causally related to the injury on 5/19/16.

In the year preceding the injuries, Petitioner earned $**74,244.00**; the average weekly wage was $**1,427.77**.

On 5/19/16, Petitioner was **53** years of age, ***married*** with **no** dependent children.

On 2/1/17, Petitioner was **54** years of age, ***married*** with **no** dependent children.

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

Respondent ***has or shall*** pay all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $**34,402.21** for TTD, $**00.00** for TPD, $**00.00** for maintenance, and $**27,158.25** for other benefits, for a total credit of $**61,560.46**.

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 $951.85/week for 37-5/7 weeks, commencing 6/13/16 through 10/2/16, 2/4/17 through 6/8/17, and 7/25/17 through 8/20/17 as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services related to the right knee from 5/19/16 through 8/17/17, as provided in Section 8(a) and Section 8.2 of the Act.

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

Respondent shall pay Petitioner permanent partial disability benefits of $775.18/week for 43 weeks, because the injuries sustained caused the petitioner 20% loss of the right knee, as provided in Section 8(e) of the Act.

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

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

Signature of Arbitrator

2/8/19
Date

ICArbDec p. 2

FEB 20 2019

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a highway maintainer, sustained accidental injuries to his right knee on 5/19/16 (16 WC 32539) and 2/1/17 (17 WC 23547) that arose out of and in the course of his employment by respondent. Petitioner has worked for respondent for 16 years. On 5/19/16 petitioner was 53 years old, and on 2/1/17 was 54 years old. As a highway maintainer petitioner's job duties are varied and include working on the roads and performing other various jobs. These jobs include cutting brush; running a chainsaw, snow plow, unloader, and grater; screeding concrete; and, performing maintenance on trucks and equipment. Petitioner denied any problems with, or treatment for, his right knee prior to 5/19/16.

On 5/19/16 petitioner was screeding concrete on his hands and knees on a hard asphalt road. This involved holding and moving a board to level the concrete, and moving his knees back and forth and from side to side as he screed the concrete.

After petitioner completed his shift he went home and his right knee was sore and swollen. He reported the incident to his supervisor. On 5/24/16 petitioner completed the Workers' Compensation Employee's Notice of Injury form. He indicated that he reported the injury on 5/22/16 to Steve Cantrell. He noted that he "told Steve Friday it was sore but didn't realize till Friday night it was swollen". He noted that the duties he was performing at the time of injury were "pouring concrete on IL 78 by Indian Creek. I was on the screed board on my hands and knees screeding concrete". He noted "I was on hands and knees running screed board for approximately 4 hours and felt knees getting sore but thought it would go away". Jennifer Boisselle completed a Form 45 for TriStar. She noted that petitioner was on his hands and knees running a 2x4 across the top of concrete to level it out and noticed soreness by the end of the day. The next day it was still sore, and on Friday evening his right knee was swollen. She noted that body motion was the object or substance that directly harmed petitioner. On 5/26/16 the Supervisor's Report of Injury or Illness was completed. The accident was described as "Employee was screeding concrete on the roadside. He was on his knees and one became sore." Petitioner continued working and his right knee continued to be painful. He presented to Dr. Malcott his primary care physician, who referred him to Dr. Werries. On 5/26/16 petitioner underwent x-rays of the right knee. The impression was probable joint body.

On 6/13/16 petitioner presented to Dr. Werries, an orthopedic surgeon. Petitioner complained of pain in the anterior and posterior right knee. He rated his pain at a 6-7/10 and constant. He reported instability and swelling of the right knee. He also reported numbness and tingling in the posterior knee, as well as popping, catching, and pain at night. Dr. Werries reviewed the x-rays and was of the opinion

that petitioner had minimal arthritic changes and evidence of effusion, and possible loose body. He examined petitioner and assessed effusion of the right knee. Petitioner was restricted from squatting, kneeling or climbing. An MRI of the right knee revealed a horizontal tear and degeneration of the posterior horn of the medial meniscus with associated small parameniscal cyst; mild tricompartmental osteoarthritis greatest in the medial compartment; 11 mm loose body in the posterior joint recess; delaminating cartilage flap at the apical ridge of the patella where there is surrounding fibrillation and focal high grade articular cartilage loss on background of mild extensive articular cartilage loss; moderate knee joint effusion; and popliteus tendinosis. Dr. Werries reviewed the MRI and assessed an acute medial meniscus tear of the right knee. He recommended a right knee arthroscopy and respondent authorized said surgery.

On 7/21/16 petitioner underwent a right knee arthroscopic partial medial meniscectomy performed by Dr. Werries. His postoperative diagnosis was right knee medial meniscus tear and grade 3A chondromalacial changes of the medial femoral condyle and femoral trochlea. Petitioner followed-up post-operatively with Dr. Werries. This treatment included a course of physical therapy.

On 7/29/16 petitioner was released to sitting work only, but respondent could not accommodate. On 8/29/18 petitioner reported pain with steps and walking down inclines. Dr. Werries restricted petitioner from climbing for 4 weeks. On 9/30/16 petitioner reported soreness after doing physical therapy. He also reported popping in his right knee. Dr. Werries released petitioner to work without restrictions. He prescribed Celebrex for pain and stiffness and encouraged him to transition to home exercise program. On 10/12/16 petitioner reported that once he returned to work he noticed popping and increased pain. He reported popping with sharp pain when riding the mower at work. He also reported pain getting on and off the mower. He continued petitioner on Celebrex and ordered a brace for him. He also performed a cortisone injection to help with patellofemoral symptoms and the pain petitioner was having. He restricted petitioner from squatting and climbing for 3 weeks. On 11/2/16 petitioner reported that the injection did not help. He continued with pain and popping of the right knee. Dr. Werries instructed petitioner to continue with his home exercises and wear his brace. He released petitioner to work with no restrictions on 11/7/16. A Synvisc ONE injection was recommended to help with pain. This was performed on 11/18/16. On 12/16/16 petitioner reported that the Synvisc injection did not help. He reported pain with or without the brace. He reported that his right knee was more painful if he steps on an incline. He stated that he stopped Celebrex due to GI upset. Mild atrophy was noted. Dr. Werries prescribed Meloxicam. He also referred petitioner to Dr. Allan for a 2nd opinion. 6-7/10. On 1/27/17

petitioner reported to Dr. Werries that his right knee was continuing to hurt him especially with walking and sitting. He rated his pain at a 6-7 on a scale of 10. Dr. Werries recommended a Hyalgan injection, but work comp denied.

On 2/1/17 petitioner was at a brush pile picking up excess brush. His feet got tangled in the brush and petitioner fell directly on his right knee. Following this injury petitioner's right knee became worse. Petitioner reported this injury to his supervisor. Petitioner initially sought treatment following this injury at Prompt Care. He was given a brace and crutches and taken off work. He was referred back to Dr. Werries.

On 2/6/17 petitioner returned to Dr. Werries. He reported increased pain after falling on his right knee on 2/1/17. He reported that the pain was at the medial aspect of the right knee. He also reported increased pain with sitting for long periods of time. He reported pain above and below the knee. He stated that he struck the anterolateral aspect of his right knee when he fell. Dr. Werries prescribed Tramadol and performed an injection. He released petitioner to a sitting job for 2 weeks. Respondent could not accommodate. On 2/20/17 petitioner reported no relief from the injection. He complained of increased pain with walking long distances, and when pushing off to take a step. Dr. Werries referred petitioner to Dr. Allan for possible surgical procedures. Petitioner was restricted from climbing or going up steep slopes.

On 3/8/17 petitioner presented to Dr. Allan. Petitioner provided a history of his injuries and treatment to date. Dr. Allan examined petitioner and assessed arthralgia of the right knee, and patellofemoral arthritis and possible lateral meniscal tear. An MRI was ordered. Petitioner was released to work with restrictions of no climbing or going up steep slopes. On 4/7/17 petitioner underwent an MRI of the right knee. Dr. Allan's impression was chondral defect of the patella, that most of the middle and posterior medial meniscus had been resected, that the lateral meniscus was intact, and loose body posteriorly. The official report showed 9 x 5.5 mm focus of near full thickness chondromalacia of the junction of the median ridge and lateral facet of the mid patella that was similar to the prior MRI; Grade 2 chondromalacia weightbearing medial femoral condyle and corresponding medial tibial plateau; Grade 2 chondromalacia more anterior aspect of the lateral femoral condyle towards the trochlea; the medial meniscus demonstrated postsurgical change of the midbody and posterior horn with diffuse intrasubstance intermediate signal (while a tear is difficult to exclude in a postoperative patient, there is no linear signal reaching fluid intensity that would be more suggestive of a new tear); moderate effusion; and 1 cm free body posterior to the PCL was again seen. Petitioner's restrictions remained the same.

On 4/7/17 petitioner returned to Dr. Allan. He continued to complain of pain of the right knee. Dr. Allan was still awaiting the final MRI report of 4/7/17. On 4/21/17 petitioner reported that his condition was unchanged. Dr. Allan reviewed the MRI and his examination findings and assessed arthralgia of the right knee and an acute medial meniscus tear of the right knee, subsequent encounter. Dr. Allan recommended a right knee arthroscopy with medial meniscectomy.

On 5/15/17 the petitioner underwent a Section 12 examination performed by Dr. Michael Nogalski, at the request of the respondent following correspondence of 5/6/17. Dr. Nogalski examined petitioner with respect to his right knee injury on 5/19/16. Petitioner provided a consistent history of the accidents and treatment to date. Dr. Nogalski examined petitioner and reviewed x-rays from 3/8/17 and an MRI from 6/22/16 and 4/7/17. He also reviewed relevant medical records related to petitioner's right knee after 5/19/16, and accident reports for each injury. Dr. Nogalski's assessment was status post right knee arthroscopy and debridement with loose bodies and chondromalacia of the patellofemoral joint and medical compartment, ongoing symptoms related to chondromalacia and degenerative disease of the patellofemoral compartment and medial compartment. He noted no clear mechanical findings suggesting any acute internal derangements, specifically referencing the claimed injury on 2/1/17.

Dr. Nogalski was of the opinion that there did not appear to be any specific acute findings that correlate with a discrete injury, nor did petitioner's description of his activities identify that the type of conditions observed by Dr. Werries at surgery came from or were specifically aggravated by this condition. He was further of the opinion that the accident on 2/1/17, as noted in the medical records, supports that there was a twisting injury and a fall, which might or could have aggravated his knee condition. Dr. Nogalski was of the opinion that petitioner appeared to be at a relative baseline from an objective standpoint on MRI and also from his examination findings by Dr. Werries and Dr. Allan. He noted that there did not appear to be a significant change in his symptoms, and his symptoms appeared to be consistent with the breakdown of the articular surfaces of the patellofemoral and medial compartments. Dr. Nogalski was of the opinion there is no causal connection between petitioner's current objective findings and the reported accidents of 5/19/16 or 2/1/17. He was of the opinion petitioner had had cartilage breakdown and this manifested itself as an inflammatory condition within the knee which reasonably can continue to cause problems. He believed petitioner's event of 5/19/16 was innocuous and while it might stress or irritate the knees with respect to kneeling, there is no description nor objective finding of a discrete activity/injury that would reasonably provide enough force or strain to cause him to have joint surface cartilage breakdown, meniscal tears, nor loose bodies. Dr. Nogalski was

of the opinion that petitioner would have some intermittent flare ups and problems with his right knee. He did not believe a repeat arthroscopy appeared to be a conclusively optimal course of action given his moderate response previously. However, he did believe removal of some of the articular cartilage within the knee may help him and alleviate symptoms. He recommended no restrictions but believed petitioner would have some difficulties with squatting and kneeling, but did not feel these activities should be restricted. He believed petitioner could return to full duty work. Dr. Nogalski placed petitioner at maximum medical improvement with respect to both injuries. He believed any progression of petitioner's articular cartilage breakdown was a normal history sequela of this condition.

On 7/25/17 petitioner underwent a right knee arthroscopy with chondroplasty of femoral sulcus and posterior medial femoral condyle, performed by Dr. Allan. His postoperative diagnosis was chondromalacia Grade 3 of the patella and femoral sulcus, chondromalacia of the posterior medial femoral sulcus Grade 3 prior posterior horn medial menisectomy. Petitioner followed up post-operatively with Dr. Allan.

On 8/2/17 the evidence deposition of Dr. Allan, an orthopedic surgeon, was taken on behalf of petitioner. Dr. Allan testified that the findings he had upon surgery were consistent with petitioner's complaints, but he did not see a true or very impressive tear or instability of the meniscus. He suspected the chondromalacia was giving petitioner his trouble. Dr. Allan opined that the fall on 2/1/17 could have either in whole or in part have aggravated or accelerated a condition in the petitioner's right knee that led to the need for surgery, even though he had underlying degenerative changes from the prior scope.

On cross examination Dr. Allan testified that when he read the MRI in 2017 he thought there might be a tear but had no way of knowing whether it was caused by the surgery or whether it was actually caused by the additional fall. Dr. Allan did not think the cartilage that he described as arthritis would have been caused by the 2/1/17 injury since Dr. Werries noted it before that date. He believed that the findings in Dr. Werries operative report were not caused by someone simply kneeling for 4 hours, unless there were some underlying changes already. However, he believed that there is a lot of twisting and pivoting when one is on the ground moving concrete back and forth. He was further of the opinion that meniscal tears can be asymptomatic. Dr. Allan was of the opinion that complex tears are often degenerative in nature.

Dr. Allan was of the opinion that kneeling for extended periods of time, assuming that there were already loose fragments, could make those loose fragments painful, and conceivably cause an individual to decide to treat. Dr. Allan opined that moving back and forth while kneeling and finishing concrete

might or could aggravate or accelerate a condition in the knee particularly if they had underlying degenerative changes. Dr. Allan was of the opinion that spreading concrete could put some torque on the knees.

On 8/8/17 petitioner reported to Dr. Allan that he had no excessive pain and no swelling. He rated his pain at a 3/10. He reported that he was not using any assistive device for ambulation. Dr. Allan took petitioner off work for an additional 2 weeks.

On 8/14/17 the evidence deposition of Dr. the Nogalski, an orthopedic surgeon, was taken on behalf of respondent. Dr. Nogalski opined that the synovitis in the suprapatellar pouch and cartilage fragments in the suprapatellar pouch were not caused by the accidents. He opined that the complex tear of the posterior horn of the medial meniscus was degenerative and not acute. He further opined that there did not appear to be a mechanism of injury that was consistent with a meniscus tear, Grade 3A chondromalacia, or a strain to the meniscus which would cause the findings as observed at surgery and on the MRI. Dr. Nogalski opined that petitioner sustained a temporary aggravation of his preexisting condition on 2/1/17. He further opined that neither surgery was related to the injuries on either 5/19/16 or 2/1/17. Dr. Nogalski noted that Dr. Werries referenced an acute medial meniscus tear when he examined petitioner on 9/13/16. Dr. Nogalski was of the opinion that the kneeling event petitioner experienced was one of many issues both at home and at work that could cause one to experience symptoms. He opined that petitioner's surgery was not related to kneeling, nor would it be related to that single activity of one day's work on 5/19/16. Dr. Nogalski was of the opinion that many people that work 16 years on their hands and knees that have better cartilage and do not have symptoms. However, he also admitted that this force is certainly a greater force than someone who sits at a desk.

On 8/17/17 petitioner last followed up with Dr. Allan. He reported pain of 1-2/10. He reported that he was ready to return to work. He also reported that he was able to return to riding a bike which he was not able to do for over a year. ROM showed restricted 125 degrees active flexion and restricted 0 degrees active extension. An exam also showed no weakness with flexion or extension. Dr. Allan released petitioner to work without restrictions on 8/21/17. Petitioner was released on an as needed basis.

On 1/31/18 Dr. David Fletcher, an occupational medicine specialist, performed an examination of petitioner, at the request of the petitioner's attorney. As part of his examination he reviewed the records of Dr. Werries, Dr. Allan, Dr. Malcott and Dr. Nogalski. Petitioner gave a history of finishing concrete on 5/19/16 screeding concrete on his hands and knees running a screed board back and forth over poured concrete. He noted that the surface was gravel and dirt and he had to twist back and forth on

his knees. Later that night he noticed that his right knee was swollen and painful. He also reported that on 2/1/17 while clearing some brush at work petitioner fell directly on his right knee. Following his examination and record review Dr. Fletcher diagnosed a right knee medial meniscus tear superimposed on pre-existing degenerative osteoarthritis/chondromalacia. He opined that the incident of 5/19/16 was the causative need for his initial knee surgery and caused petitioner's acute meniscus tear superimposed on preexisting degenerative changes. He further opined that the incident on 2/1/17 was the causative need for petitioner's 2nd surgery, that aggravated and accelerated his preexisting condition. He opined that there is definitely an objective change in petitioner's physical exam findings after the second incident. He also noted that there were definite changes in petitioner's subjective complaints that were worse, and his examination showed new acute findings. Dr. Fletcher did not believe the 2nd surgery was inevitable and causally related to the 5/19/16 event, but did believe that the 2nd incident caused the necessity for his 2nd surgery, not the initial 5/19/16 incident. Dr. Fletcher was of the opinion that petitioner had reached maximum medical improvement.

On 9/10/18 the evidence deposition of Dr. Fletcher was taken on behalf of the petitioner. Dr. Fletcher is board certified in occupational medicine and preventative medicine. Dr. Fletcher testified that he is very familiar with petitioner's job duties. He was of the opinion that screeding concrete is done on hands and knees and is a very, very labor intense activity that requires crawling around on cement, basically making sure the concrete is scraped in a very clear fashion. He was of the opinion that it requires twisting around the back, crawling around on the knees, and squatting. He noted that it is a very physical activity that requires a rocking motion back and forth on the hands and knees causing pressure on the patellofemoral joint and prepatellar bursa. He was of the opinion that people also develop meniscal type of injuries as a result of the twisting that goes on. He believed that it is sort of a repetitive twisting because of the kneeling and squatting positions they do. He was of the opinion that this duty puts force on the patellofemoral joint in the front part of the knee, and a lot of loading on the meniscus structures, both the lateral and medial meniscus, which are shock absorbers between the femur and the lower part of the leg, with the fibula/tibia. He testified that he saw no evidence of any records indicating that petitioner had preexisting right knee problems prior to 5/19/16. Dr. Fletcher was of the opinion that petitioner had degenerative changes in his right knee as of 5/19/16. Dr. Fletcher was of the opinion that petitioner had an acute injury evidenced by the horizontal tear in his posterior horn of his medial meniscus, had loose body present, and had joint effusion. Dr. Fletcher opined that petitioner had an acute injury on an asymptomatic preexisting degenerative joint disease.

With respect to the injury on 2/1/17 Dr. Fletcher was of the opinion that there was a complete change in symptoms after 2/1/17 consistent with the mechanism of injury petitioner reported. He opined that the injury on 2/1/17 was an acute injury superimposed on preexisting degenerative changes (preexisting chondromalacia). He opined that the MRI and operative findings were different from before the injury. He opined that the operative findings were consistent with the mechanism of injury. Dr. Fletcher did not agree with Dr. Nogalski's opinion that the second injury was only a temporary aggravation because without the 2nd surgery petitioner would not be back to work. Dr, Fletcher testified that Dr. Nogalski could not state that the aggravation was temporary since petitioner was still symptomatic and not working when he examined him.

On cross examination Dr. Fletcher testified that the rocking type of motion while doing the screeding activity causes a lot intraarticular joint forces and leads to an overload of the meniscal structures, which can break down and cause an acute injury. He further testified that if you have someone that has got an osteoarthritic joint, you can have loosening of the cartilage and actually have one of the pieces of cartilage break off and have a loose body like what happened with petitioner.

Petitioner testified that he has not seen Dr. Allan since he was released from his care. He denied any problems with or treatment for his right knee prior to 5/19/16. He testified that today he cannot walk as far as he used to. He testified that he used to be able to walk a mile and can now walk a half mile without pain. He testified that walking down slopes bothers him at work and in his daily activities. At work petitioner gets down on the creeper by sitting on the ground first and not by kneeling on his knees. He stated that his job takes longer. He testified that he puts ice on his right knee about three times after work. Petitioner takes no prescriptions for his pain. He rates his pain at a 4-5/10. Petitioner is working the same job and making the same pay as he was prior to the injuries.

Petitioner testified that he was not wearing any knee pads when he was screeding on 5/19/16 because he was never given any by respondent.

F. IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?

5/19/16 Date of Accident 16 WC 32539

It is unrebutted that on 5/19/16 petitioner sustained an injury to his right knee while screeding concrete for four hours with no kneepads on his knees kneeling on asphalt. It is also unrebutted that prior to 5/19/16 petitioner had an asymptomatic degenerative right knee. Petitioner presented unrebutted testimony that screeding concrete involves more than simply kneeling on the ground. He testified that

screeding concrete involves kneeling on his hands and knees, using his hands to run the screed board over the concrete back and forth and side to side, while his knees move in synch with his hands back and forth and side to side. While petitioner was performing this activity for 4 hours on 5/19/16 he noticed pain in his right knee that included swelling in his right knee by later that night. Petitioner reported the injury, and as the days went by his condition worsened.

Casual connection opinions between petitioner's right knee condition and this activity were offered into evidence by Dr. Allan, petitioner's treating physician; Dr. Nogalski, respondent's examining physician; and Dr. Fletcher, petitioner's examining physician.

Dr. Allan opined that the findings in Dr. Werries operative report were not caused by someone simply kneeling for 4 hours, unless there were some underlying changes already present, which in petitioner's case were already present. Dr. Allan also believed that there is a lot of twisting and pivoting when one is on the ground moving the concrete back and forth. Dr. Allan was of the opinion that kneeling for extended periods of time, assuming that there were already loose fragments, could make those loose fragments painful, and conceivably cause an individual to decide to treat. Dr. Allan opined that moving back and forth while kneeling and finishing concrete could aggravate or accelerate a condition in the knee, particularly if that person had underlying degenerative changes. He was of the opinion that spreading concrete can put some torque on the knees.

Dr. Nogalski opined that there is no causal connection between petitioner's objective findings and the accident on 5/19/16. He believed petitioner's event on 5/19/16 was innocuous and while it may stress or irritate the knees with respect to kneeling, there is no description nor objective finding of a discrete activity/injury that would reasonably provide enough force or strain to cause him to have joint surface cartilage breakdown, meniscal tears, or loose bodies. He believed the kneeling event of 5/19/16 was one of many issues at home and at work that could cause one to experience symptoms, but not necessitate surgery, but then admitted that the force on the petitioner's knees that is associated with screeding is greater than for someone sitting at a desk.

Dr. Fletcher opined that the incident of 5/19/16 was the causative need for petitioner's initial knee surgery and caused his acute meniscus tear superimposed on his preexisting degenerative changes. Dr. Fletcher was of the opinion that screeding concrete is done on hands and knees and is a very, very labor intense activity that requires crawling around on cement, basically making sure the concrete is scraped in a very clear fashion. He was further of the opinion that screeding requires twisting around the back, crawling around the knees, and squatting. It also requires a rocking motion back and forth on the hands

and knees causing pressure on the patellofemoral joint and prepatellar bursa. Dr. Fletcher was also of the opinion that people develop meniscal type of injuries as a result of the twisting that goes on. Dr. Fletcher was of the opinion that although petitioner had no problems with, or treatment for his right knee prior to 5/19/16, he did have preexisting degenerative changes in the right knee. He opined that the petitioner had an acute injury that was evidenced by the horizontal tear in his posterior horn of his medial meniscus, the loose bodies present, and the joint effusion. As a result, he opined that the 5/19/16 accident was an injury on an asymptomatic preexisting degenerative joint disease that resulted in petitioner's need for the 1st surgery. Dr. Fletcher testified that the rocking type of motion while screeding concrete causes a lot of intraarticular joint forces and leads to an overload of the meniscual structures, which can break down and cause an acute injury.

Based on the above, as well as the credible evidence, the arbitrator finds that both Dr. Allan and Dr. Fletcher had a clearer understanding of petitioner's mechanism of injury than did Dr. Nogalski. Both Dr. Allan and Dr. Fletcher understood that screeding concrete required a rocking type of motion with the hands and knees, as well as torqueing of the knees in order to screed the concrete. The arbitrator finds it significant that petitioner was performing this activity for 4 hours without any knee pads on an asphalt surface. The arbitrator also finds it significant that both Dr. Allan and Dr. Fletcher believed petitioner had an asymptomatic preexisting degenerative condition in his knee that was made symptomatic by the 4 hours of concrete screeding on 5/19/16 and resulted in a knee that became symptomatic and remained symptomatic.

The arbitrator finds Dr. Fletcher and Dr. Allan had a clearer understanding of the mechanism of injury as it relates to the injury on 5/19/16 and petitioner's preexisting degenerative knee condition. As such, the arbitrator adopts the opinions of Dr. Fletcher and Dr. Allan finding them more persuasive than those of Dr. Nogalski, thus finding petitioner's current condition of ill-being as it relates to his right knee causally related to the injury on 5/19/16 through 1/31/17.

2/1/17 Date of Accident 17 WC 23547

It is unrebutted that on 2/1/17 petitioner was picking up excess brush at a brush pile and his feet got tangled in the brush and he fell directly on his right knee. Following this injury it is documented that his right knee complaints worsened. He reported pain above and below the knee, at the medial aspect of the right knee, and increased pain with sitting for long periods of time.

Casual connection opinions between petitioner's right knee condition and this activity were offered into evidence by Dr. Allan, petitioner's treating physician; Dr. Nogalski, respondent's examining physician; and Dr. Fletcher, petitioner's examining physician.

Dr. Allan opined that the findings upon surgery were consistent with petitioner's complaints. He opined that the fall on 2/1/17 could either in whole or in part have aggravated or accelerated a condition in the petitioner's right knee that led to the need for surgery, even though he had underlying degenerative changes from the prior scope.

Dr. Nogalski opined that the accident on 2/1/17, as noted in the medical records, supports that there was a twisting injury and a fall, which might or could have aggravated his knee condition. However, he then goes to opine that the fall on 2/1/17 only caused a temporary aggravation of his preexisting condition on 2/1/17. The arbitrator gives little weight to this opinion given that petitioner's condition following the injury on 2/1/17 did not improve until after his second surgery on 7/25/17.

Dr. Fletcher was of the opinion that there was a complete change in symptoms after the 2/1/17 injury consistent with the mechanism of injury petitioner reported. He further opined that the MRI and operative findings were different from before the injury, and the operative findings were consistent with the mechanism of injury. Dr. Fletcher did not agree with Dr. Nogalski's opinion that the second injury was only a temporary aggravation because without the 2nd surgery petitioner would not be back to work. He further noted that Dr. Nogalski could not state that the aggravation was temporary since petitioner was still symptomatic and not working when he examined him.

Based on the above, as well as the credible evidence, the arbitrator finds the opinions of Dr. Nogalski inconsistent and the opinions of Dr. Allan and Dr. Fletcher more persuasive and consistent with the credible evidence. As such, the arbitrator finds the petitioner's current condition of ill-being as it relates to his right knee causally related to the injury on 2/1/17.

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?

5/19/16 Date of Accident 16 WC 32539

Having found petitioner's current condition of ill-being as it relates to his right knee causally related to the injury on 5/19/16 through 2/1/17, the arbitrator finds all medical services petitioner received for his right knee from 5/19/16 through 1/31/17 were reasonable and necessary to cure or relieve petitioner from the effects of the injury on 5/19/16. As such, the respondent shall pay all reasonable and

necessary medical expenses related to the petitioner's right knee from 5/19/16 through 1/31/17 pursuant to 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.

2/1/17 Date of Accident 17 WC 23547

Having found petitioner's current condition of ill-being as it relates to his right knee causally related to the injury on 2/1/17, the arbitrator finds all medical services petitioner received for his right knee from 2/1/17 through 8/17/17 were reasonable and necessary to cure or relieve petitioner from the effects of the injury on 2/1/17. As such, the respondent shall pay all reasonable and necessary medical expenses related to the petitioner's right knee from 2/1/17 through 8/17/17 pursuant to 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.

K. WHAT TEMPORARY BENEFITS ARE IN DISPUTE?

Petitioner alleges that he was temporarily totally disabled from 6/3/16 through 10/2/16, 2/4/17 through 6/8/17, and 7/25/17 through 8/18/17, for a period of 37-3/7 weeks. Respondent disputes this claim on the basis of liability arguing that there is no causal connection between the petitioner's current condition of ill-being as it relates to his right knee and the injuries on 5/19/16 and 2/1/17. Having found petitioner's current condition of ill-being as it relates to his right knee causally related to the injury on 5/19/16 through 1/31/17, and also finding petitioner's current condition of ill-being as it relates to his right knee causally related to the injury on 2/1/17 through 8/20/17 (the date before Dr. Allan released him to full duty work), the arbitrator finds the petitioner was temporarily totally disabled from 6/3/16 through 10/2/16, 2/4/17 through 6/8/17, and 7/25/17 through 8/20/17, for a period of 37-5/7 weeks.

The arbitrator finds the respondent shall receive credit in the amount of $34,402.21 for temporary total disability benefits paid.

L. WHAT IS THE NATURE AND EXTENT OF THE INJURY?

For injuries that occurred after 9/1/11, according to 820 ILCS 305/8.1B(b) the Commission shall base its determination of permanent partial disability based upon five factors including an AMA report, the occupation

of the injured employee, the age of the employee at the time of injury, the employee's future earning capacity and evidence of disability corroborated by treating medical records.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no AMA rating was offered into evidence. The Arbitrator therefore gives no weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the petitioner was a highway maintainer at the time of the injury, and is currently working this position without restrictions. For these reasons the arbitrator gives lesser weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 53 years old on 5/19/16 and 54 years old on 2/1/17. Following the injury on 5/19/16, petitioner was ultimately returned to work full duty, but continued with ongoing symptomatology and treatment up to and including the injury on 2/1/17. Following the injury on 2/1/17 petitioner told Dr. Allan on 8/17/17 that he was ready to return to work. Dr. Allan returned petitioner to his regular duty job and released him from his care. Petitioner testified that walking down slopes bother him at work. He also now gets down on the creeper by sitting on the ground first and not by kneeling on his knees. He also testified that his job duties take longer to perform. He ices his right knee about three days a week after work. Given his age the arbitrator finds the petitioner could work possibly up to another decade before reaching Medicare retirement age. Therefore, 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 that the petitioner is working his regular duty job and making the same money as he was prior to the injuries. Therefore, the arbitrator gives no weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator finds the petitioner underwent two surgeries as a result of the injuries on 5/19/16 and 2/1/17. The first was a right knee arthroscopic partial medial meniscectomy on 7/21/16, and right knee arthroscopy with chondroplasty of the femoral sulcus and posterior medial femoral condyle on 7/25/17. Following the 2nd surgery petitioner was released to full duty work by Dr. Allan on 8/17/17. At that time petitioner's right knee range of motion showed 125 degrees of active flexion and restricted 0 degrees active extension. An exam showed no weakness with flexion or extension. Petitioner testified that today he cannot walk as far as he used to. He testified that he used to be able to walk a mile and can only now walk a half mile without pain. He testified that walking down slopes bothers him at work and in his daily activities. At work petitioner gets down on the creeper by sitting on the ground first and not by kneeling on his knees. He stated that his job takes longer. Therefore, the arbitrator gives greater to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds the petitioner sustained a permanent partial disability to the extent of 20% loss of use of his right leg pursuant to Section 8(e) of the Act.

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

Matthew Kuhls,

Petitioner,

20IWCC0303

vs.

NO: 18 WC 5317

Radiac Abrasives,

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 6, 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.

Capítulo 1

20IWCC0303

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 $55,300.00. 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: JUN 4 - 2020
o4/2/20
DLS/rm
046

Deborah L. Simpson

Barbara N. Flores

Marc Parker

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

20IWCC0303

KUHLS, MATTHEW
Employee/Petitioner

Case# **18WC005317**

18WC037291

RADIAC ABRASIVES
Employer/Respondent

On 9/6/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0969 RICH RICH & COOKSEY PC
THOMAS C RICH
6 EXECUTIVE DR SUITE 3
FAIRVIEW HTS, IL 62208

2795 HENNESSY & ROACH PC
RICHARD A DAY
415 N 10TH ST SUITE 200
ST LOUIS, MO 63101

20IWCC0303

STATE OF ILLINOIS)
)SS.
COUNTY OF Jefferson)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Matthew Kuhls
Employee/Petitioner

v.

Radiac Abrasives
Employer/Respondent

Case # 18 WC 5317

Consolidated cases: 18 WC 37291

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael Nowak**, Arbitrator of the Commission, in the city of **Mt. Vernon**, on **8/9/19**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **12/27/17**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**41,600.00**; the average weekly wage was $**800.00**.

On the date of accident, Petitioner was **30** years of age, ***married*** with **3** dependent children.

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

Respondent shall be given a credit of $**19,337.88** for TTD, $**0** for TPD, $**0** for maintenance, and $**5,458.04** for other benefits, for a total credit of $**24,795.92**.

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 $10,488.24, as set forth in Petitioner's exhibit 1, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall authorize and pay for prospective medical care as recommended by Dr. Raskas, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $533.33/week for 83 6/7 weeks, commencing 12/29/17 through 7/25/18 (29 6/7 weeks), July 27, 2018 through November 11, 2018, (15 3/7 weeks) and from November 13, 2018, through August 9, 2019 (38 4/7 weeks), 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.

Michael K. Nowak, Arbitrator

8/29/19
Date

ICArbDec19(b)

SEP 6 - 2019

FINDINGS OF FACT

20IWCC0303

Petitioner is a laborer for Respondent, Radiac Abrasives, and has been so employed for approximately 9 years. (T.13) His job entails operating machinery and lifting and/or moving heavy parts. (T.14) He sustained two injuries in the course of his employment, the first on December 27, 2017 (18 WC 05317), and the second on November 12, 2018, (18 WC 37291), when Respondent required him to perform job activities outside of his work restrictions. (T.22; RX1)

On December 27, 2017, Petitioner injured his low back when he was moving a grinding wheel out of a cart. (T.15-16) He testified that the grinding wheels weigh anywhere from 2 to 400 pounds, and he would ordinarily be tasked with moving the heavier wheels on account of his size. (T.16) Petitioner candidly testified that he suffered a prior injury at work involving his lower back, but that he returned to work full duty after his last injury without any restrictions. (T.14) He sustained no accidents or injuries in the interim and estimated that it had been roughly two years prior to the December 2017 accident since he had seen Dr. Raskas, the physician who treated him for the prior injury. (T.15) Petitioner testified that he did not immediately report the injury the day it occurred and went home, because he presumed it was a strain that would go away and did not want to file another workers' compensation claim. (T.17)

When Petitioner woke the following day of December 28, 2017, he was still in pain and decided to report the incident to his supervisor at work. (T.17) He was then moved to assist in operating a Karvit bushing machine, which required him to scrape the inside of produce wheels weighing approximately 8 pounds with a putty knife and then place them on a balancer. (T.38-39) He testified that he continued working until around lunch time, when he left due to being in extreme pain. (T.39-40)

Petitioner thereafter sought medical care and treatment at SSM Occupational Medicine and reported low back pain after he "grabbed a wheel and pulled it off." (T.17-19; PX3, 12/28/17) He attempted to relieve his pain with Biofreeze, Aleve, and Tylenol to no avail. *Id.* He was given Naprosyn and Flexeril and taken off work for one week. *Id.* Petitioner remained symptomatic on follow-up one week later and was placed on light duty. (PX3, 1/4/18) Petitioner thereafter returned to see Dr. Raskas on January 5, 2018, and Dr. Raskas noted Petitioner's new injury as follows:

> Matthew is a 30-year-old male. He is known to us as, seven years ago, he underwent a lumbar laminectomy with discectomy at the L3-L4 segment. His pain seven years ago was equally low back and right leg. The entire right leg was bothering him at that time. After the surgery, his leg and back pain drastically improved. He had 2/10 back pain. His leg pain had resolved. He returned to work as a laborer and continued to work without any issues up until about two years ago. Two years ago, he was involved in a work-related injury when he was moving a heavy item and he noticed predominantly low back pain. This pain was worse at 10/10. He started physical therapy, activity modifications, and his pain improved down to 1-2/10. He returned to work at full duty about six months after that accident. He never had leg pain at the time of that accident which occurred two years ago.
>
> He returns today with a new injury, a similar injury in fact, where he was lifting a heavy object or heavy wheels that can weigh up to 30 pounds in repetitive

> motion that he does several times a day. The pain had worsened in his low back when moving a heavy object on December 28, 2017. It happened in the morning that day. He continued to work throughout the day doing the same activity and his pain significantly worsened. He was hoping that the back pain would just go away. He woke up the following day with severe low back pain, 10/10, and notified his supervisor. The supervisor placed him on light duty. He did that job for about three hours and could not tolerate it any further, and they told him, to go home, and he has been doing light activity at home. He has also been doing stretches and light exercises and his symptoms have not improved. . . (PX4, 1/5/18)

Physical examination demonstrated decreased sensation along the anterior right thigh compared with full sensation on the left, limited lumbar range of motion secondary to pain, and tenderness to palpation of the lumbar soft tissue. *Id.* Petitioner also reported that he had a degree of intermittent numbness and tingling in his right anterior thigh without injury, but these symptoms worsened significantly following the injury on December 28, 2017. *Id.* Dr. Raskas noted that Petitioner's old MRI demonstrated a disc herniation at the L4-5 segment and post-operative changes at L3-4, and he recommended a new MRI to identify any progression or new injury as a result of his December work injury. *Id.* His assessment was lumbar radiculopathy and herniated nucleus pulposus with strain and pain. *Id.* He prescribed physical therapy and took Petitioner off work. *Id.*

The MRI of March 26, 2018, demonstrated disc protrusions with facet arthropathy from L3-4 through L5-S1 contributing to foraminal and canal stenosis in addition to the laminectomy changes at L3-4. (PX5) Petitioner returned to Dr. Raskas on March 27, 2018, at which time Petitioner reported that he was having difficulty standing to make dinner. (PX4, 3/27/18) Dr. Raskas re-reviewed Petitioner's notes from August 21, 2015, through March 10, 2018, compared prior those findings to Petitioner's new MRI, and noted that there were significant inflammatory changes in addition to Petitioner's old pathology. *Id.* Dr. Raskas' impression was post-laminectomy syndrome with an exacerbated herniated disc at L4-5. *Id.* He believed that Petitioner required bariatric surgery, since Petitioner was 30 years old, weighed 535 pounds, and could not lose any weight with traditional measures alone. *Id.* If Petitioner was able to reduce his weight below 300 pounds and remained symptomatic, Dr. Raskas would reevaluate him for further care and treatment. *Id.* He did not believe, however, that a surgical consultation was appropriate for Petitioner at his current weight. *Id.* Dr. Raskas did not believe physical therapy would make a difference in Petitioner's condition and prescribed anti-inflammatory medication. *Id.* With regard to causation Petitioner's work status, he stated, "Presently I do not see how he can return to work. I think that this is due to a combination of his work injury and pre-existing conditions." *Id.*

On June 25, 2018, Respondent had Petitioner examined by Dr. Benjamin Crane. (RX1) His history noted that Petitioner had an excellent recovery and function level following his 2011 operation with Dr. Raskas and stated, "He states he did quite well following that surgery with almost complete resolution of his back and leg pain." *Id.* Petitioner reported constant back pain rated 4 to 5 out of 10 that increased to 8 or 9 out of 10 with activity. *Id.* Dr. Crane's physical examination was positive for back pain and painful range of motion. *Id.* After he reviewed Petitioner's prior records and his current MRI films, Dr. Crane believed that Petitioner sustained worsening of his chronic low back pain. *Id.* He later stated, "At this point in time, it is my opinion that the alleged work injury of 12/28/2017 worsened his low back from a 4-5/10 to now a 5-6/10." *Id.* medication. *Id.* He believed, however, that Petitioner could return to light work with restrictions, and he recommended physical therapy and anti-inflammatory medication with light duty restrictions of no bending, pulling, pushing or stooping.

no lifting anything heavier than 10 pounds, and no overhead lifting. *Id.* He again stated, "[I]t is my opinion that the alleged incident of 12/28/2017, is the prevailing factor in causing his work injury and the need for work restrictions. That being said, his weight does play some role in his current condition but is not the sole reason he is unable to return to work at this time." *Id.*

Petitioner attempted to return to work on July 26, 2018, but he suffered a significant increase in symptoms during his attempt. (T.21) Petitioner presented to SSM Health that day, and the HPI consistently noted that Petitioner had been off work since December and presented with complaints of increased pain after being made to stand while attempting to do light duty work. (PX3, 7/26/18) Petitioner was again taken off work and urged to follow up with a specialist. *Id.*

Petitioner returned to Dr. Raskas on August 3, 2018, and he noted that Petitioner unsuccessfully attempted to return to work per the instructions of Respondent's section 12 examiner. (PX4, 8/3/18) He noted that Petitioner began experiencing sharp, stabbing low back pain that forced him to sit down after just 90 minutes of working. *Id.* Petitioner was sent home on account of his pain, and Petitioner had not returned to work since. *Id.* Petitioner at the present time weighed 550 pounds and continued to exhibit limited lumbar range of motion, decreased sensation along the right anterior thigh, and tenderness to palpation of his lumbar soft tissue on examination. *Id.* Dr. Raskas recommended four weeks of physical therapy. *Id.* After attending therapy at Med Plus, Petitioner continued to have high pain levels with activity. (PX6) The therapist's discharge note stated, "He has attempted to build exercise tolerance [with] little success." *Id.* Petitioner returned to Dr. Raskas on September 21, 2018, at which time Dr. Raskas noted that Petitioner had been on a diet and had no success in losing weight. (PX4, 9/21/18) He stated:

> I do not think injections ware likely to result in meaningful improvement in his condition. The only thing that is likely to meaningfully improve his herniated disc symptoms in his back is bariatric surgery. He has been on a diet and really has not been able to lose weight either. I think if the patient had bariatric surgery and lost 200 or 300 pounds, he might be a surgical candidate if he had continued symptoms such as he presents with today. . . I have recommended restrictions that he will need until such time as he can lose 200 to 300 pounds. *Id.*

Dr. Raskas restricted Petitioner to no lifting, pushing, or pulling greater than 15 pounds with alternation between sitting and standing as needed to control pain. *Id.* A few days later on September 25, 2018, however, Dr. Raskas took Petitioner off work "until after down 300 lbs." (PX4, 9/25/18)

Respondent had Petitioner examined by Dr. Crane yet again on October 8, 2018, at which time Dr. Crane reviewed additional records and noted Petitioner's prior unsuccessful attempt to return to work. (RX1) He noted that physical therapy and anti-inflammatory medication provided Petitioner with minimal relief and that Petitioner could not sit, stand, or walk for any significant amount of time. *Id.* Dr. Crane also felt that any improvement in Petitioner's condition was linked to weight loss and stated, "I feel he needs to continue to work on weight reduction." *Id.* He also recommended work hardening and light duty work restrictions of no bending, pulling, pushing, overhead lifting or stooping, and no lifting greater than 10 pounds. *Id.* He again concluded that the index injury on December 28, 2017, was the prevailing factor in Petitioner's continued back pain and need for continued treatment. *Id.*

Petitioner again attempted to return to work pursuant to the direction of Respondent's examiner, and injured his back yet again when he bent over too far while trying to operate a wheel machine. (T.21-22) Although Dr. Crane's restrictions included no bending or stooping, Petitioner testified that he was required to bend and stoop, and these activities resulted in increased pain. (T.22) Petitioner presented to the emergency room at Salem Township Hospital, where it was noted that Petitioner began having severe pain after working, and was given Motrin. (PX7) The attending nurse noted that while Dr. Crane instructed Petitioner to go back to work, Petitioner's treating physician instructed him to remain off work. *Id.* Petitioner returned to Dr. Raskas on January 18, 2019, at which time Dr. Raskas noted that Petitioner was still attempting to lose weight and doing therapy exercises. (PX4, 1/8/19) Petitioner reported significant increased back pain and bilateral leg symptoms with any activity. *Id.* Petitioner weighed 582 pounds, and Dr. Raskas again opined that Petitioner could only make meaningful improvement with bariatric surgery. *Id.* He instructed Petitioner to remain off work and continue attempting to lose weight. *Id.*

Petitioner testified that he has attempted to lose weight as Dr. Raskas recommended, but to no avail on account of his limited mobility and pain. (T.19-20) Petitioner has in fact gained weight since his first injury on December 27, 2017, due to the lack of movement. (T.20) Prior to December 27, 2017, Petitioner was able to work, sit, stand, and move without pain. (T.20) At the time of Arbitration, however, Petitioner testified that just sitting in the chair at during the hearing caused pain, and he wished to proceed with bariatric surgery to improve his condition. (T.19-20)

Both Dr. Raskas and Dr. Crane testified by way of deposition. Dr. Raskas testified that from his perspective, having treated Petitioner before and after the December 2017 incident, Petitioner's current symptoms and need for treatment was caused by the lifting injury in December of 2017. (PX9, p.10-11) Dr. Raskas testified that in addition to the disc herniation at L4-5, there was another herniation at L5-S1 with some post-laminectomy changes at L3-4. *Id.* at 12. Dr. Raskas believed that Petitioner's symptoms would "regress quite a bit" following bariatric surgery, as he has had patients of body habitus similar to Petitioner who have undergone same and responded well to treatment thereafter. *Id.* at 12-13, 17. He made no such recommendation for bariatric surgery previously during his treatment of Petitioner prior to the December 2017 injury. *Id.* at 13-14. As of the last date he saw Petitioner, Petitioner could not work in his normal occupation in his current condition, and his prospects for being gainfully employed in any capacity were "almost zero and none." *Id.* at 17, 19. Dr. Raskas stated that should Petitioner remain symptomatic after his bariatric surgery, he would be a candidate for discectomy and fusion. *Id.* at 18, 55.

Following the deposition of Dr. Raskas, Respondent requested an addendum report from Dr. Crane, which he authored on March 13, 2019. (RX1) Although he indicated that he appreciated no herniation at L5-S1, his opinion with respect to causation and treatment was unchanged. *Id.* Dr. Crane testified by way of deposition on April 10, 2019, and stated that Petitioner candidly informed him of his back surgery in 2011 consisting of right L3-4 laminotomy and foraminotomy. (RX2, p.9) He testified that although Petitioner was not pain free prior to his December 2017 injury and he could not identify any discernible changes on Petitioner's MRI films from March of 2015 to March of 2018 or visualize any pathology at L5-S1, Petitioner clearly suffered a worsening of his symptoms and an aggravation of his preexisting condition. *Id.* at 9-10, 17, 19, 27. He testified consistently on cross-examination that the restrictions placed on Petitioner were the result of his work injury. *Id.* at 27.

Respondent disputed accident and questioned whether Petitioner worked on the wheel production machine on the date of his injury based on the lack of any confirmation print outs, and brought Petitioner's current supervisor, Jason Rodotz, to the hearing. (T.31-35, 77-78) Mr. Rodotz admitted he was not in the building on the date of Petitioner's injury and was in fact on vacation on December 27, 2017. (T.78) He testified he had no first-hand knowledge of the incident. (T.78-79) He testified that production reports are generated the following day after wheel orders are completed; however, Petitioner's production reports ended on December 22, 2017. (T.81-83) He later testified that, "There was never any work entered under him for that month." (T.85) He testified that this "suggested" that there was no work performed by the operator. (T.85)

When asked whether there was any reason production wouldn't be documented, Mr. Rodotz stated, "No. If he would have did wheels, he would have confirmed it in PDC. Like I said, I'm not for sure, I wasn't there that day, but he could have been on -- being that was close to the holidays, he could have been sweeping for all I know that day. I don't know." (T.86) He testified that when injuries occur and an accident report is completed, a member of upper management forms a team to find the cause of the accident and actively participates in the investigation. (T.93) He testified that a different supervisor would have been involved in the investigation since he was on vacation, and would have provided him with a report. (T.93) However, he never saw any report concerning the injury Petitioner reported on November 12, 2018. (T.93) Respondent did not ask about any report concerning December 27, 2017.

On cross-examination, counsel for Petitioner asked Mr. Rodotz what the confirmation report indicated Petitioner was doing since it suggested Petitioner was not creating wheels on that date, and he responded, "It doesn't tell me anything he was doing." (T.95) Counsel then asked him whether Respondent was attempting to represent Petitioner wasn't working on any wheels on December 27, 2017, and if so, why Respondent did not investigate or dispute the matter in December of 2017 or January of 2018. (T.97) Mr. Rodotz responded, "I don't know what he did on that day because I was not there." (T.97) When asked by the Arbitrator whether there was any disciplinary action taken against Petitioner for filing an accident report claiming injury on December 27, 2017, the following exchange took place:

ARBITRATOR NOWAK: I have one. Was there any discipline filed against him for when he filed the accident report claiming an injury on 12-27?

THE WITNESS: I do not know that. I don't know if there was any discipline.

ARBITRATOR NOWAK: I understand you weren't there, but you wouldn't have learned when you returned?

THE WITNESS: I did not learn if there was discipline filed.

Q. (MR. RICH CONTINUING) And you were a supervisor?

A. Yeah, I did not learn that. So if there was something filed, you would think it would be known.

Q. Through you. I mean, you, as his direct supervisor, you would have heard about that or known about some discipline levied against him?

A. Yes. (T.98)

Respondent also brought Lori Martin, its HR generalist, to the hearing. (T.99, 102) She likewise had no first-hand knowledge of Petitioner's accident or his job activities on the day of December 27, 2017. (T.101) She testified that she was new and "didn't know a lot of the process" at that time. (T.101) She acknowledged, however, that Petitioner advised her that his back was hurting at approximately 10:30 on December 28, 2017. (T.102) She testified that that she left for lunch shortly thereafter and "[w]hen [she] came back, the supervisor and the EHS person was on the phone calling a doctor." (T.103-104) She further testified that when Petitioner attempted to returned to work on light duty, "[H]e would come after he had been working maybe one or two hours, and he would come back to me and say that, I just can't – I just can't do this." (T.104) She acknowledged that the physician's notes on the Workers' Compensation First Report of Injury or Illness indicate the cause of injury as "moved a wheel." (T.108)

CONCLUSIONS

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

The Supreme Court holds that the term "accident" encompasses anything that happens without design or any event that is unforeseen by the victim. *E. Baggot Co. v. Indus. Comm'n*, 125 N.E. 254, 255 (1919). An injury is also accidental within the meaning of the Act if "a workman's existing physical structure, whatever it may be, gives way under the stress of his usual labor." *Laclede Steel. Co. v. Indus. Comm'n*, 128 N.E.2d 718, 720 (1955). If the injury coincides with these definitions and is traceable to a definite time, place, and cause, then said injury is accidental within the meaning of the Act. *Id.*

Based upon the evidence, the Arbitrator finds that Petitioner sustained accidental injuries that arose out of and in the course of his employment with Respondent. Though Respondent disputes that Petitioner sustained any injury on the alleged date, said dispute is unsupported by the evidence. Petitioner's reporting of his injury sparked no suspicion at the time he reported his injury, nor was any disciplinary action taken against Petitioner for this purported lack of documentation that Respondent raised at the time of the hearing. (T.98) Additionally, by the testimony of Respondent's own HR personnel, Petitioner's attending supervisor contacted a physician, who indicated on the injury report that the accident occurred when Petitioner moved a wheel, consistent with Petitioner's testimony and each medical record in the evidence. (T.103-104, 108) Respondent produced no credible evidence to support its dispute, and none of the witnesses had any first-hand knowledge that was inconsistent with Petitioner's report of injury. Since all of the contemporary evidence supports Petitioner's claim, the Arbitrator finds he sustained his burden of that he suffered an accident which arose out of and in the course of his employment.

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

Pursuant to Illinois law, 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). The 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, 272-73 (5th Dist. 2007). The employer takes the employee as he or she is found. [*Id.*, Emphasis added]. If a preexisting condition is aggravated, exacerbated, or accelerated by an accidental injury, the employee is entitled to benefits. *Sisbro, Inc. v. Indus. Comm'n*, 797 N.E.2d 665, 672 (Ill. 2003); *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). Even though a workers' compensation claimant has a preexisting condition which may make him or her more vulnerable to injury, recovery for an accidental injury will not be denied as long as it can be shown that the employment was also a causative factor. *Sisbro, Inc. v. Indus. Comm'n*, 797 N.E.2d 665, 672-73 (Ill. 2003).

Causal connection between work duties and injured condition may be established by chain of events including workers' compensation claimant's ability to perform duties before date of accident and inability or decreased ability to perform same duties following date of accident. *Darling v. Indus. Comm'n of Illinois*, 176 Ill. App. 3d 186, 530 N.E.2d 1135 (1988); *Pulliam Masonry v. Indus. Comm'n*, 77 Ill. 2d 469, 397 N.E.2d 834 (1979). Circumstantial evidence, especially when entirely in favor of the Petitioner, is sufficient to prove a causal nexus between an accident and the resulting injury. *Gano Electric Contracting v. Industrial Comm'n,* 260 Ill.App.3d 92, 96–97, 631 N.E.2d 724 (4th Dist. 1994); *International Harvester v. Industrial Comm'n,* 93 Ill.2d 59, 442 N.E.2d 908 (Ill. 1982).

In this case, the evidence establishes without rebuttal that Petitioner, although having a preexisting lumbar spine condition, suffered an aggravation of that preexisting condition that links his current condition of ill-being to his work injury of December 27, 2017. Respondent's own examiner indicated that despite Petitioner's prior lumbar condition of ill-being and his weight, his December 2017 injury was the prevailing factor in the change in his condition that brought about his inability to continue working full duty. (RX1) Dr. Raskas, Petitioner's treating physician who cared for him prior to and after the December 2017 injury, likewise stated that his new injury played a role in Petitioner's condition of ill-being. (PX4, 3/27/18)

Based upon the clear chain of events, the opinions of both Petitioner's treating physician and Respondent's examiner, and the above precedent, the Arbitrator finds that Petitioner sustained his burden of proof in establishing that his current condition of ill-being and his need for continuing treatment and weight loss surgery is causally related to his accident of December 27, 2017.

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

Issue (K): Is Petitioner entitled to any prospective medical care?

Respondent stipulated at the hearing that it did not dispute the reasonableness and necessity of Petitioner's treatment, but disputed liability in tandem with its disputes regarding accident and causal connection.

Based upon the foregoing, and the record taken as a whole, the Arbitrator finds Respondent is liable for $10,488.24 as set forth in PX 1 and shall pay said expensed pursuant to the fee schedule. .

Upon establishing causal connection and the reasonableness and necessity of recommended medical treatment, employers are responsible for necessary and prospective medical care required by their employees, including treatment required to diagnose, relieve, or cure the effects of the claimant's injury. *Plantation Mfg. Co. v. Indus. Comm'n*, 294 Ill.App.3d 705, 691 N.E.2d 13, 229 Ill.Dec. 77 (Ill. 2000); *F & B Mfg. Co. v. Industrial Comm'n*, 758 N.E.2d 18 (1st Dist. 2001).

The Arbitrator finds the matters of *Warren v. SOI/IYC St. Charles*, 15 I.W.C.C. 1000 (2015) and *Farris v. Unity Hospice*, 12 I.W.C.C. 0784 (2012) instructive. In *Warren*, the claimant was a security guard that weighed 360 pounds. *Quinn Warren v. SOI/St. Charles,* 15 I.W.C.C. 1000 (2015). Prior to his work accident, he was able to work and perform his duties without incident despite his weight. *Id.* Following his work injury, which occurred when he attempted to restrain a combative inmate, and suffered from marked back pain with radiculopathy into his lower extremities. *Id.* The claimant was recommended for additional treatment to his lumbar spine, but his physician opined, "He is not a surgical candidate until he has had significant weight loss." *Id.* The claimant was referred for bariatric surgery as a result of his physician's recommendation, but his employer disputed liability for same. *Id.* Given the fact that the claimant was working full duty with no restrictions prior to his work injury at his current weight, the Commission found the claimant's current condition of ill-being was causally related to the injury and awarded benefits, including prospective care in the form of bariatric surgery. *Id.* Here, in contrast with the claimant in *Warren*, Petitioner does not suffer from significant degeneration, as not even Respondent's examiner, Dr. Crane, noted any such findings. (RX1) To the contrary, Dr. Crane noted no significant disc height loss and only slight endplate changes with maintained lumbar lordosis. *Id.*

In another similar case, *Farris v. Unity Hospice*, 12 I.W.C.C. 0784 (2012), the claimant sustained a low back injury, and both the claimant's treating physician and the respondent's examining physician opined that Petitioner should lose weight before proceeding with any type of surgical intervention for his lumbar spine. *Id.* at 2-3. However, in that case, due to the claimant's weight of 610 pounds, both the claimant's treating physician and the respondent's examining physician opined that the claimant's body habitus prevented the completion of adequate diagnostic lumbar spine testing. *Id.* The Commission concluded that a causal connection existed between the work accident and the claimant's low back condition. *Id.* at 4. Additionally, the Commission

awarded prospective medical care and treatment in the form of a referral to a bariatric surgeon for a recommendation as to whether bariatric surgery would be appropriate for the claimant. *Id.*

Based upon the above findings as to accident and causal connection, Respondent is liable for Petitioner's past and prospective medical treatment. The Arbitrator notes that Petitioner has been attempting to lose weight but without success on account of his inability to engage in any meaningful activity; Petitioner has in fact gained weight since his injury despite his best efforts. (T.20; PX4, 1/8/19) Dr. Raskas credibly opined that Petitioner will not be able to make any progress without bariatric surgery. (PX4, 1/8/19) Therefore, the medical treatment including weight loss surgery that has been prescribed Petitioner is both reasonable and necessary.

Therefore, Respondent shall authorize and pay for the treatment recommended by Dr. Raskas, including but not limited to bariatric surgery.

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

The parties agreed that Petitioner was temporarily and totally disabled from December 29, 2017, through July 25, 2018, and from July 27, 2018, through September 24, 2018, and that there was no underpayment or overpayment of TTD benefits during this period. (T.6) Respondent disputes Petitioner's periods of disability from September 25, 2018, through November 11, 2018, and from November 13, 2018, to present. (T.6-7) Dr. Raskas took Petitioner off work until such time that he could lose approximately 300 pounds. (PX4, 9/25/18, 1/8/19) As Respondent has not provided the bariatric surgery that would allow Petitioner to return to work or obtain the necessary treatment that would allow him to do so, Petitioner remains temporarily and totally disabled.

Respondent shall therefore pay temporary total disability benefits for a period of 83 6/7 weeks for Petitioner's disability from December 29,2017 through July 25, 2018 (29 6/7 weeks), July 27, 2018 through November 11, 2018, (15 3/7 weeks) and from November 13, 2018, through August 9, 2019 (38 4/7 weeks).

Respondent shall receive a credit for benefits which have been paid.

STATE OF ILLINOIS)
) SS.
COUNTY OF JEFFERSON)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☒ Reverse: accident in 18 WC 37291	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify:	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MATTHEW KUHLS,

Petitioner,

20IWCC0304

vs.

NO: 18 WC 37291

RADIAC ABRASIVES,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Respondent herein and notice given to all parties, the Commission, after considering all issues, and being advised of the facts and law, reverses the Decision of the Arbitrator in 18 WC 37291 and finds that Petitioner failed to prove he sustained a new work accident on November 12, 2018. The Commission instead finds that the November 12, 2018 event represents a continuation of Petitioner's December 27, 2017 work injury covered by 18 WC 5317.

I. FINDINGS OF FACT

Petitioner alleged two separate work accidents in two consolidated claims. In 18 WC 5317, Petitioner alleged low back injuries from picking up a grinding wheel out of a cart on December 27, 2017. In 18 WC 37291, Petitioner claimed an aggravation of his low back pain from going back to work on November 12, 2018. In a separate Decision, the Commission affirmed and adopted the Decision of the Arbitrator in 18 WC 5317 and remanded the case to the Arbitrator pursuant to *Thomas v. Industrial Commission*, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980). The present Decision addresses the Commission's reversal as it relates to the November 12, 2018 accident in 18 WC 37291 only.

A. Pre-November 12, 2018

Petitioner began working for Respondent as a laborer in 2010. On December 27, 2017, he sustained a low back injury as he was picking up a 200 to 400-pound grinding wheel out of a cart.

20IWCC0304

Petitioner testified that he was usually given the harder jobs and the heaviest wheels to lift, because he was a larger guy. When he was hired by Respondent, he weighed a little over 450 pounds. After the December 27, 2017 incident, Petitioner finished his shift and went home. Petitioner testified that he did not tell anyone about his injury before he left work, because he initially thought it was something simple, such as a strain, that would go away. However, he was still in pain when he woke up the next morning.

On December 28, 2017, Petitioner presented to SSM Health Medical Group with complaints of low back pain. Petitioner told Nurse Practitioner Heidi Vanessa Thompson that prior to this work accident, he had a low back surgery in 2011 for a herniated disc. Nurse Practitioner Thompson diagnosed Petitioner with a lumbar strain and prescribed Naprosyn and Flexeril. When Petitioner returned on January 4, 2018, Dr. Mahvish Zahoor's assessment was acute midline low back pain without sciatica. Dr. Zahoor provided light duty restrictions and indicated that Petitioner would soon see an orthopedic surgeon.

Petitioner began seeing Dr. David Raskas of the Orthopedic Sports Medicine and Spine Care Institute on January 5, 2018. Dr. Raskas noted that Petitioner had underwent a L3-L4 laminectomy with discectomy seven years prior, but after the surgery, his leg and back pain had drastically improved. He reported that Petitioner had returned to work as a laborer and continued to work without any issues until two years ago when he experienced low back pain from moving a heavy item at work. Dr. Raskas indicated that through physical therapy and activity modifications, Petitioner's pain improved, and he was again able to return to full duty work six months after that accident. At the hearing, Petitioner testified that he was able to do his job, sit, stand, and move without pain prior to December 27, 2017.

Concerning his new complaints of low back pain, Dr. Raskas noted a recurrent low back strain, right lower extremity radicular symptoms, and new complaints of numbness and tingling in the right anterior thigh. His assessment also included lumbar radiculopathy, lumbar pain, and a herniated lumbar nucleus pulposus. Dr. Raskas indicated that Petitioner had intermittent numbness and tingling in his right anterior thigh over the last year and a half, but the numbness had significantly worsened since the December 2017 accident. He ordered an MRI, recommended physical therapy, and took Petitioner off work.

On March 23, 2018, the lumbar MRI revealed partial laminectomy changes at L3-L4 along with disc bulges and protrusions with facet arthropathy from L3-L4 to L5-S1, contributing to bilateral mild foraminal stenosis at all three levels and mild to moderate spinal canal stenosis at L3-L4 and L4-L5.

On March 27, 2018, Dr. Raskas diagnosed Petitioner with post-laminectomy syndrome and a L4-L5 herniated disc that was related to his prior surgeries and prior work injury. Nevertheless, Dr. Raskas opined that Petitioner's condition had been exacerbated by his most recent December 27, 2017 work injury. He then recommended bariatric surgery to address Petitioner's longstanding weight problems and indicated that evaluation by a spine surgeon was not appropriate until his morbid obesity was controlled. Dr. Raskas kept Petitioner off work and stated that it was due to a combination of Petitioner's work injury and preexisting condition.

Dr. Benjamin Crane thereafter authored a §12 report at Respondent's request on June 25, 2018. Dr. Crane indicated that Petitioner had done well following his 2011 back surgery with an almost complete resolution of pain. Petitioner advised Dr. Crane that he did well for four or five years until he re-injured his back at work. Dr. Crane reported that Petitioner never fully recovered from that second injury and was left with back pain that he rated at a four or five on a one-to-ten pain scale. Petitioner told Dr. Crane that after his new December 2017 work accident, his current pain was slightly worse at a five or six on the one-to-ten pain scale. Dr. Crane diagnosed Petitioner with low back pain and opined that he had suffered an exacerbation and worsening of his chronic low back pain. Dr. Crane recommended light duty restrictions of no bending, pulling, pushing, or stooping and no lifting over ten pounds or overhead lifting. He opined that the December 2017 accident was the prevailing factor in causing Petitioner's injury and need for work restrictions.

On July 28, 2018, Petitioner informed Dr. Zahoor that he had went back to light duty work but started having low back pain after standing for 30 minutes. Petitioner was taken off work until he was seen again by his orthopedic specialist. When Petitioner returned to Dr. Raskas on August 3, 2018, he reported that he had returned in late June to his previous position with duties of heavy lifting, repetitive motion, and standing several hours per day. Dr. Raskas noted that Petitioner's pain had returned after he was standing for a prolonged period of time at work and did repetitive lifting of 30 pounds several times over 90 minutes. Dr. Raskas recommended physical therapy, which Petitioner began on August 17, 2018. Petitioner was subsequently discharged from physical therapy on September 14, 2018 with several goals not met due to his inability to tolerate standing.

On September 21, 2018, Petitioner told Dr. Raskas that he had again tried to return to work for an hour and a half, but they had him standing continuously, bending forward, and leaning up against a table to manipulate items that fell at mid-thigh height. At the time of this visit, Petitioner weighed 545 pounds, and Dr. Raskas opined that the only treatment likely to meaningfully improve Petitioner's herniated disc symptoms was bariatric surgery. He stated that if Petitioner lost 200 or 300 pounds, he might then be a surgical candidate if he still had back problems. However, until then, there was no need for a spine surgeon to be involved in Petitioner's treatment. Dr. Raskas recommended restrictions of no lifting, pushing, or pulling greater than 15 pounds and alternate between sitting and standing. He indicated that the restrictions should remain in effect until Petitioner lost 200 to 300 pounds.

On September 25, 2018, Dr. Zahoor reported that Petitioner had again attempted to return to work, but he was there for only two hours before he developed low back pain. On the same day, Dr. Raskas took Petitioner off work until after he got down to 300 pounds.

At Respondent's request, Dr. Crane performed a second §12 examination on October 8, 2018. Dr. Crane again opined that the December 2017 accident was the prevailing factor in causing Petitioner's continued back pain and need for treatment. He further indicated that nothing surgical could be done for Petitioner until he worked on his weight reduction. Dr. Crane recommended a course of work conditioning followed by an FCE to determine Petitioner's final restrictions. In the meantime, he recommended light duty restrictions of no bending, pulling, pushing, or stooping and no lifting overhead or over ten pounds.

Dr. Crane also acknowledged that morbid obesity was a factor in Petitioner's continued

low back complaints and ability to return to work. He explained that excessive weight puts added strain on the back and causes it to potentially wear out faster. He further indicated that patients with morbid obesity tend to experience more back pain for longer periods of time.

B. Post-November 12, 2018

Petitioner again attempted to return to light duty work on November 12, 2018. Petitioner testified that he was put back on a machine and worked for a little over three and a half hours before leaving with back complaints. Petitioner testified that he reported that the bending and stooping he was doing increased his pain to his supervisor named "Jason." He could not recall Jason's last name. Petitioner further testified that he was not claiming a new injury on November 12, 2018, and instead, this injury was preexisting and the same as his first injury. He clarified that he viewed the second injury as a continuation of the December 27, 2017 injury.

Jason Rodotz, a production supervisor for Respondent, also testified at the hearing. Mr. Rodotz testified that when Petitioner returned to work on November 12, 2018, he was placed at a job within his restrictions. He testified that Petitioner had not reported the injury to him, because he was on vacation that day and not there. Nevertheless, Mr. Rodotz indicated that he would have still eventually seen or received a copy of any accident investigation report. However, he did not see any kind of report concerning an accident Petitioner had on November 12, 2018.

Lori Martin, Respondent's HR generalist, also testified that any work injuries would be brought to her attention. Ms. Martin indicated that on November 12, 2018, she spoke with Petitioner about how he had been back working light duty for a period of time and could no longer work. However, she testified that Petitioner did not tell her that he had sustained a new injury on November 12, 2018. She also never saw any outside document or investigation report showing that an injury had been reported.

The treatment records show that on November 12, 2018, Petitioner presented to Salem Township Hospital and complained of low back pain since December 28, 2017. The treating doctor indicated that Petitioner required a work release after being at work for four hours. Petitioner was diagnosed with chronic back pain, prescribed cyclobenzaprine, and advised to follow up with his orthopedic doctor. On the same day, Dr. Raskas again took Petitioner off work until after he got down to 300 pounds.

Petitioner last saw Dr. Raskas on January 18, 2019. At that time, Dr. Raskas opined that Petitioner was still not a surgical candidate given his weight of 582 pounds. He stated that Petitioner needed to lose around 300 pounds before he could be considered for surgery. Dr. Raskas kept Petitioner off work and again indicated that bariatric surgery would lead to the only meaningful improvement for his herniated disc.

When the parties deposed Dr. Raskas, he testified consistent with his treatment notes and attributed Petitioner's current condition to the December 2017 accident. Regarding the November 12, 2018 accident, Dr. Raskas testified that Petitioner had went back to work and ended up in the emergency room, but it was not an additional injury since 2017. He testified that he thought Petitioner was still dealing with the same condition and problem that had been persistently

20IWCC0304

symptomatic since 2017. Dr. Raskas clarified that there was no new injury in November of 2018, and it was a continuation of the same symptoms Petitioner had been experiencing.

Thereafter on March 13, 2019, at Respondent's request, Dr. Crane authored an addendum after reviewing Petitioner's March 23, 2018 MRI. Dr. Crane wrote that he did not appreciate any disc herniation at L5-S1 on the MRI. He further noted that his initial §12 report remained correct. When the parties later deposed Dr. Crane on April 10, 2019, he testified consistent with all of his §12 reports. Dr. Crane testified that the December 2017 work injury had caused an exacerbation of Petitioner's low back pain and he had suffered an aggravation of his preexisting condition. He testified that he had recommended the light duty restrictions contained in his report and never mentioned anything to Petitioner about going back to work or allowing him to return to full duty. Dr. Crane believed that Petitioner's work restrictions were also a result of the work accident.

Petitioner's consolidated cases proceeded to a §19(b) hearing on August 9, 2019. Through two Decisions issued on September 6, 2019, the Arbitrator found that Petitioner sustained compensable work accidents that arose out of and in the course of his employment on both December 27, 2017 and November 12, 2018.

II. CONCLUSIONS OF LAW

Following a careful review of the entire record, the Commission finds that Petitioner did not sustain a new work accident on November 12, 2018, and instead, the November 12, 2018 event was a continuation of Petitioner's December 27, 2017 work accident that falls under 18 WC 5317.

Petitioner testified that he was not claiming a new injury on November 12, 2018, because his injury was preexisting and a continuation of the December 27, 2017 injury. Dr. Raskas further testified that he did not believe there was a new injury in November of 2018, and Petitioner just had a continuation of the same symptoms he had been experiencing since 2017. Ms. Martin also indicated that Petitioner did not tell her that he had sustained a new injury on November 12, 2018. As such, the record does not support a finding that Petitioner sustained a new accident on November 12, 2018. Although Petitioner testified that he could not work that day due to pain, the treatment records do not show that an aggravation or worsening of his preexisting lumbar condition occurred that day due to a new accident.

For these reasons, the record supports a finding that Petitioner failed to prove that he sustained a new work accident on November 12, 2018, and as such, all benefits are denied under 18 WC 37291. Nevertheless, the Commission affirms and adopts the Decision of the Arbitrator in 18 WC 5317 as it relates to the December 27, 2017 accident and finds that the November 12, 2018 event was a continuation of Petitioner's condition and care from his December 27, 2017 injury.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator in 18 WC 37291 dated September 6, 2019, is hereby reversed as stated herein.

IT IS THEREFORE FOUND that Petitioner failed to prove he sustained a new work accident that arose out of and in the course of his employment on November 12, 2018. The Commission therefore denies all benefits under 18 WC 37291.

20 IWCC0304

IT IS FURTHER FOUND that the November 12, 2018 event was a continuation of Petitioner's December 27, 2017 work injury that falls under 18 WC 5317, which the Commission has affirmed and adopted in a separate Decision. In the 18 WC 5317 Decision, the Commission found that Petitioner is entitled to reasonable and necessary medical expenses of $10,488.24 as well as prospective medical care pursuant to §8(a) and §8.2 of the Act. The Commission further found that Respondent shall pay Petitioner temporary total disability benefits of $533.33 per week for 83 6/7 weeks for the periods of 12/29/17 to 7/25/18, 7/27/18 to 11/11/18, and 11/13/18 to 8/9/19, as provided by §8(b) of the Act.

DATED: JUN 4 – 2020

Deborah L. Simpson

Barbara N. Flores

Marc Parker

DLS/met
O- 4/2/20
46

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

RAMON ALEXIS-SANTIAGO.,

Petitioner,

vs. NO: 12 WC 2364

RON'S STAFFING SERVICE and A. LAVA & SONS,

Respondents.

20IWCC0305

DECISION AND OPINION ON REMAND

This matter comes before the Commission on remand from the Circuit Court. The Circuit Court reversed the part of the Commission's decision and opinion on review dated October 30, 2018, ordering Respondents to pay medical bills directly to the providers. The Circuit Court remanded the matter to the Commission "with directions to modify the award to provide that the medical bills should be paid to [Petitioner], not directly to the medical providers." The Circuit Court otherwise confirmed the Commission's decision and opinion on review.

The Commission hereby complies with the Circuit Court's order and directions by modifying the award of medical expenses as follows:

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondents shall pay the sum of $23,248.59 directly to Petitioner for reasonable, necessary and related medical expenses pursuant to §§8(a) and 8.2 of the Act.

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

Bond for the removal of this cause to the Circuit Court by Respondents is hereby fixed at the sum of $25,200.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

Stephen Mathis

D. Douglas McCarthy

SPECIAL CONCURRENCE

I concur with the decision of the Majority. I write separately to address the Circuit Court's order and the Commission's decision to award the medical bills directly to the providers pursuant to Section 8(a) and 8.2 of the Act.

Section 8(a) of the Act states, in part, "If the employer does not dispute payment of first aid, medical, surgical, and hospital services, the employer shall make such payment to the provider on behalf of the employee." *820 ILCS 305/8(a)* (West 2013). Section 8.2(e-20) of the Act states, in part, "In the case of a procedure, treatment, or service deemed compensable, the provider shall not require a payment rate, excluding interest provisions under subsection (d), greater than the lesser of the actual charge or the payment level set by the Commission in the fee schedule established in this Section. Payment for services deemed not covered or not compensable under this Act is the responsibility of the employee unless provider and employee have agreed otherwise in writing." *820 ILCS 305/8(e-20)* (West 2013). Section 8(a) defines the type of compensation to which an injured employee is entitled *i.e.* medical care, and Section 8(e-20) defines how and in what amount such compensation is paid. Thusly, we must employ the rules of statutory construction which are well-established:

> Our primary goal, to which all other rules are subordinate, is to ascertain and give effect to the intention of the legislature. [citation omitted]. We determine this intent by reading the statute as a whole and considering all relevant parts. [citation omitted]. We must construe the statute so that each word, clause, and sentence, if possible, is given a reasonable meaning and not rendered superfluous [citation omitted], avoiding an interpretation which would render any portion of the statute meaningless or void [citation omitted]. We also presume that the General Assembly did not intend absurdity, inconvenience, or injustice. [citation omitted]. The Workers' Compensation Act is to be interpreted liberally [citation omitted], to effectuate its main purpose-providing financial protection for interruption or termination of a worker's earning power. [citation omitted]. *Sylvester v. Industrial Commission*, 197 Ill. 2d 225, 232, 756 N.E.2d 822 (2001).

In assessing legislative intent "the court should consider, in addition to the statutory language, the reason for the law, the problems to be remedied, and the objects and purposes sought. [citation omitted]." *People v. Donoho*, 204 Ill. 2d 159, 172, 788 N.E.2d 707 (2003).

In construing the language of Section 8.2(e-20) in context with Section 8(a), ordering payment directly to the providers is consistent with underlying intent of the Act- providing financial protection to an injured employee. Once the matter proceeds to hearing and the decision is final, the medical bills awarded are compensable and no longer in dispute. As such, the employer is mandated by Section 8(a) to pay the providers directly on behalf of the employee.

Moreover, Section 8.2 of the Act was amended on November 27, 2018 and January 20, 2019 creating a cause of action in favor of the medical providers solely against employers for any interest accrued due to non-payment of medical bills thereby releasing any obligation on the employee's behalf for interest. It would seem unjust to hold employers liable for interest on unpaid medical bills if they have no control in paying those bills. In the present matter, certain medical expenses were found compensable and others not. Conceivably, Petitioner could choose to pay the non-compensable bills from the monies he receives for the awarded medical expenses which would expose Respondent to interest and a potential civil complaint.

As such, ordering payment to the providers directly is consistent with the language and intent of the Act.

DATED: JUN 4 - 2020

L. Elizabeth Coppoletti

LEC

D: 5/6/2020

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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 Permanent Disability	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JEFFREY HINES,

Petitioner,

vs. NO: 15 WC 1962

STATE OF ILLINOIS,

Respondent.

20IWCC0306

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 permanent disability and commencement date of Section 8(f) permanent total disability benefits, 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.

The Commission affirms the Arbitrator's finding that Petitioner established entitlement to permanent total disability under the odd-lot theory of recovery. The evidence demonstrates Petitioner has permanent restrictions which preclude him from returning to work as a stationary engineer, and the vocational reports from Respondent's chosen vocational counselor demonstrate Petitioner complied with the guided job search process for two years; while there was one report noting Petitioner failed to follow-up with employers after a job fair at Kankakee Community College (#35 – April 26, 2019), the next report reflects Petitioner had performed the required follow-up and was back to "demonstrat[ing] 100% compliance" (#36 – May 14, 2019). The Commission finds Respondent's arguments on the issue are inconsistent with the record and without merit.

The Arbitrator found Petitioner entitled to permanent total disability benefits of $1,225.87 per week commencing on April 9, 2019. The Commission observes there are two

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errors in the award as written: 1) the commencement date overlaps the awarded maintenance period, and 2) the benefit rate is miscalculated.

I. Permanent Total Disability Commencement Date

The Arbitrator's Decision awards maintenance benefits from June 1, 2017 through May 17, 2019; this was the stipulated period and reflects maintenance through the date of hearing. ArbX1. The Arbitrator's Decision also, however, awards permanent total disability benefits commencing on April 9, 2019, thereby awarding both maintenance and permanent total disability for the period of April 9, 2019 through May 17, 2019. The Commission believes this to be a simple error occasioned by the resetting of the hearing date from April 9, 2019 to May 17, 2019.

The Commission finds the permanent total disability commencement date is May 18, 2019. The award of permanent total disability benefits from April 9, 2019 through May 17, 2019 is hereby vacated.

II. Permanent Total Disability Benefit Rate

The Arbitrator awarded permanent total disability benefits of $1,225.87 per week. In so doing, it appears the Arbitrator calculated the rate using the current hourly rate for stationary engineers ($45.97). The Commission finds this is contrary to the statute, as it mistakenly incorporates a §8(d)1 wage differential into a §8(f) award.

Section 8(f) states "compensation shall be payable at the rate provided in subparagraph 2 of paragraph (b) of this Section for life" and §8(b)2 states the compensation rate "shall be equal to 66 2/3% of the employee's average weekly wage computed in accordance with the provisions of Section 10." To be clear, the Act dictates a claimant's permanent total disability rate is the same as the claimant's temporary total disability rate.

Petitioner's temporary total disability rate is $1,186.87 per week ($1,780.00 / 3 x 2 = $1,186.87). Pursuant to §8(f), Petitioner's permanent total disability benefit rate is $1,186.87.

All else is affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 15, 2019, as modified above, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $1,186.87 per week for a period of 158 weeks, representing May 16, 2014 through May 31, 2017, that being the period of temporary total incapacity for work under §8(b) of the Act. Respondent shall have a credit of $196,907.00 for TTD benefits already paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner maintenance benefits in the amount of $1,186.87 per week for a period of 102 1/7 weeks, representing June 1, 2017 through May 17, 2019, as provided in §8(a) of the Act. Respondent shall have a credit of $111,298.87 for maintenance benefits already paid.

20IWCC0306

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner permanent total disability benefits of $1,186.87 per week for life, commencing on May 18, 2019, as provided in §8(f) of the Act. The award of permanent total disability benefits from April 9, 2019 through May 17, 2019 is vacated. Commencing on the second July 15 after the entry of this award, Petitioner may become eligible for cost-of-living adjustments, paid by the Rate Adjustment Fund, as provided in §8(g) of the Act.

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

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

Pursuant to Section 19(f)(1), this decision is not subject to judicial review.

DATED: JUN 4 - 2020

L. Elizabeth Coppoletti

LEC/mck

D: 5/6/2020

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L. Elizabeth Coppoletti

Stephen Mathis

D. Douglas McCarthy

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HINES, JEFFREY
Employee/Petitioner

Case# **15WC001962**

STATE OF ILLINOIS
Employer/Respondent

20IWCC0306

On 7/15/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.07% 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

6097 ASSISTANT ATTORNEY GENERAL
ANA DIAZ VAZQUEZ
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

1745 DEPT OF HUMAN SERVICES
BUREAU OF RISK MANAGEMENT
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

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

JUL 15 2019

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

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

JEFFREY HINES,
Employee/Petitioner

v.

STATE OF ILLINOIS,
Employer/Respondent

Case # **2015** WC **1962**

Consolidated cases: _____

20 I W C C 0 3 0 6

An *Application for Adjustment 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 **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. ☐ 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 **Permanent total disability**

FINDINGS

On **May 16, 2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**92,560.00**; the average weekly wage was $**1,780.00**.

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

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

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

Respondent shall be given a credit of **$196,907** for TTD, $**0** for TPD, $**111,298.87** for maintenance, and $**0** for other benefits, for a total credit of **$308,205.87.**

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

ORDER

Temporary Total Disability:

Petitioner is entitled to temporary total disability benefits of $1,186.67 per week for a period of 158 weeks from May 16, 2014 through May 31, 2017. Respondent shall be given a credit of $196,907.00 for this time period.

Petitioner is entitled to maintenance benefits of $1,186.67 per week for a further period of 102-1/7 weeks from June 1, 2017 through May 17, 2019. Respondent shall be given a credit of $111,298.87 for this time period.

Permanent Total Disability

Petitioner is permanently and totally disabled as provided in Section 8(f) of the Act. Respondent shall pay Petitioner permanent and total disability benefits of $1,225.87/week for life, commencing April 9, 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.

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

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

Robert M. Harris

Signature of Arbitrator Robert M. Harris

July 15, 2019
Date

BEFORE THE ILLINOIS WORKERS COMPENSATION COMMISSION

JEFFREY HINES,	)	
	)	
Petitioner,	)	
	)	
v.	)	No. 15-WC-1962
	)	
STATE OF ILLINOIS,	)	
	)	
Respondent.	)	

MEMORANDUM OF DECISION OF ARBITRATOR

Findings of Fact

Accident:

On May 16, 2014, Petitioner, Jeff Hines, was employed by Respondent, the State of Illinois, as a Local Union 399 stationary engineer working at the Shapiro Developmental Center. (Tr. p. 14). Petitioner worked for Respondent since 1991. (Tr. p. 14). Petitioner has a high school diploma, but no other formal education. (PX7 p. 6). Petitioner worked as a police officer for seven years prior to being employed by Respondent. (Tr. p. 14). As a stationary engineer, Petitioner was required to maintain a high-pressure steam boiler, transport chemicals and oil drums throughout the facility, as well as other maintenance tasks that would arise. (Tr. pp. 15-16, PX6, RX2).

Petitioner explained that on May 16, 2014, he suffered an injury to his left shoulder when he was trying to lift safety relief valves for the boiler. He felt "instant pain like I never had before" in his left shoulder. (Tr. p. 18). Petitioner testified, "I wet myself because it hurt really bad." (Tr. p. 18). He reported the accident to his employer and sought medical treatment at the St. Mary's Hospital emergency room. (Tr. p. 19).

Medical treatment:

The St. Mary's records reflect a history that Petitioner "lifted heavy metal object at work and developed sudden severe left shoulder pain." (PX1 p. 10). Petitioner related his pain as an 8-9 out of 10, and the pain was worse with range of motion. (PX1 p. 10). X-rays were taken and Petitioner was placed in a sling. (PX1 p. 10-11). On May 19, 2014, Petitioner returned to St. Mary's complaining that he "really cannot use his left arm." (PX1 p. 13). Dr. Panuska recommended an MRI and modified work consisting of no use of the left arm. (PX1 p. 13). Petitioner was provided a topical pain medication and was instructed to apply heat and discontinue the sling. (PX1 p. 13).

On June 5, 2014, Petitioner returned to Dr. Panuska at St. Mary's and the MRI had not yet been authorized. (PX1 p. 15). Dr. Panuska recommended Ibuprofen and kept Petitioner off work. (PX1 p. 15). On June 16, 2014, Petitioner underwent the MRI on his left shoulder. On June 18, 2014, Petitioner returned to Dr. Panuska who reviewed the MRI and diagnosed a complete tear of the supraspinatus tendon. (PX1 p. 16). He recommended Petitioner follow along with Dr. Michael Corcoran, continue pain medications, and remain off work. (PX1 p. 16).

On July 2, 2014, Petitioner returned to Dr. Panuska, who did not perform an examination, but noted, "he cannot really move his left arm too well." (PX1 p. 21). Dr. Panuska recommended Petitioner continue his medications and remain off work. (PX1 p. 21).

On July 14, 2014, Petitioner reported to Dr. Corcoran, and told him that he was lifting a heavy object on May 16, 2014 and felt an acute pop with pain and swelling in his left shoulder. (PX2 p. 58). Dr. Corcoran noted that Petitioner has been unable to function since the time of the injury. (PX2 p. 58). Dr. Corcoran also noted the MRI findings, and felt that Petitioner may have adhesive capsulitis in the shoulder. (PX2 p. 59). Dr. Corcoran recommended arthroscopic surgery. (PX2 p. 59).

On July 16, 2014, Dr. Panuska agreed with Dr. Corcoran and referred Petitioner to Dr. Corcoran for surgery, and discharged Petitioner from St. Mary's clinic. (PX1 p. 22). On August 1, 2014, Petitioner returned to Dr. Panuska for a pre-operative physical, and Dr. Panuska again noted Petitioner's MRI revealed a full-thickness tear of the supraspinatus tendon. (PX1 pp. 25-26).

On August 11, 2014, Petitioner underwent surgery. Dr. Corcoran performed a left shoulder arthroscopy, rotator cuff repair, chondroplasty of the glenoid, chondroplasty of the humerus, labral debridement, and subacromial decompression. (PX2 p. 68). Petitioner's post-surgical diagnoses were (1) left shoulder grade 3 chondromalacia on the humerus and glenoid, (2) 4.5 cm tear of the rotator cuff, and (3) impingement syndrome.

Petitioner returned to Dr. Corcoran on August 20, 2014 after surgery. (PX2 pp. 55-56). Dr. Corcoran explained that "his tear was sizeable in nature," and that the "tissue was also thinned and poor quality." (PX2 p. 56). Because of this, Dr. Corcoran explained, "we are going to be very conservative with his care." (PX2 p. 56). Petitioner was instructed to do no lifting or active motion with the left shoulder. (PX2 p. 56). Dr. Corcoran recommended Petitioner remain off work. (PX2 p. 56). On September 17, 2014, Petitioner was instructed to begin physical therapy and to remain off work. (PX2 pp. 52-53). Petitioner began physical therapy at ATI. (PX3).

Petitioner returned to Dr. Corcoran on October 15, 2014 with continued pain. (PX2 pp. 49-50). Dr. Corcoran recommended continued physical therapy, medications, and for Petitioner to remain off work. (PX2 p. 50). Petitioner again saw Dr. Corcoran on November 12, 2014, and reported that his pain was "severe" and

"stabbing." (PX2 p. 45). Dr. Corcoran administered a cortisone injection into the left shoulder subacromial space. (PX2 p. 46). Petitioner was instructed to continue his home exercise plan and remain off work. (PX2 p. 46). Petitioner returned to Dr. Corcoran on November 19, 2014 reporting incomplete temporary improvement after the injection. (PX2 p. 42). Petitioner indicated his pain was "severe," "sharp," and worse with sleeping and range of motion. (PX2 p. 42). Dr. Corcoran resumed Petitioner's physical therapy and kept Petitioner off work. (PX2 p. 43).

On December 17, 2014, Petitioner reported to Dr. Corcoran that he was having difficulty with physical therapy. (PX2 p. 38). Dr. Corcoran noted popping and clicking on physical exam, noted that Petitioner was making "slow progress," and diagnosed Petitioner with adhesive capsulitis of the shoulder. (PX2 p. 39). Dr. Corcoran continued physical therapy, and recommended activity modification and cryotherapy. (PX2 p. 39). He indicated that Petitioner could attempt to return to work with restrictions of no use of the left arm. (PX2 p. 39). Respondent had no light duty work within those restrictions, so Petitioner remained off work.

On January 14, 2015, Petitioner reported to Dr. Corcoran having continued difficulties with his left shoulder. (PX2 p. 36). Dr. Corcoran recommended an MR arthrogram of the left shoulder to rule out a recurrent rotator cuff tear. (PX2 p. 36). The MR arthrogram was completed on March 2, 2015 and found no recurrent tear. (PX2 p. 63). Dr. Corcoran refilled Petitioner's pain medications and continued to recommend no use of the left arm. (PX2 p. 36).

On January 21, 2015, Petitioner was examined by Respondent's hired orthopedic surgeon, Dr. William Vitello pursuant to §12 of the Act. (RX3). In his February 6, 2015 report, Dr. Vitello opined that "[b]ased on the mechanism of injury, his ongoing symptoms, failure of conservative care, and no evidence of intervening injury, it is my opinion that his current condition is related to the May 16, 2014 work injury." (RX3 2/6/15 report p. 4). He further stated that "[b]ased on his objective findings, there are signs that he does have persistent impingement and/or failure of the rotator cuff repair." (RX3 2/6/15 report p. 4). He opined that Petitioner had not reached MMI. (RX3 2/6/15 report p. 4). Dr. Vitello agreed with the recommendation for an MR arthrogram. (RX3 2/6/15 report p. 4).

Petitioner returned to Dr. Corcoran March 4, 2015, and Dr. Corcoran noted that Petitioner has continued to have difficulty with left shoulder pain. (PX2 p. 32). Petitioner reported "a catching pain in his mid-range of flexion and abduction." (PX2 p. 32). Dr. Corcoran indicated that Petitioner "has failed conservative treatment of a cortisone injection as well as continued therapy since the time of surgery." (PX2 p. 33). Dr. Corcoran recommended a second opinion with Dr. Tomasz Antkowiak, continued Petitioner's work restrictions, and to return to him after seeing Dr. Antkowiak. (PX2 p. 33).

On April 1, 2015, Petitioner reported to Dr. Antkowiak, who diagnosed Petitioner with adhesive capsulitis, and agreed with Dr. Corcoran's work restrictions of no use of the left arm. (PX2 p. 30). Dr. Antkowiak noted that Petitioner's post-surgical pain was "not uncommon for the type of surgery that he had especially with the relatively large tear that was repaired." (PX2 p. 30). Dr. Antkowiak discussed that Petitioner would need to "live with" his limitations. (PX2 p. 30). Dr. Antkowiak instructed Petitioner to follow-up with Dr. Corcoran. (PX2 p. 30).

Petitioner saw Dr. Corcoran again on April 29, 2015 with continued pain, and Dr. Corcoran continued Petitioner's work restrictions. (PX2 pp. 25-26). On June 10, 2015, Petitioner continued to have popping and clicking in the shoulder on exam. (PX2 p. 22). Dr. Corcoran recommended Petitioner continue conservative management and his work restrictions of no use of the left arm. (PX2 p. 23). On July 22, 2015, Petitioner reported continued difficulty "reaching out, overhead activity and reaching across his body." (PX2 p. 18). He noted weakness and range of motion difficulties despite continued home exercises, cryotherapy, and pain medication. (PX2 p. 18). Dr. Corcoran recommended a functional capacity evaluation ("FCE"). (PX2 p. 18).

On September 11, 2015, Petitioner returned to Dr. Corcoran with persistent pain and discomfort in his left shoulder. Dr. Corcoran noted that the FCE had not yet been approved. (PX2 p. 15). Dr. Corcoran again recommended the FCE and continued Petitioner's work restrictions. (PX2 p. 16). On October 9, 2015, Petitioner still had not undergone the FCE, but reported no change in his symptoms. (PX2 p. 12). Dr. Corcoran recommended Petitioner follow up after the FCE. (PX2 p. 13).

The FCE was performed and completed on October 30, 2015, and Petitioner returned to Dr. Corcoran on November 6, 2015. (PX2 pp. 8, 70-76). Petitioner reported that he had "terrible pain during the functional capacity examination," and that he "has been worsening status post the exam." (PX2 p. 9). Dr. Corcoran gave Petitioner restrictions based on the FCE: no frequent lifting above shoulder, no more than 10 pounds occasional lifting above shoulder, no frequent lifting from desk to chair over 30 pounds, no occasional lifting from desk to chair over 17 pounds, no frequent carrying over 17 pounds, and no occasional carrying over 37 pounds. (PX2 p. 10). Dr. Corcoran placed Petitioner at MMI. (PX2 p. 10).

On January 11, 2016, Dr. Vitello issued an addendum report at Respondent's request. (RX3 1/11/16 report pp. 1-2). Dr. Vitello reviewed the FCE report and opined that Petitioner could attempt to return to work with restrictions. (RX3 1/11/16 report p. 2).

Between November 6, 2015 and the end of January 2016, Respondent was unable to accommodate Petitioner's restrictions, and therefore, Petitioner remained off work. (Tr. pp. 25-26). In January 2016, Petitioner received a call from Dave Klintworth, who indicated that Respondent could now accommodate the restrictions. (Tr. pp. 26-27). Petitioner worked under those restrictions for parts of two weeks between January

27, 2016 and February 8, 2016. (Tr. p. 27). Petitioner testified that he felt "extreme pain" in his left shoulder when attempting to perform the light duty work provided by Respondent. (Tr. p. 27). Petitioner testified that the pain was "excruciating" and compared the pain to being stabbed with a knife. (Tr. p. 28).

On February 8, 2016, Petitioner returned to Dr. Corcoran reporting that he had sharp pain in the shoulder while vacuuming in his restricted capacity at work. (PX2 p. 5, PX5). Dr. Corcoran indicated that Petitioner may need future arthroscopic surgery due to increased pain. (PX2 p. 6). Dr. Corcoran kept Petitioner off work for two weeks, refilled Petitioner's pain medications, and recommended continued cryotherapy. (PX2 p. 6).

On February 22, 2016, Petitioner returned to Dr. Corcoran and reported continued pain despite two weeks of rest. (PX2 p. 2). Dr. Corcoran modified Petitioner's permanent work restrictions to no use of the left arm and instructed Petitioner to follow up on an as-needed basis. (PX2 p. 3, Tr. p. 29, 32-33). Respondent was unable to accommodate Petitioner's restrictions and Petitioner remained off work. (Tr. pp. 29-30). In an effort to avoid long-term use of opioid pain medication, Petitioner obtained a medical cannabis card, and the medical cannabis has helped to relieve some of his pain. (Tr. pp. 37-38).

On June 11, 2016, Petitioner was seen by Dr. Vitello again at Respondent's request. Dr. Vitello noted that Petitioner attempted to return to work with the restrictions outlined in the FCE but "could not perform his work." (RX3 6/10/16 report p. 3). Dr. Vitello stated that "the true nature and extent of his physical capabilities at this point are unknown. (RX3 6/10/16 report p. 3). Dr. Vitello opined that Petitioner had not reached MMI. (RX3 6/10/16 report p. 4).

On February 23, 2017, Petitioner again returned to Dr. Vitello at Respondent's request. Dr. Vitello noted that Petitioner's pain was essentially unchanged from the prior examination. (RX3 2/23/17 report p. 1). Dr. Vitello opined that Petitioner had "residual impingement in the shoulder with some crepitus with internal rotation." (RX3 2/23/17 report p. 4). Dr. Vitello reiterated his opinion that the "left shoulder is causally related to his reported injury," opined that all of Petitioner's treatment has been reasonable, necessary, and appropriate, and stated that Petitioner was at MMI. (RX3 2/23/17 report p. 5). Dr. Vitello stated that he would not expect any improvement of the condition over time. (RX3 2/23/17 report p. 5).

Petitioner tried to return to work in January 2016 and in February 2016, Petitioner began suffering left-shoulder pain. Petitioner testified he re-injured himself at work, but medical records also suggest that Petitioner had pain while vacuuming. On February 22, 2016, Dr. Corcoran placed Petitioner on a permanent restriction of no work with the left arm. There is no dispute regarding this. There is also no dispute Petitioner has not returned to any medical provider for further treatment or evaluation of his left shoulder injury since February 22, 2016.

On February 23, 2017, following his re-examination of Petitioner, Section 12 examining expert Dr.

Vitello deferred to the FCE results for Petitioner's work capabilities. Dr. Vitello did not review any medical records nor offer any comment on treating physician Dr. Corcoran's record and opinion from February 22, 2016 when he placed Petitioner on a permanent restriction of no work with the left arm. Lastly, in his February 23, 2017 Section 12 report, Dr. Vitello again criticized Petitioner's pain complaints and he offered a current causal connection opinion and opined "all of his treatment has been reasonable, necessary, and appropriate."

Next, as a result of the aforementioned restrictions set by Dr. Corcoran on February 22, 2016, Respondent was not able to accommodate Petitioner's restriction. Consequently, the question becomes whether Petitioner falls under the odd-lot category of Permanent Total Disability, or whether another Section of the Act applies. Petitioner has not returned to any medical provider for further treatment or evaluation of his left shoulder injury since February 22, 2016. On February 23, 2017, following his exam of Petitioner, Dr. Vitello deferred to the FCE results for Petitioner's work capabilities.

Vocational Counseling and Job Search:

On July 17, 2017, Respondent initiated vocational counseling services. (PX7 p. 3, Tr. pp. 40-41). Petitioner began working with Melanie Kamen, MA, CRC of Creative Case Management, who completed a Transferrable Skills Analysis and Labor Market Survey on July 24, 2017. (PX7 p. 2). In August 2018, Kamen left the employment of Creative Case Management, and a new vocational counselor, Tracy Peterlin, was assigned.

In her labor market survey, Kamen determined Petitioner was a candidate for vocational services, and identified potential occupations earning between $9.17 and $19.88 per hour. (PX7 p. 3). Kamen noted that Petitioner's "subjective physical complaints may require reasonable accommodation from a potential employer." (PX7 p. 3).

Petitioner retained his own vocational counselor, Lisa Byrne, for the purposes of obtaining an updated labor market survey. After reviewing Kamen's report, the FCE, and interviewing Petitioner, Ms. Byrne concluded that more likely than not, Petitioner is not employable given his age, limited education and work experience, skillset, and medical restrictions. (Tr. p. 72-74). In her report, Byrne indicated that Petitioner's permanent medical restriction of the inability to use his left arm for work would also need to be accommodated by a potential employer and would need to be considered by each specific potential job to ensure that it is an appropriate fit for his needs. (PX7 p. 3).

Petitioner began keeping job contact logs in November 2017. (PX10, Tr. pp. 34-35). Those job logs reflect 1,178 job contacts between November 7, 2017 and May 7, 2019. (PX10). Petitioner testified that he applied for roughly 50 jobs per month. (Tr. p. 35). Petitioner was unable to find a job through his work with

the vocational counselor. (Tr. p. 35). Petitioner obtained one interview for a call center/dispatcher position but was not hired. (PX7 p. 4). Petitioner did not receive any other interviews or job offers. (PX7 p. 4). Byrne also noted that Petitioner would not be able to pass a pre-employment drug test, as he requires either opioid or cannabis medication to control his pain. (PX7 p. 6). Byrne concluded that after this long his return-to-work efforts appeared to have failed. (PX7 p. 6). According to Byrne, "he would need selective employment based on his restrictions and need to perform work with only one arm." (PX7 p. 7). Further, "If he were able to find an employer willing to accommodate him, it would most likely be for entry-level work, may only offer part-time hours, and would more likely than not resulted in wages of around $8.25 to $12.00 per hour." (PX7 p. 7).

Respondent did not offer the labor market survey completed by Kamen into evidence. Respondent did offer several vocational reports, dated between November 1, 2018 and May 14, 2019, into evidence. (RX4). In each report, Peterlin indicates Petitioner demonstrated compliance with the vocational process for the reporting period. (RX4). Peterlin also repeatedly states that "[m]edically appropriate positions available in the community continue to be limited in this vocational counselor's opinion." (RX4). On March 28, 2019, for the first time, Peterlin indicated that "given the length of time that the client has been searching for work with limited success, it is this vocational counselor's opinion that skill enhancement is necessary for the client to be competitive in the job market." (RX4).

In light of this recommendation, Petitioner completed computer training courses, as he had never regularly used a computer before. (Tr. pp. 33-34). Certificates of completion for computer training courses were offered into evidence as Petitioner's Exhibit 11. Despite this training, Petitioner's computer knowledge is still very limited. (PX7 p. 4). As of May 14, 2019, the date of the last vocational report Respondent offered into evidence, Peterlin's prognosis for Petitioner finding a job "is guarded due to his age, his medical restrictions, and his lack of computer skills..." (RX4).

Lisa Byrne testified on behalf of Petitioner at hearing. Byrne testified as to her labor market survey and vocational evaluation of Petitioner. (Tr. pp. 59-60). Byrne testified that she reviewed the labor market survey prepared by Melanie Kaman, as well as Petitioner's work history, medical restriction, and job search logs. (Tr. p. 65). Byrne testified that it appeared as though Petitioner's job search was "very thorough." (Tr. p. 65). Byrne explained that, it is more likely than not, due to his permanent restrictions, there may not be a job market for Petitioner, based on his very limited education, work experience. (Tr. p. 66, 72-74). Byrne also explained that the number of prospective jobs is limited because Petitioner resides in Kankakee. (Tr. p. 66). Byrne testified that if she were to look in the Chicago market for jobs suitable for Petitioner, there may be hundreds of potential jobs, but when she looked in and around Kankakee, there were "a very few number of jobs." (Tr. p. 66). Byrne testified, "there are not as many jobs in his area as others." (Tr. pp. 66-67). Byrne testified that

some of the jobs needed to be eliminated because Petitioner is limited to only the use of one hand. (Tr. p. 70). Byrne testified that if he was somehow able to find a market, it would be for entry level wages. (Tr. p. 67). Byrne testified that Petitioner's transferrable skills translate to entry level occupations. (Tr. p. 68). Byrne testified that she struggled to come up with even 10 data points for jobs for which Petitioner would potentially qualify. (Tr. pp. 117-18, 120, 137). Byrne testified that while she did come up with 10 potential jobs for Petitioner, she does not know whether any of them would be able to accommodate Petitioner's restriction of one-handed work only. (Tr. pp. 120-21).

Despite the lack of data points for actual jobs within Petitioner's geographical area, Byrne concluded that, if Petitioner could find a job, he would likely earn between $8.25 and $12.00 per hour. (Tr. p. 71). However, Byrne reiterated that, more likely than not, Petitioner is unemployable based on his local labor market. (Tr. p. 73). Byrne testified that the jobs she located were not necessarily available to someone who only has use of one arm, and that each specific job would have to be modified or tailored to his restrictions. (Tr. pp. 74-76). In order to come to a range of potential earnings, Byrne was required to assume that jobs could potentially accommodate his physical restrictions. (Tr. p. 123). However, Byrne does not know whether those jobs would actually accommodate him. Therefore, in reality, there are fewer jobs that actually are available to Petitioner. (Tr. p. 123). Byrne testified that it is impossible to determine whether a one-armed person can actually do the job by simply looking at a job description. (Tr. p. 124). The availability of jobs would depend on the specific employer accommodating Petitioner's restrictions. (Tr. p. 124).

Current Wages for Stationary Engineer:

Respondent stipulated that the current wage for a Local Union 399 stationary engineer employed by the state of Illinois is $45.97 per hour. (Tr. pp. 139-40). Petitioner's Exhibit 8 is the Local Union 399 Negotiated Prevailing Wage Certification Form confirming the wage of $45.97 per hour for a Local Union 399 journeyman operating engineer. (PX8).

Petitioner's current condition:

Petitioner continues to have "extremely sharp" pain in his left shoulder, which he described as "god awful." (Tr. pp. 36-37). Petitioner testified that it is like a "butcher knife" is stabbing him in the shoulder. (Tr. p. 36). Petitioner testified that there is never a time when his pain is completely gone. (Tr. p. 38).

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

The Arbitrator finds and concludes Petitioner's current condition of ill-being is causally related to his May 16, 2014 work accident. This finding is supported by Petitioner's contemporaneous report of injury to his supervisors, the consistent histories provided in the medical records, and the opinions of Petitioner's treating physicians and Respondent's §12 examiner. It should also be noted that Respondent voluntarily paid all of Petitioner's medical bills related to this accident, paid his TTD and maintenance benefits, and provided vocational counseling services to Petitioner for nearly two years.

Further, and very significant, **in his final, February 23, 2017 Section 12 report, Respondent's examining expert Dr. Vitello offered a current causal connection opinion; based on this opinion alone, Respondent had no reasonable basis to challenge causal connection.**

While a medical opinion is not essential to support the conclusion that an accident caused a claimant's condition of ill-being (see *Univ. of Ill. v. Indus. Comm'n*, 365 Ill.App.3d 906, 912 (1st Dist. 2006)), here the opinions of Petitioner's treating physicians, as well as those of Respondent's Section 12 examiner, all support a finding of causal connection. At Petitioner's first visit with Dr. Corcoran, Dr. Corcoran documented his opinion that the Petitioner's injury was "work-related," noted the onset of symptoms to be "5/16/14," and indicated it was an acute injury. (PX2 p. 58). Those same opinions are reflected in each subsequent note from Dr. Corcoran. (PX2 pp. 2, 5, 9, 12, 15, 18, 22, 25, 32, 35, 38, 42, 45, 49, 52). Dr. Antkowiak also made the same findings. (PX2 p. 29). Even Respondent's Section 12 examiner, Dr. Vitello, determined that Petitioner's left shoulder injury is causally related to the May 16, 2014 work accident. (RX3 2/6/15 report p. 4, 2/23/17 report p. 5). There is no contrary evidence.

The Arbitrator also notes that Petitioner was not undergoing any treatment for his left shoulder in the time leading up to the accident, and that Petitioner made consistent complaints of pain in his lower back after the accident. With respect to causation, proof of prior good health and change immediately following and continuing after an injury may establish that an impaired condition was due to the injury. *Granite City Steel Co. v. Indus. Comm'n*, 97 Ill.2d 402 (1983). To constitute an accidental injury within the meaning of the Act, the claimant need only show that some act or phase of the employment was a causative factor of the resulting injury. *Teska v. Indus. Comm'n*, 266 Ill.App.3d 740, 742 (1st Dist. 1994). Every natural consequence that flows from the injury which arose out of and in the course of the claimant's employment is compensable under the Act. Id.

Based on the medical evidence of Petitioner's treating physicians, the opinions of Respondent's Section 12 examiner, and the history of the onset of Petitioner's symptoms, the Arbitrator finds and concludes Petitioner's current condition is causally related to the work accident in which he was involved while working for Respondent on May 16, 2014.

Issue L. Nature and Extent of the Injury:

The Arbitrator finds and concludes Petitioner has proven by a preponderance of the credible evidence he is entitled to a permanent total disability award pursuant to Section 8(f) under an "odd-lot" theory.

An employee is totally and permanently disabled when he is unable to make some contribution to industry sufficient to justify payment of wages to him. *AMTC of Ill. v. Indus. Comm'n*, 77 Ill.2d 482, 487 (1979). An employee need not be reduced to complete physical incapacity to be entitled to PTD. *Ceco Corp. v. Indus. Comm'n*, 95 Ill.2d 278, 286-87 (1983). Rather, the employee must show that he is unable to perform services except those that are so limited in quantity, dependability, or quality that there is no reasonably stable market for them. *Alano v. Indus. Comm'n*, 282 Ill.App.3d 531, 534 (1st Dist. 1996).

When a claimant's disability is limited and it is not obvious that the claimant is not employable, the claimant may still demonstrate entitlement to PTD by proving he fits within the "odd-lot" category. *Westin Hotel v. Indus. Comm'n*, 372 Ill.App.3d 527, 544 (1st Dist. 2007). The odd-lot category consists of those who, though not altogether incapacitated for work, are so handicapped that they will not be employed regularly in any well-known branch of the labor market. *Valley Mould & Iron Co. v. Indus. Comm'n*, 84 Ill.2d 538, 547 (1981). An employee seeking odd-lot status must establish by a preponderance of the evidence that he falls within the odd-lot category. Id. A claimant generally fulfills this burden by showing (1) a diligent but unsuccessful search for employment, or (2) that the claimant will not be regularly employed in a well-known branch of the labor force due to his or her experience, age, training, and skills. Alano, 282 Ill.App.3d at 534-35. If a claimant makes this showing, the burden shifts to the employer to show that the employee is employable in a stable labor market and that such a market exists. *Valley Mould*, 84 Ill.2d at 547, *City of Chicago v. Ill. Workers' Comp. Comm'n*, 373 Ill.App.3d 1080, 1091 (1st Dist. 2007).

Here, the evidence indicates Petitioner satisfied his burden by clearly demonstrating that he engaged in a diligent but unsuccessful job search. The evidence presented at hearing demonstrates that for nearly two full years, between July 2017 and May 2019, Petitioner fully cooperated with the vocational counselor hired by Respondent. Petitioner made 1,178 contacts with potential employers over the nearly two-year duration of his job search, averaging approximately 50 contacts per month. (PX10). Petitioner submitted job applications both

in person and online, attended job fairs, made follow-up calls regarding resumes he sent, and completed computer training. (PX10). Petitioner's vocational counselor, Lisa Byrne, testified that in her opinion, Petitioner's job search was "very thorough," (Tr. p. 65), and that Petitioner "fully cooperated with his job search efforts." (Tr. p. 67). Quite tellingly, Respondent did not call either of its vocational counselors to testify at the hearing and did not offer the labor market survey completed by its vocational counselor into evidence. However, the Arbitrator highlights that the vocational reports Respondent offered into evidence each confirm that Petitioner complied with the vocational process in all aspects. (RX 4).

There is no evidence in the record that Petitioner disregarded or avoided potential employment opportunities or refused any work that was offered to him. There is no evidence that Petitioner applied for any jobs that were beyond his qualifications or that he purposefully avoided applying for jobs within his qualifications.

The Arbitrator finds and concludes Petitioner's job search was diligent in terms of the duration, the number of contacts, and the quality of those contacts. Despite these diligent and compliant efforts, Petitioner's job search was unfortunately unsuccessful. As such, Petitioner fully satisfied his burden to demonstrate by a preponderance of the evidence that he completed a diligent but unsuccessful job search.

While a diligent job search is, in itself, enough to shift to Respondent the burden of establishing that suitable employment exists for claimant, (*Westin Hotel*, 372 Ill.App.3d at 544), Petitioner here has also presented evidence that, due to his experience, age, training, and skills, he will not be regularly employed in a well-known branch of the labor force, thereby demonstrating that he falls within the "odd-lot" category.

Petitioner's vocational counselor, Lisa Byrne, testified that Petitioner is, more likely than not, unemployable based on his skills, his limited education and work experience, his physical restrictions, and his local labor market. (Tr. pp. 72-73, 74). Byrne explained that she attempted to look for jobs suitable for Petitioner in and around Kankakee, where Petitioner resides, but there were a very few number of jobs in his area. (Tr. pp. 66-67, 70, 73). Byrne testified that she struggled to locate even 10 data points for jobs Petitioner could even potentially qualify for based on his skills, work experience, and education. (Tr. pp. 117-18, 120, 137). Byrne testified that of those jobs, some would need to be eliminated because Petitioner is limited to only the use of one hand. (Tr. p. 120). Byrne testified that the jobs she was able to locate were not necessarily available to someone who only has use of one arm, and that each specific job would have to be modified or tailored to his restrictions. (Tr. p. 120-21). The availability of those jobs would depend on the specific employer accommodating Petitioner's restrictions. (PX7 p. 7, Tr. p. 124). In order to come to a range of potential earnings, Byrne was required to assume that the jobs would accommodate Petitioner's physical restrictions of only using one arm. (Tr. p. 123). Byrne did not know whether the occupations she listed would

hire Petitioner given his restrictions. (Tr. p. 137). As Byrne noted, it is impossible to determine whether a one-armed person can actually do the job based solely on a job description. (Tr. p. 124).

Significantly, Byrne's opinions were not refuted or rebutted. Inexplicably, Respondent presented no countervailing evidence. Respondent did not call either of its two vocational counselors to testify. Respondent did not offer a labor market survey into evidence. Respondent submitted Vocational Reports #23 through #36 at the hearing but oddly did not offer Vocational Reports #1 through #22. However, even Respondent's vocational counselor Peterlin appears to agree with Byrne, as the May 14, 2019 vocational report offered by Respondent reflects Peterlin's opinion that ***Petitioner's prognosis for finding a job "is guarded due to his age, medical restrictions, and his lack of computer skills." Peterlin also repeatedly stated, "medically appropriate positions available in the community continue to be limited."*** (RX4). This is strong evidence that the likelihood of Petitioner obtaining stable labor market employment is questionable, at best. The totality of the evidence indicates the likelihood of stable, suitable, physically accommodated employment is very weak.

Accordingly, the Arbitrator finds and concludes that while only one of the two methods is required, Petitioner has satisfied his burden to demonstrate that he is permanently and totally disabled under an "odd-lot" theory both by demonstrating a diligent but unsuccessful job search, and by presenting evidence that, due to his experience, age, training, and skill, he will not be regularly employed in a well-known branch of the labor force. As such, the burden shifts to Respondent to demonstrate that Petitioner is employable in a stable job market and that such a market exists. **The weight of the credible preponderant evidence indicates Respondent has *not* satisfied that burden.** Respondent offered no persuasive evidence that Petitioner is employable in a stable labor market or that such a market even currently exists. As Respondent did not present the testimony of either of its vocational counselors at the hearing and did not offer its own labor market survey into evidence, the opinions of Petitioner's vocational counselor stand unrefuted and unrebutted – as well as maintaining credibility. ***As such, the only testimony from a vocational counselor in the record is Byrne's opinion that, more likely than not, Petitioner is not employable in a stable job market.***

Further, it is the Commission's function, to choose between conflicting medical opinions. *International Vermiculite Co. v. Industrial Comm'n*, 77 Ill.2d 1, 4, 31 Ill.Dec. 789, 394 N.E.2d 1166, 1168 (1979); *ARA Services, Inc. v. Industrial Comm'n*, 226 Ill. App. 3d 225, 232, 168 Ill. Dec. 756, 590 N.E. 2d 78, 82 (1992). **Not only may the Commission decide which medical view is to be accepted, it may attach greater weight to the opinion of the treating physician.** *International Vermiculite Co. v. Industrial Comm'n*, 77 Ill.2d 1, 4, 31 Ill.Dec. 789, 394 N.E.2d 1166, 1168 (1979); *ARA Services, Inc. v. Industrial Comm'n*, 226 Ill. App. 3d 225, 232, 168 Ill. Dec. 756, 590 N.E. 2d 78, 82 (1992). In this matter, the Arbitrator places greater weight, credibility and reliance

on the opinions of treating physician and surgeon Dr. Corcoran over those of Respondent's Section 12 examining expert Dr. Vitello. The Arbitrator accordingly adopts the opinions of Dr. Corcoran.

The evidence shows Petitioner tried to return to work in January 2016; however, the evidence shows that in February 2016, Petitioner began suffering left-shoulder pain. It is clear Respondent was not able to accommodate Petitioner's restriction It is somewhat unclear – and not definitive – as to what caused this pain, as Petitioner testified he re-injured himself at work, but medical records also suggest that Petitioner had pain (also?) while vacuuming. However, the Arbitrator emphasizes that there is no medical opinion in the record – even from Respondent's examining expert Dr. Vitello – that "vacuuming" either severed the chain of causation or was the sole cause of a temporary aggravation of his shoulder condition. Therefore, the Arbitrator finds this record entry to have no import. The facts remains Petitioner did not return to work after February 8, 2016 and there is no argument or credible evidence that Petitioner did not return to work for any reason other than an uninterrupted link to his original work injury. Further, **significantly, on February 22, 2016, Dr. Corcoran placed Petitioner on a permanent restriction of no work with the left arm.** There is no dispute regarding this. There is also no dispute Petitioner has not returned to any medical provider for further treatment or evaluation of his left shoulder injury since February 22, 2016.

On February 23, 2017, following his re-examination of Petitioner, Section 12 examining expert Dr. Vitello deferred to the FCE results for Petitioner's work capabilities. **Very significantly, Dr. Vitello did <u>not</u> review any medical records - which means he did not review - nor offer any comment on - treating physician Dr. Corcoran's record and opinion from February 22, 2016 when he placed Petitioner on a permanent restriction of no work with the left arm. Therefore, Respondent offered <u>no</u> expert medical opinion to directly challenge, let alone rebut, Dr. Corcoran's permanent work restrictions, which clearly severely restrict Petitioner's actual ability to work and actual ability to seek and obtain gainful, stable labor market employment. Lastly, in his February 23, 2017 Section 12 report, Dr. Vitello again criticized Petitioner's pain complaints yet he offered a current causal connection opinion and opined "all of his treatment has been reasonable, necessary, and appropriate." Based on this opinion alone, Respondent had no reasonable basis to challenge any medical treatment Petitioner received.**

Based on all of the above, the Arbitrator finds and concludes Petitioner has proven by a preponderance of the credible evidence he is permanently and totally disabled under the "odd-lot" theory. Because the Arbitrator finds and concludes Petitioner is permanently and totally disabled, Respondent shall pay Petitioner benefits of $1,225.87 per week for the remainder of his life pursuant to Section 8(f) of the Act.

Robert M. Harris

Robert M. Harris, Arbitrator

Dated: July 15, 2019

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

Antonio Nellum,

Petitioner,

vs. NO: 18 WC 32382

Prairie Farms,

Respondent.

20IWCC0275

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 16, 2019 is hereby affirmed and adopted.

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

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

20IWCC0275

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: MAY 13 2020
d: 050720
BNF/mw
045

Barbara N. Flores

Deborah L. Simpson

Deborah L. Simpson

Marc Parker

Marc Parker

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

NELLUM, ANTONIO L
Employee/Petitioner

Case# **18WC032382**

PRAIRIE FARM
Employer/Respondent

20IWCC0275

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

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

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

0980 HASSELBERG GREBE SNODGRASS
KENNETH SNODGRASS
401 MAIN ST SUITE 1400
PEORIA, IL 61602

2396 KNAPP OHL & GREEN
DAVID L GREEN
6100 CENTER GROVE RD
EDWARDSVILLE, IL 62025

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Antonio L. Nellum
Employee/Petitioner

v.

Prairie Farms
Employer/Respondent

Case # **18** WC **32382**

Consolidated cases: **N/A**

20IWCC0275

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

20IWCC0275

FINDINGS

On the date of accident, **October 4, 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.

Per the stipulation of the parties, in the year preceding the injury Petitioner earned **$42,900.00**; the average weekly wage was **$825.00**.

On the date of accident, Petitioner was **46** years of age, ***single*** with **3** dependent children.

Respondent is entitled to a credit of **$0** for all benefits paid through group insurance under Section 8(j) of the Act.

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

ORDER

Petitioner failed to prove that he sustained an accident that arose out of and in the course of his employment with Respondent and, as such, all benefits are denied. The remaining issues are moot and the Arbitrator makes no conclusions as to those issues.

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

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

Melinda M. Rowe-Gillman

Signature of Arbitrator

9/30/19

Date

ICArbDec19(b)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(B)

Antonio L. Nellum
Employee/Petitioner

Case # **18** WC **32382**

v.

Consolidated cases: **N/A**

Prairie Farms
Employer/Respondent

20IWCC0275

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that he began working as a back dock worker for Respondent in mid-September of 2018 but would occasionally work as a stacker in the cooler after he finished his regular shift. Petitioner testified that testified that the stacker position moved stacks of milk around with a metal hook by placing the hook in the bottom crate and then dragging the stack to where it needed to be placed in the cooler. He testified that four gallons of milk were in a crate and that a stack was six crates high.

Petitioner testified that at approximately 11:15 p.m. on October 4, 2018 he was in the cooler stacking milk when he grabbed a stack and the bottom crate split down the corner, and that when this happened the top crate fell towards him so he stuck his right arm out to catch the falling crate and then maneuvered his body around the stack to try to "down stack" the stack with his left arm. Petitioner explained that down-stacking was removing the top crate from the stack, then the next crate, etc., until you reached the broken crate and could re-stack the entire stack. He testified that Petitioner testified that he was unable to down-stack the stack so he started waiving his left arm and hollering for someone to come help him, and that he waited approximately 3-4 minutes for someone to appear. According to Petitioner, after the 3-4 minutes had passed a co-worker came to his aid and down-stacked the stack of crates for him.

Petitioner testified that after this incident his whole right shoulder had a sharp pain in it and that it went weak. Petitioner admitted, however, that he did not report this incident to anyone before he left work at 12:09 a.m. on October 5, 2018. Petitioner also admitted he knew he hurt himself on October 4, 2018, but did not report it because there was nobody around to report it to. On cross examination, however, Petitioner admitted that his supervisor, Kyle Hansen, was at the plant when his shift ended at 12:09 a.m. on October 5, 2018.

Petitioner testified that when he returned to work for Respondent on Friday, October 5, 2018 at 1:59 p.m. as a back dock worke,r he looked to report what had occurred the previous night to the supervisor on duty which he claimed would have been "Kyle." Petitioner testified that he called Kyle on the back dock phone, that he spoke with Kyle, and that he told Kyle that he hurt his shoulder the night before and that he thought he needed to go see a doctor. However, on cross examination, Petitioner admitted he did not tell Kyle Hansen about this accident until 4:00 p.m. or 5:00 p.m. In addition, Petitioner claimed that he did not see any supervisors when he clocked in on Friday at 1:59 p.m., but admitted that there were supervisors there to whom he could have reported this accident.

Bruce Clevenger was called as a witness by Respondent at the time of arbitration. He testified that he is a jug side cooler worker for Respondent and that he was working with Petitioner in the cooler at the time of the accident at issue. He testified that he was working no more than 15 feet away from Petitioner at the time of this alleged accident. He testified that when the case "barely split" Petitioner asked for help, and that he came to Petitioner's assistance within 15-20 seconds. He testified that he then re-stacked the stack for Petitioner. He testified that the stack was only slightly leaning and that he could hold up the stack "with a finger" and that "a minute, two minutes, tops" went by from when he walked over to Petitioner until he completed re-stacking the stack for Petitioner. He further testified that after this incident he continued to work with Petitioner in the cooler for approximately 45 minutes, and that Petitioner never told him that he had hurt himself.

Mr. Clevenger testified that there were two supervisors at the plant when this incident occurred and that employees were to report any accidents immediately. In addition, Mr. Clevenger testified that the night before this alleged accident occurred, Petitioner had complained about working in the cooler.

On cross-examination Mr. Clevenger was asked by Petitioner's counsel where Mr. Hansen was in the facility to which he responded that "we have a phone that we call Kyle Hansen to the cooler, and, boom, he is right there."

Kyle Hansen was called as a witness by Respondent at the time of arbitration. He testified that he is a night-shift production supervisor and works 4:00 p.m. to 1:00 a.m. He testified that employees were taught to report accidents by the end of their shift when they occurred, and that he was there around the time that Petitioner claimed that he was hurt.

Mr. Hansen testified that on October 5, 2018 at some point after 4:00 p.m. he called Petitioner into the office to tell him he was going to work in the cooler after his regular shift ended at 10:00 p.m. He testified that Petitioner told him that he was not going to be able to do the job (*i.e.,* referring to the cooler job) because of the pins in his shoulder. Mr. Hansen further testified that Petitioner said that he was not going to do it (*i.e.,* referring to the cooler job). He testified that he then discharged Petitioner for refusing to work in the cooler. He testified that only after Petitioner was told he was terminated did he tell him that he had hurt himself the night before. He testified that Petitioner never requested to see a doctor. He further testified that there were five supervisors at the plant at 2:00 p.m.

The Application for Adjustment of Claim was entered into evidence at the time of arbitration as Petitioner's Exhibit 1. The Petition for 19(b) Hearing was entered into evidence at the time of arbitration as Petitioner's Exhibit 2. The Notice of Motion and Order was entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The Request for Hearing was entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The Petition in Support of TTD Benefits and Medical Treatment was entered into evidence at the time of arbitration as Petitioner's Exhibit 5.

The transcript of the deposition of Dr. Miguel Ramirez taken on June 13, 2019 was entered into evidence at the time of arbitration as Petitioner's Exhibit 6. Dr. Ramirez testified that he is an orthopedic surgeon, that he is board-certified in orthopedic surgery, and that he specializes in shoulder and elbow surgery. (PX6).

Dr. Ramirez testified that he performed surgery on Petitioner on October 17, 2017, at which time it was noted that he had a superior labral tear, degenerative changes in his shoulder, and a full-thickness rotator cuff tear. He testified that he performed debridement of the shoulder as well as rotator cuff repair, an arthroscopic biceps tenodesis, and a subacromial decompression. He testified that prior to performing surgery he reviewed Petitioner's MRI dated July 31, 2017, which revealed a high-grade partial thickness tears of the rotator cuff, a very large labral tear, and cartilage damage to the shoulder. He testified that the

previous surgery was performed as a result of a different accident at work for a different employer, and that he eventually released Petitioner to return to work with no restrictions on April 16, 2018. (PX6).

Dr. Ramirez testified that before Petitioner was returned to work in April 2018, he performed an injection into the right shoulder on March 15, 2018 as he was having some tendonitis-type symptoms and a little bit of scar tissue. He testified that a corticosteroid injection was given to help bring down the inflammation in Petitioner's rotator cuff and to hopefully get rid of the some of the scar tissue that was causing him pain. He testified that it was not uncommon for him to have to do an injection like this after a surgery. When asked whether the injection seemed to help Petitioner, Dr. Ramirez responded that he believed that it helped as evidenced by the fact that he saw him the following visit and he was ready to go back to work full duty. He testified that Petitioner followed-up with him again on July 16, 2018 for another injection, at which time he had a different problem than he previously had. He testified that Petitioner had more biceps tendonitis in July, so the pain that he had was anterior as opposed to the typical lateral pain that he had before. He testified that he told Petitioner that if the injection did not improve his pain that he would order an MRI, and that he did not return until November 29, 2018. (PX6).

Dr. Ramirez testified that at the time of the November 29, 2018 visit, Petitioner stated that he was lifting a heavy object, that it was falling back on him, and that since then he had been having anterior shoulder pain. He testified that he thought that Petitioner had re-aggravated the biceps tendonitis that he had seen him for, so he gave him another cortisone injection at that point to hopefully reduce the inflammation in the biceps. He testified that the injection did not help and that Petitioner indicated that he wanted an MRI because the pain had not improved. He testified that as of November 29, 2018 and thereafter Petitioner's subjective complaints increased, as he stated that the pain was worse than it was, especially after the injury, and that the injections that helped him before did not help him at that point. He testified that his plan at that point was to obtain an MRI to see if there were any new tears that were causing some of Petitioner's pain. (PX6).

Dr. Ramirez testified that Petitioner called in again on December 26, 2018 and reported increased pain, and that the MRI was eventually performed on January 8, 2019. He testified that the MRI showed that Petitioner had a full-thickness re-tear of the rotator cuff, that he had some fraying of the labrum which one sees post-operatively, and that he had a little arthritis as seen before, but that the salient findings were a re-tear of his rotator cuff. He testified that the re-tear was of the supraspinatus tendon, which was one of the tendons that Petitioner tore previously. He testified that when he saw Petitioner on January 14, 2019, he gave him the options of proceeding with another injection, doing more therapy, or repairing the rotator cuff. He testified that Petitioner at that time was still having increased subjective complaints, which was consistent with a re-tear of the rotator cuff. He testified that Petitioner wanted to get it repaired. (PX6).

Dr. Ramirez testified that as of January 14, 2019, he took Petitioner off work. He testified that he has not seen Petitioner since that date. He agreed that he understood that Petitioner was a truck driver. He testified that the basis for keeping Petitioner off work was that he was in a significant amount of pain and did not feel like he could perform his duties safely with the amount of pain that he had from the rotator cuff tear. He agreed that rotator cuff tears of the nature Petitioner had can be painful, that they can restrict someone's lifting abilities, and that he thought it was reasonable to keep him off work. When asked whether he thought the condition was going to improve based on what he had found as of January 14, 2019 without the surgery, Dr. Ramirez responded that rotator cuff tears did not heal and if anything, they just got bigger over time. He testified that symptoms could improve even though the tear did not heal, but that the natural history showed that eventually it catches up and the pain usually comes back. (PX6).

Dr. Ramirez testified that untreated rotator cuff tears get bigger over time and can lead to rotator cuff arthropathy where the tear gets very big, you start developing osteoarthritis, and eventually the rotator cuff tear is no longer repairable and you require a shoulder replacement as opposed to a rotator cuff repair. When asked to compare the MRIs dated October 17, 2017 and January 8, 2019, Dr. Ramirez testified that

the MRI that was done in 2017 showed basically a high-grade partial thickness tear of the rotator cuff, so the rotator cuff was intact but basically "hanging by a thread." He testified that Petitioner also had a large labral tear and some degenerative changes. He further testified that the most recent MRI did not show labral pathology but basically post-operative changes, and that Petitioner had a full-thickness tear of the rotator cuff at that time as opposed to the high-grade partial thickness tear. He testified that the high-grade partial thickness meant that the rotator cuff was still attached, that it was just almost completely torn, and that it had not torn all the way through. He testified that in a full-thickness tear, it was torn all the way through and completely detached from the bone. He testified that the type of surgery he would perform for Petitioner would be that of an arthroscopic rotator cuff repair, which would involve debridement, another decompression of the inflamed bursa, and then repairing the rotator cuff back to where it came from. (PX6).

Dr. Ramirez testified that he believed that Petitioner's accident on October 4, 2018 -- when a stack of milk crates about 5-6 feet high fell against his right shoulder and he attempted to hold the remaining crates so they would not fall over – could have caused a re-tear of his rotator cuff. He testified that Petitioner's right shoulder condition that had previously been repaired made him more susceptible to having a re-tear and that once you repaired the rotator cuff, sometimes either part of it cannot heal or does not heal so that it is susceptible to re-tearing. When asked what other things by way of the MRI that he saw that might have evidenced an additional trauma other than the rotator cuff tear, Dr. Ramirez responded that it was really hard to say and that other than the fact that it was torn at the area where they had repaired it, it was almost impossible to tell if it was a new trauma or it was old. When asked whether the milk carton accident could have aggravated any sort of degenerative changes that Petitioner had in his right shoulder, Dr. Ramirez responded in the affirmative and testified that every time you injured the shoulder it was an arthritic shoulder and that you could have an aggravation of the joint. (PX6).

Dr. Ramirez testified that the surgery that he proposed for Petitioner was causally related to the accident that he described having occurred on October 4, 2018. He testified that he had no other reason to believe that there was another injury, that Petitioner stated that this had happened, and that since then he was having increased pain so it "kind of falls together." He testified that there was nothing that he had seen in Petitioner's records which would indicate any other evidence of trauma other than what he described to him occurring on October 4, 2018. (PX6).

On cross examination, Dr. Ramirez agreed that the operative report of October 17, 2017 made reference to his having seen a full-thickness rotator cuff tear. He agreed that the prior injury that necessitated the October 17, 2017 surgery was a significant injury to Petitioner's right shoulder. He agreed that if someone had had a rotator cuff tear, they were potentially more susceptible to additional rotator cuff problems in the future. He agreed that individuals did not need to have a specific event to have future rotator cuff pathology, but further testified that given enough time eventually most of them did re-tear. (PX6).

On cross examination, Dr. Ramirez agreed that at the time of the March 15, 2018 visit, Petitioner complained of anterior shoulder pain. He agreed that anterior shoulder pain could be a sign of rotator cuff pathology, but further testified that it depended on where exactly the location was. He agreed that he gave Petitioner a subacromial injection on that date and that a subacromial injection was given for suspected rotator cuff pathology. He agreed that Petitioner stated that he received relief from that injection. He agreed that when Petitioner came back on April 16, 2018 he said he was doing well, that his pain had been well controlled, and that he was released to full duty without restrictions and instructed to return as needed. He agreed that on July 16, 2018 Petitioner returned again because he started having increased pain in his right shoulder, and that the pain was mostly anterior. He agreed that this was the same area of the shoulder that had pain on March 15, 2018. He agreed that Petitioner did not mention any additional accident or event that caused that increased pain. He agreed that increased pain could signify rotator cuff pathology. He further agreed that it was possible that Petitioner had increased pain because the injection wore off. (PX6).

On cross examination, Dr. Ramirez agreed that on July 16, 2018 he gave Petitioner another subacromial injection, which was the same injection he have him on March 15th. He agreed that the plan was to see what, if any, relief Petitioner had from that injection and to go from there. He agreed that he was considering ordering an MRI at that time but was going to hold off and see how Petitioner did. He agreed that it was possible that since Petitioner did not return to him after July 16th until November 29th, either he did not receive relief and merely did not return or he received some relief at least for some period of time. (PX6).

On cross examination, Dr. Ramirez agreed that Petitioner reported to him that he was lifting a heavy object and then started having anterior shoulder pain. When asked what he was lifting, Dr. Ramirez responded that he believed it was a milk crate. He testified that he believed that it was on something and that it fell. He testified that he was not clear as to whether Petitioner was putting it up on something or something was falling necessarily, and that they did not talk about the specifics of the injury. He testified that he did not know the weight of the object that Petitioner was lifting, nor did he know how he was lifting it. He agreed that if the history of lifting a heavy object was inaccurate, his opinions regarding causation as to the right shoulder could change. (PX6).

On cross examination, Dr. Ramirez agreed that the shoulder pain at the visit on November 29, 2018 was in the same area of the shoulder that Petitioner had pain on March 15th and July 16th. He agreed that he gave Petitioner a subacromial injection on November 29, 2018, which was the same injection he gave him on March 15th and July 16th. He agreed that relief from a subacromial injection was going to vary patient by patient and by condition as well. He agreed that he may give a subacromial injection to a patient and never see them again, that they may call two weeks later and say that it did not help at all, or that they may call three months later and say that it was not helping anymore but that it did. He agreed that the March 15, 2018 subacromial injection gave Petitioner approximately four months of relief. He agreed that it was possible that the right shoulder pain Petitioner claimed to have experienced in early October of 2018 could have been from no injury or event at all, but just because the July 16, 2018 injection wore off. (PX6).

On cross examination, Dr. Ramirez testified that at the time of the November 29, 2018 visit, he did not believe that he gave Petitioner any work restrictions. When asked if, after he saw Petitioner on July 16, 2018, he would have undergone an MRI between July 16, 2018 and October 4, 2018 he would agree that it was possible that the pathology seen on an MRI in that timeframe could have been the same as the MRI that he saw January 8, 2019, Dr. Ramirez responded in the affirmative. When asked whether Petitioner asked to be taken off work as of the time of the January 14, 2019 visit, Dr. Ramirez responded that he believed that he asked him if he felt that he could continue doing his job, and that he stated that he could not keep doing his job safely so he decided to take him off. He testified that it was his understanding that Petitioner was working then. When asked if he knew where, Dr. Ramirez responded that his understanding was that Petitioner was at Prairie Farms and testified that he did not know if he had a new job at that point or not. He testified that he assumed that Petitioner was still working at the same location, but that he did not ask him if that was different. (PX6).

On cross examination when asked what changed between November 29, 2018 and January 14, 2019 as far as work restrictions were concerned, Dr. Ramirez testified that in November he believed that the pain was reasonable at the time and that the injection would probably knock it down in a couple of days so that Petitioner could go back to work. He testified that at the January visit after the MRI was obtained he figured it was not going to get better, that Petitioner had a rotator cuff tear, and that they should protect the shoulder. (PX6).

On cross examination, Dr. Ramirez agreed that it was fair to say that it was possible that Petitioner would have needed the surgery he was recommending before October 4, 2018 if an MRI diagnosed it. He testified that a forceful contraction on the rotator cuff could make a tear. He testified that it was impossible to say how much weight there would need to be in order to cause the rotator cuff tear, and that it depended

on the strength and integrity of the rotator cuff at the time, the individual, and their age. He testified that it was highly unlikely that just being struck by something caused a tear on the rotator cuff. (PX6).

On redirect, Dr. Ramirez testified that when he gave the injections in March and July of 2018, he was not suspecting another rotator cuff tear at that time. He testified that it would be consistent with his treatment plan sometimes that he would have to give a patient an injection for scar tissue. He agreed that when he saw Petitioner on July 16, 2018 he also gave him another injection and thought it might be biceps tendonitis. He testified that he was not at that point in time suspecting that Petitioner had another rotator cuff tear because his complaints were different. He agreed that he released Petitioner to return to work on April 15, 2018 without restrictions, and that at that point in time he indicated that he was satisfied with his recovery. (PX6).

On redirect, Dr. Ramirez agreed that he gave Petitioner an injection on November 29, 2018 and that previous injections had given him months of relief. He agreed that, in this case, when Petitioner reported the new injury, the injection did not help. He agreed that Petitioner was calling in indicating that he was having ongoing pain and was asking for pain medication, which was different. He agreed that at that point in time he started to suspect that there might be a rotator cuff tear and decided that he was going to get an MRI. When asked to assume that Petitioner had come back to him after the injections within a week or two as he did with the last one and how he would have changed his treatment plan, Dr. Ramirez responded that he would have just obtained an MRI. (PX6).

On redirect when asked of the significance of the change in Petitioner's complaints after the November 29, 2018 visit, Dr. Ramirez testified that he felt that shortly after his surgery his complaint was more biceps-related so he was going more down the route of thinking biceps pathology and that this time, he felt more pain and that it was more globalized. He testified that Petitioner still had the same anterior pain but he also had some more lateral-sided pain and more diffuse pain, which "tipped" him to whether there was something else going on. (PX6).

On redirect, Dr. Ramirez agreed that at no time when he did the July 16, 2018 injection did he restrict Petitioner from work. He agreed that when Petitioner had the July 16th injection he was released to return to work full duty with no restrictions. He testified that it was very unlikely that he would release someone to return to work full duty with no restrictions if he thought they had a rotator cuff tear. When asked what was the most significant thing that led him to place restrictions on Petitioner in regards to his work as of January 14, 2019, Dr. Ramirez responded that it was the amount of pain that he was having and his basically stating he was unable to return to work, as well as the MRI findings. He agreed that he knew that Petitioner had a complete tear of the rotator cuff. (PX6).

On redirect, Dr. Ramirez agreed that the type of event or trauma as described by Petitioner's attorney was the type that could cause a reccurrence of a rotator cuff tear as evidenced on the MRI based on his physical examination findings. When asked specifically what was significant to him in regard to the trauma, Dr. Ramirez responded that it was mostly the description of having to hold up the cartons from falling, as that particular motion could cause the tear. (PX6).

On further cross examination, Dr. Ramirez agreed that Petitioner could have had a rotator cuff tear in the timeframe of March 15, 2018 and July 16, 2018 and that he just did not suspect it. He agreed that on November 29, 2018, he did not restrict Petitioner from work. He agreed that he was not sure how much the crates weighed or exactly what amount of force was towards Petitioner. (PX6).

On further redirect, Dr. Ramirez agreed that 24 gallons of milk was not an insignificant amount of weight to be holding up. (PX6).

With respect to Group Exhibit 3 (*i.e.*, medical records of OSF Orthopedics) attached to the transcript of the deposition of Dr. Ramirez, the records reflect that Petitioner was seen on July 31, 2017 with a chief complaint of right shoulder pain. It was noted that Petitioner worked at Brenntag Midwest as a truck driver, that he stated he as at work pulling a one-ton cylinder, and that it got caught on uneven ground while he was still pulling. It was noted that Petitioner felt a sharp pain in the bicep, that he stated his pain was posterior and radiated into the bicep, and that his range of motion was limited with certain movements. It was noted that Petitioner noticed tingling in the right hand, that he was unable to sleep, and that the pain was constant. The impression was noted to be that of (1) acute pain of the right shoulder; (2) labral tear of the right shoulder; (3) hyperlipidemia with target LDL less than 100; (4) essential hypertension; (5) uncontrolled type 2 diabetes mellitus with hyperosmolarity without coma, without long-term current use of insulin; (6) obstructive sleep apnea. It was noted that Petitioner had a labral tear as well as high-grade partial-thickness rotator cuff tears. It was noted that given Petitioner's age, occupation, and activity level, Dr. Ramirez recommended right shoulder arthroscopic labral repair, decompression, and possible rotator cuff repair. Included within the records was an interpretive report for an MRI of the right shoulder performed on July 6, 2017, which was interpreted as revealing (1) articular surface delaminating partial-thickness tear of the supraspinatus tendon; underlying mild tendinosis; (2) articular surface delaminating partial-thickness tear of the infraspinatus tendon extending along the myotendinous junction; (3) high-grade partial-thickness tear of the cranial fibers of the subscapularis; mild loss of muscular bulk; (4) extensive, near circumferential labral tear, particularly affecting the posterior labrum; clinical correlation for findings of multidirectional glenohumeral joint instability recommended; (5) significant articular cartilage loss along the posteroinferior glenoid; (6) mild to moderate degenerative changes of the acromioclavicular joint, with mild associated mass effect; Type III acromion with laterally downsloping orientation; correlation with clinical findings of impingement recommended; (7) subacromial/subdeltoid bursa. (PX6).

The records of OSF Orthopedics reflect that Petitioner underwent x-rays of the right shoulder on July 31, 2017, which were interpreted as normal. At the time of the October 27, 2017 visit, it was noted that Petitioner stated that he was doing well and that his pain had been well-controlled. The assessment was noted to be that of non-traumatic complete tear of the right rotator cuff. Petitioner was recommended to continue the sling and not to lift anything heavier than a coffee cup. Petitioner was recommended to start physical therapy in three weeks and to follow-up in three weeks. At the time of the November 17, 2017 visit, it was noted that Petitioner stated that he was doing well and that his pain had been well-controlled. It was also noted that Petitioner continued to have anterior pain and that he complained of numbness. It was also noted that Petitioner was to still use the sling for sleeping and when outdoors for the next two weeks, and that he could remove it altogether after that. Petitioner was recommended not to lift anything heavier than a coffee cup and also to start physical therapy. Petitioner was further recommended to return in six weeks. At the time of the December 18, 2017 visit, it was noted that Petitioner stated that he was doing well, that he was working with physical therapy, and that his pain had been well-controlled. It was also noted that Petitioner continued to have a "knot" on his upper bicep, which caused pain with certain movements. Petitioner was recommended to advance to phase 3 of the therapy protocol and could progressively increase lifting at home to match strengthening done in therapy. Petitioner was recommended to return in six weeks and it was noted that he would likely be released to full activity at that point. (PX6).

The records of OSF Orthopedics reflect that Petitioner was seen on January 29, 2018, at which time it was noted that he continued to experience pain both at rest and with movement, that he stated his shoulder was still swollen and that ice made it worse, and that he was in therapy but stated that he still felt weak and did not believe that they had started strengthening. Petitioner was recommended to continue in therapy, remain off work and follow-up in six weeks. The records reflect that Petitioner underwent a right shoulder subacromial injection on March 15, 2018. At the time of the March 15, 2018 visit, it was noted that Petitioner stated that he was doing well, that he complained of anterior shoulder pain, and that he was working with physical therapy and doing well. It was noted that Petitioner had a well-healed cuff but

continued to have anterior shoulder pain, likely a little bit of scar tissue versus biceps tendonitis. Petitioner was recommended to undergo a corticosteroid injection and continue with therapy. Petitioner was also recommended to return in one month for re-evaluation and it was noted that he was likely to be returned to full activity at that point. At the time of the April 16, 2018 visit, it was noted that Petitioner stated that he was doing well, that he had completed therapy and continued home exercises, that his pain had been well-controlled, and that he was very satisfied with his results. It was also noted that Petitioner stated that he was doing well, that he stated that he only had issues when reaching up to get this, that he stated his last physical therapy session was last week, and that he was continuing to do stretches and exercises at home to keep his range of motion and strength. It was noted that Petitioner's rotator cuff was well-healed, that his pain was low, that he had good strength, that he was very satisfied with his result, and that he was released to full activity without restrictions. Petitioner was instructed to return as needed. (PX6).

The records of OSF Orthopedics reflect that Petitioner underwent a right shoulder subacromial injection on July 16, 2018. At the time of the July 16, 2018 visit, it was noted that Petitioner stated that he recently started having increased pain, that it was mostly anterior, and that he had had no injuries that he remembered. It was noted that it was likely biceps tendinitis and that Dr. Ramirez would try a corticosteroid injection to see how it did over the next couple of weeks. It was noted that if Petitioner had no relief from the injection, an MRI would be ordered. Petitioner was recommended to return as needed. Petitioner was also given a prescription for Tramadol. At the time of the November 29, 2018 visit, it was noted that Petitioner stated that he thought he may have re-injured himself at work, that he stated that he was lifting a heavy object, and that he then started having anterior shoulder pain. It was noted that Petitioner denied any previous shoulder pain prior to this episode. It was also noted that Petitioner stated that cases of milk fell on him at Prairie Farms, that he denied taking pain medication, and that the pain was in the same area of his shoulder as his original injury. It was noted that Petitioner likely had biceps tendinitis and that he was recommended to undergo a corticosteroid injection. Petitioner was recommended to return as needed. (PX6).

The records of OSF Orthopedics reflect that Petitioner called in on December 13, 2018, at which time it was noted that he stated that the injection had not helped at all, and that the pain was in the front of the shoulder and did not radiate. It was noted that Petitioner was asking for an MRI. The Telephone Encounter dated December 19, 2018 noted that Petitioner was calling in regards to wanting Dr. Ramirez to change the MRI order to with contrast, that he stated that the last time he had an MRI without contrast it did not show anything, that he had to have another MRI with contrast, and that he was wanting to avoid this issue again. The Telephone Encounter dated December 26, 2018 noted that Petitioner stated that he was still having pain in the right shoulder and wanted Dr. Ramirez to order him something to help with the pain, that he was not doing anything to help relieve pain, and that he was to ice the shoulder and take over-the-counter pain medications until hearing back from Dr. Ramirez. At the time of the January 14, 2019 visit, it was noted that Petitioner was seen for the MRI results and that he denied a change in symptoms. The assessment was noted to be that of (1) complete tear of right rotator cuff; (2) essential hypertension; (3) uncontrolled type 2 diabetes mellitus with hyperglycemia; (4) morbid obesity due to excess calories; (5) obstructive sleep apnea. It was noted that Petitioner had a re-tear of his rotator cuff and that after a discussion was had about treatment options, he had opted for surgical repair. (PX6).

Included within the records of OSF Orthopedics was an interpretive report for an MRI of the right shoulder performed on January 8, 2019, which was interpreted as revealing (1) post-operative changes of the rotator cuff repair with full-thickness, partial width tear of the supraspinatus tendon; (2) degenerative fraying/tear of the posterior to posteroinferior glenoid labrum with associated subcortical cystic change and small paralabral cyst; (3) mild to moderate degenerative arthritis right glenohumeral and acromioclavicular joints. Also included within the records of OSF Orthopedics was a work slip dated January 14, 2019, which indicated that Petitioner would be out of work until his follow-up after surgery. The Operative Report dated October 17, 2017 noted that Petitioner underwent (1) right shoulder extensive glenohumeral debridement;

(2) right shoulder arthroscopic double row rotator cuff repair; (3) right shoulder arthroscopic biceps tenodesis; (4) right shoulder subacromial decompression for pre-operative diagnoses of right shoulder labral tears, right shoulder biceps tendinitis, and right shoulder subacromial impingement and post-operative diagnoses of right shoulder superior labral tear, right shoulder degenerative anterior and posterior labral tears, right shoulder glenohumeral osteoarthritis changes, right shoulder biceps tendinitis, right shoulder full-thickness rotator cuff tear, and right shoulder subacromial impingement. (PX6).

The Office Note of May 30, 2019 was entered into evidence at the time of arbitration as Petitioner's Exhibit 7. The records reflect that Petitioner was seen on that date, at which time he stated that he continued to have uncontrolled, constant pain as well as decreased range of motion and strength within the shoulder. It was noted that Petitioner would still like surgery and was working with work comp to do so. It was noted that Petitioner wanted to talk about getting pain mediation [*sic*]. It was also noted that Petitioner still needed surgery to repair the cuff and may schedule at any time. Petitioner was given a prescription for Tramadol. (PX7).

The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 8.

The Application for Adjustment of Claim and Approved Settlement Contract for 17 WC 18245 was entered into evidence at the time of arbitration as Respondent's Exhibit 1. The Application for Adjustment of Claim for 17 WC 18245 referenced an alleged date of accident of June 7, 2017 involving the right shoulder and bicep while moving a cylinder. The Settlement Contract Lump Sum Petition and Order for 17 WC 18245 was approved on January 16, 2019 and was settled for approximately 13.3% of the body as a whole. (RX1).

The transcript of the deposition of Dr. Chris Kostman taken on July 10, 2019 was entered into evidence at the time of arbitration as Respondent's Exhibit 2. Dr. Kostman testified that he is a board-certified orthopedic surgeon. He testified that approximately half of his practice was upper extremity injuries, including shoulders. (RX2).

Dr. Kostman testified that he performed an IME of Petitioner. He testified that Petitioner reported that the bottom crate broke and that the stack leaned forward towards his body, and that he supported the stack of milk crates with his right palm and left palm with the crates coming forward and resting onto his right shoulder. He testified that Petitioner also reported that he was alone when this occurred, that he described that in the cooler where this occurred he was waving for someone's attention, and that it was 3-5 minutes later when someone arrived to pull the crates one by one off from the stacked leaning position against his body. He testified that Petitioner also reported that he started a new job driving semi-tractor trailers on October 17th with an orientation, that he started driving activities two days later around October 19th, that he described his work as driving a manual transmission semi-tractor trailer truck without any manipulation of his loads, and that he had some difficulty with this activity that he did 7-8 hours a day for approximately four days a week until November 30th when he was released from that occupation because he was unable to get a postal license. (RX2).

Dr. Kostman testified that after performing a physical examination he thought that Petitioner's rotator cuff weakness was consistent with his MRI scan findings demonstrating a rotator cuff tear, and that his AC joint tenderness was consistent with his AC joint arthritis evident on plain films and his MRI scan. He testified that the four-view shoulder x-rays that were performed showed two prior metal anchors in the greater tuberosity, prior evidence of acromioplasty, degenerative change involving the glenohumeral joint with inferior osteophyte formation off the humeral head and neck, and moderate AC joint degenerative changes. He testified that he reviewed the MRI of the right shoulder from July 6, 2017 and that there was a high-grade tear of the supraspinatus that was found at the time of surgery to be full-thickness, but that he agreed with the radiologist's interpretation that it looked like a high-grade tear on the MRI scan. He testified

that he further agreed with the radiologist as to arthritis involving the glenohumeral joint as well. He testified that he reviewed the operative report from the surgery of October 17, 2017 as well. (RX2).

Dr. Kostman testified that he reviewed medical records from Dr. Ramirez dated March 15, 2018, and that they indicated that Petitioner continued to have anterior shoulder pain, that it was elected to give him a corticosteroid injection along with the recommendation of continuing to do more therapy, and that the injection was delivered into the right shoulder joint through an interval portal. He testified that he also reviewed the medical records of Dr. Ramirez dated April 16, 2018, at which time it was noted that Petitioner was doing well, had completed therapy, and continued his home exercise program. He testified that Petitioner was released to full activity without restrictions and was recommended to follow-up on as needed basis. He testified that he also reviewed the medical records of Dr. Ramirez dated July 16, 2018, at which time Petitioner came back having been released from care for right shoulder pain. He testified that Petitioner described recently having increased pain, mostly anterior, and that Dr. Ramirez recommended a corticosteroid injection, similar to the one previously given. (RX2).

Dr. Kostman testified that he also reviewed the medical records of Dr. Ramirez dated November 29, 2018, and that the notes described a possible distal clavicle resection but that this was not performed according to the records. He testified that it was noted that Petitioner was one-year status post rotator cuff repair and that he may have re-injured it at work lifting a heavy object, and that he started having anterior shoulder pain. He testified that the injection that was given was to the posterior part of the shoulder joint, and that it was different from the prior two injections which were given in the interval and likely to be, based on the location of the injection, intraarticular. He testified that the formulation was also different on that injection. He testified that there were a variety of reasons that someone would get a subacromial injection, such as rotator cuff tendinitis, subacromial bursitis, and several different inflammatory conditions. (RX2).

Dr. Kostman testified that he had seen the situation where a steroid injection might be beneficial initially, but that follow-up injections were less beneficial and may not be as effective. He testified that in some cases the steroid no longer had a significant effect as far as decreasing inflammation, and that in this case the last injection was a bit different formulation and also appeared through the notes to have been given in a different location. He testified that he also reviewed the MRI of January 8,2019, and that it showed post-operative change rotator cuff repair with a full-thickness supraspinatus rotator cuff tear, and that it also showed findings involving the glenohumeral joint that were very similar in that they were degenerative changes. (RX2).

Dr. Kostman testified that his diagnosis of Petitioner's right shoulder was that of a right shoulder strain, right shoulder rotator cuff tear, right shoulder glenohumeral joint arthritis, right shoulder acromioclavicular joint arthritis, and status post right shoulder rotator cuff repair and biceps tenodesis. He testified that it was his opinion that the accident of October 4, 2018 did not cause or permanently aggravate Petitioner's right shoulder rotator cuff tear or the right shoulder glenohumeral joint arthritis. He testified that the incident described by Petitioner was a series of stacked milk cartons weighing approximately 40 pounds each where the base carton broke, and that he stopped that from falling over and basically supported it with his bilateral hands. He testified that it was essentially supporting someone who was leaning over against you, and that he did not think that that was a mechanism for a recurrent rotator cuff tear or a permanent aggravation of Petitioner's glenohumeral arthritis. He testified that he did not believe that the incident of October 4, 2018 was a cause or permanent aggravation of Petitioner's AC joint arthritis for the similar reason, in that he did not believe that the mechanism of injury fit with permanent aggravation or causing that diagnosis. (RX2).

Dr. Kostman testified that it was his opinion that Petitioner may elect to have medical management or operative management for his right shoulder because of his underlying rotator cuff tear. When asked whether Petitioner required restrictions for his right shoulder, Dr. Kostman responded that he did not believe

that he required restrictions as related to his October 4, 2018 incident, but that his patients who had rotator cuff tears, glenohumeral arthritis, and AC joint arthritis may have difficulty with heavy lifting activities, particularly above-chest lifting and reaching activities. He testified that what he typically recommended for his patients with those diagnoses would be that they avoid heavy above-chest lifting, but that he typically did not have any restriction for below-chest lifting. He testified that he believed that Petitioner was at maximum medical improvement for his right shoulder related to his accident. (RX2).

On cross examination, Dr. Kostman testified that he did not find in any of his review of the documentation any other incident or trauma or accident that would have been related by Petitioner subsequent to his return to work from his surgery in October of 2017. He testified that there was nothing in his review of the records which would indicate that the event did not occur on October 4, 2018. He agreed that he reviewed the witness statement of Bruce Levenger, which he believed was consistent with the history that was provided by Petitioner. (RX2).

On cross examination when asked whether he agreed that Petitioner had another tear in the shoulder, Dr. Kostman responded that whether it was another tear or whether it was a failure of the healing, he thought the MRI clearly identified a tear in the supraspinatus tendon of Petitioner's shoulder. He agreed that other than the event that Petitioner described to him which was corroborated by a co-worker, they did not have any other evidence of any type of trauma to the shoulder area in the medical records following Petitioner's surgery. (RX2).

On cross examination, Dr. Kostman agreed that he reviewed Dr. Ramirez's deposition. He agreed that Dr. Ramirez compared the two MRIs, but further testified that he did not agree with his comparison of those two MRIs. He testified that he did not agreed that the first MRI showed a high-grade partial thickness tear of the rotator cuff. He did agree, however, that the second MRI showed that the rotator cuff was completely torn. He testified that he agreed with the interpretation of the initial MRI scan but that the intraoperative findings demonstrated that it was a full-thickness tear, which was a more accurate assessment than the MRI scan. (RX2).

On cross examination, Dr. Kostman testified that from what he had reviewed there were no diagnostic films prior to October 4, 2018 that indicated that Petitioner's first surgical repair had not been done successfully. He agreed that Petitioner's physical examination findings were consistent with his MRI scan findings. He agreed that trauma could cause rotator cuff tears. He agreed that trauma could aggravate the type of arthritis that he had described on direct examination and that it could make it symptomatic. He testified that he did not have any comment as far as the medical necessity of the procedures performed by Dr. Ramirez. He testified that it was relatively uncommon to have an injection subsequent to surgery and that he rarely gave injections after surgery. He testified that the basis for that was that injections, especially intraarticular injections, could weaken structural tissues that were trying to heal. (RX2).

On cross examination, Dr. Kostman agreed that Petitioner was released to return to work full duty as of April 16, 2018. He agreed that Petitioner's first injection was approximately three months later on July 16, 2018 and that he was told if there was no relief that Dr. Ramirez may order an MRI. He agreed that Petitioner did not return to see Dr. Ramirez after his release until November 29, 2018, which was about 4½-5 months later. He agreed that at that point in time, the medical records indicated that Petitioner had had a new injury that he reported on October 4, 2018. He agreed that Petitioner indicated that subsequent to the October 4, 2018 incident at work with the milk crates, he had had increased discomfort and pain. (RX2).

On cross examination, Dr. Kostman testified that the note dated April 16, 2018 stated that Petitioner was allowed to work full activity without restrictions. He agreed that there was nothing that he reviewed in the medical records that indicated that Petitioner would have been restricted in any fashion from his activities prior to October 4, 2018. He testified that he did not believe that Petitioner needed any restrictions

related to the October 4, 2018 event. He testified that for patients that presented in his practice with glenohumeral arthritis and rotator cuff tears that had difficulty with above-chest lifting, he would write restrictions for those activities if they had difficulties with those activities. He testified that weight restrictions could vary, depending on the patient. When asked that type of weight limitations he would place on someone having difficulty with above-shoulder lifting, Dr. Kostman responded that it could range anywhere from 5-30 pounds depending on the patient. (RX2).

On cross examination, Dr. Kostman testified that he assumed Petitioner's position as a truck driver was a heavy job. He testified that Petitioner described being a left-handed individual. He agreed that, taking out the causation issue as to the October 4, 2018 event, surgery was a reasonable alternative for treating Petitioner's current condition, and he further testified that it would be a revision rotator cuff repair. He testified that many of his patients with rotator cuff tears and glenohumeral arthritis could perform at the heavy workload capacity and agreed that some did not. He agreed that it varied from patient to patient. (RX2).

On redirect, Dr. Kostman testified that a rotator cuff tear could be symptomatic without trauma and agreed that this was something that he saw in his practice. He agreed that arthritis could become symptomatic without trauma and that this was something that he saw in his practice. (RX2).

The medical records of OSF Center for Occupational Health were entered into evidence at the time of arbitration as Respondent's Exhibit 3. The records reflect that Petitioner was seen on June 7, 2017, at which time it was noted that he was trying to spin a one ton cylinder by him to move it on a customer site to get it on the truck, that he was bent forward and pulling on the edge of the container toward him when the container got caught on an uneven part of the parking lot, and that he then felt a sharp pain in the right shoulder anteriorly and laterally. It was noted that Petitioner had some transient numbness and weakness for a few minutes after the injury where he felt the whole arm on the right was affected. The assessment was noted to be that of acute pain in the right shoulder. It was noted that Petitioner appeared to have an internal derangement or other issue like a proximal bicep tear. It was noted that an MRI was recommended to determine the pathology and that Petitioner had "a big mechanism of injury." Petitioner was issued work restrictions and was given a prescription for Hydrocodone-Acetaminophen. At the time of the June 21, 2017 visit, it was noted that Petitioner reported that the Norco was not helping, that he had not taken his blood pressure medications, and that, per the patient's request, he was allowing his supervisor to be in the same room. It was noted that Petitioner requested something stronger for his pain and that he was scheduled for an MRI arthrogram on July 6, 2017. It was noted that Dr. Braun was not sure why Petitioner's pain was so severe at that point, and that they would try some Percocet and refer him to a pain specialist for further pain management. It was noted that Petitioner may be a non-responder to opioids, and that his non-occupational health issues made it difficult to treat with non-opioids. It was also noted that Petitioner was referred to an orthopedic specialist to at least consider a steroid injection to help him with his pain, and may need further treatment advice pending his MRI. Petitioner was issued work restrictions. (RX3).

The records of OSF Center for Occupational Health reflect that Petitioner was seen on November 21, 2017, at which time it was noted that he stated that he went through the work comp process with a second opinion through an IME, that was surgery was done October 17, 2017, that he stated that he had repair of his rotator cuff, labrum and biceps tendon, that he saw Dr. Ramirez on November 17, 2017, and that he planned to start physical therapy as soon as it was approved by work comp. It was noted that Petitioner worked as a truck driver and was currently off work, and that he had a restriction of no lifting on the right and had been instructed to maintain his arm to his side and not abduct it. It was noted that Petitioner stated that Dr. Ramirez stopped his Oxycodone and started him on Norco, that he did not feel that this controlled his pain as well, and that he had an area of pain in his anterior shoulder that was the most significant. It was noted that Petitioner stated that Dr. Ramirez told him that it was due to a nerve being cut, that he stated that his pain radiated to his elbow at times, that when sitting his pain was 4-5/10 and worsened with arm movement, and that he had noticed decreased strength in his right hand and arm. The

assessment was noted to be that of a complete rotator cuff tear/rupture of the right shoulder, not trauma. Petitioner was taken off work until his next appointment, and was recommended to return on December 19, 2017. (RX3).

The medical records of Dr. Mary Stapel were entered into evidence at the time of arbitration as Respondent's Exhibit 4. The records reflect that Petitioner was seen on June 21, 2017, at which time it was noted that he refused a blood pressure check in his right arm due to shoulder pain. It was noted that Petitioner stated that he had been depressed and had been having a lot of right shoulder pain. It was noted that Petitioner did not want to be working and that he wanted to switch to Dr. Stapel for his worker's comp case. It was noted that Petitioner was feeling "pretty ok", that he was moving the cylinders by himself prior, that it was about a one-ton cylinder, that he was spinning it to line it up with his trailer, and that it stuck and that that was when he was hurt. It was noted that Petitioner was lifting weights, that he was working out, that his energy was really good, and that he was actually losing weight. It was also noted that Petitioner's 17-year-old son was hit by a car and killed on May 1, 2017, that it was hard for him to talk about it, and that he had grief from that. The assessment was noted to be that of uncontrolled hypertension, acute pain of the right shoulder, and uncontrolled type 2 diabetes mellitus, among other issues. Petitioner was recommended to take his blood pressure medications. (RX4).

The records of Dr. Stapel reflect that Petitioner was seen on June 27, 2017, at which time he was seen for right shoulder pain. It was noted that the date of accident was that of June 7, 2017, that it happened at 9:30 a.m., that Petitioner was picking up and moving a one-ton cylinder that was 1300 pounds empty, that he was rolling them up the piece of wood, that he was bumping it up onto the piece of wood, and that he was turning it. It was noted that the parking lot was uneven, that Petitioner was yanking it around, that it got caught on an uneven part of the parking lot, and that it was "like yanking on a parked car." It was noted that Petitioner felt something in his shoulder that let go, that it hurt, that he had pretty much gotten it up onto the trailer at that point, that it pretty much hurt immediately, and that it constantly hurt. It was noted that Petitioner had tried ice and heat as well as Icy Hot topically. It was also noted that Petitioner hurt more in the upper arm near the front of the shoulder as well as a bit on the biceps groove area, and also a bit through to the back. It was noted that it was always aching through the side or the back and that movement created sharp pain. It was noted that an MRI was scheduled and that Petitioner was seeing an orthopedist. It was noted that it felt similar to what happened on the left with the biceps, that it was not in good shape, and that Petitioner went through a lot in the waiting and that it was in worse shape due to continuing to work. The assessment was noted to be that of acute pain of the right shoulder. It was noted that Petitioner was unable to work even with basic office work, as even filing or holding a phone hurt his primary/dominant arm. (RX4).

The medical records of Dr. Miguel Ramirez were entered into evidence at the time of arbitration as Respondent's Exhibit 5. The records were duplicative of those as contained in Petitioner's Exhibit 6. (RX5; PX6).

The medical records of Center for Health were entered into evidence at the time of arbitration as Respondent's Exhibit 6. The records were duplicative of those as contained in Petitioner's Exhibit 6. (RX6; PX6).

The medical records of OSF St. Francis Medical Center were entered into evidence at the time of arbitration as Respondent's Exhibit 7. The records reflect that Petitioner was seen for physical therapy on March 15, 2018, at which time it was noted that he continued to limited by pain in the anterior region of the right shoulder (near the bicipital groove), that he stated that he had been doing better and was up to 50% better, but when it flared up last Tuesday (no mechanism of injury, just woke up with it) he had slid back and the pain was very limiting to any overhead greater than 70 degrees. It was noted that Petitioner felt that the pain was what was limiting him from strengthening his arm like he felt it could, and that presently his pain got up to a 5/10 with overhead motion. It was noted that Petitioner stated that he had always had

pain in the anterior aspect of the shoulder with flexion, but that the side was not that bad. It was noted that Petitioner had presented to 28 physical therapy sessions, that throughout the course of therapy he had been motivated and compliant, and that subjectively he was reporting improvement until last week when he woke up with magnification of pain in the right anterior shoulder with decreased shoulder range of motion. It was noted that Petitioner had been consistently experiencing limiting pain to shoulder range of motion greater than 90 degrees in the sagittal plane throughout the course of therapy, and that this recent flare-up had set him back significantly, even causing pain in the frontal and scapular plane. It was noted that Petitioner's strength was improving in the available range, but functionally he lacked strength and range of motion for all overhead motion and work duties. It was noted that there was visible and palpable swelling of the right shoulder anteriorly and that Petitioner was hypersensitive over the right bicipital groove. It was further noted that Petitioner may benefit from further medical work-up to address the limiting right anterior shoulder pain and further skilled physical therapy to address continued limitations. (RX7).

The records of OSF St. Francis Medical Center reflect that Petitioner underwent physical therapy on March 27, 2018, at which time it was noted that he reported decreased pain after the injection, that he was able to reach overhead again with less pain in the right arm, and that he stated he was still having discomfort with reaching like he did before the injection but nothing like it was after his flare-up. It was noted that Petitioner had functional limitation or restriction including difficulty reaching overhead, difficulty with lifting or carrying, decreased independence with self-care tasks such as bathing and dressing, difficulty with work due to an inability to raise the arm and exhibit enough strength to hold the steering wheel, and difficulty performing work duties of driving a semi. (RX7).

Timecards were entered into evidence at the time of arbitration as Respondent's Exhibit 8. The 2018 Calendar was entered into evidence at the time of arbitration as Respondent's Exhibit 9.

The Sheehy Mail Contractors Employment Records were entered into evidence at the time of arbitration as Respondent's Exhibit 10. It was noted that Petitioner's start date was that of October 17, 2018. The Driver Statement of On-Duty Hours noted that Petitioner worked 10-hour days for the timeframe of October 9 through October 13, 2018. The Contract Personnel Questionnaire noted that Petitioner worked for Central Transport from April 2018 to October 2018, and that he worked for Sheehy Mail from October 2018 to present; no reference was made of his having worked for Respondent. The Application for Employment dated October 9, 2018 noted that Petitioner's Employment History included having worked for Central Transport from April 2018 to present; no reference was made of Petitioner having worked for Respondent. The DOT Mandated Drug Test Results Medical Review Officer Report noted a collection date of October 9, 2018 for Pre-Employment Testing. (RX10).

Correspondence To/From Petitioner's Counsel dated July 25, 2019 were entered into evidence at the time of arbitration as Respondent's Exhibit 11. The letter pertained to a subpoena for production of employment records subsequent to Petitioner's departure from Respondent. (RX11).

The Medical Payments Ledger was entered into evidence at the time of arbitration as Respondent's Exhibit 12. The 19(b) Response was entered into evidence at the time of arbitration as Respondent's Exhibit 13.

The Prairie Farms Safety Rules were entered into evidence at the time of arbitration as Respondent's Exhibit 14. As it pertains to the Plant, #4 referenced a requirement to report all injuries, accidents and near accidents to your supervisor before the end of the work day. (RX14).

CONCLUSIONS OF LAW

With respect to disputed issue (C), the Arbitrator finds that Petitioner failed to prove that he sustained an accidental injury on October 4, 2018 that arose out of and in the course of his employment with Respondent.

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.

While the Arbitrator does not question that a milk crate in the stack slightly tore and leaned towards Petitioner on October 4, 2018, the Arbitrator does question the veracity of the accident description as provided by Petitioner at the time of arbitration. Related thereto, the Arbitrator finds the testimony of Petitioner's co-worker, Bruce Clevenger, to be credible and of great significance in this matter.

Mr. Clevenger testified that he was working near Petitioner at the time of this alleged incident and that he came to assist him within 15-20 seconds of his having called for help. According to Mr. Clevenger, the milk crate barely split, the stack was slightly leaning, and when he helped Petitioner he was able to hold up the stack "with a finger." He testified that he then down-stacked the stack for Petitioner, and that the entire incident took no more than two minutes. This is in stark contrast, however, to Petitioner's claims that he held the stack for 3-4 minutes before anyone assisted him, the size of the split in the crate, and the extent to which the stack was leaning towards him. In addition, the evidence reveals that Petitioner continued to work with Mr. Clevenger for approximately 45 minutes after this incident and yet he never told him he was injured, despite Petitioner's assertions that he had sharp pain in his right shoulder as well as weakness at the time of the incident at issue.

As to Petitioner's assertions that he did not report this incident on October 4, 2018 because there was nobody around to report it to, the Arbitrator finds Petitioner's claim that there was no one to report this accident to as not credible. The witness testimony reveals there were supervisors at the plant during Petitioner's shift on October 4, 2018 into the early morning hours of October 5, 2018, and even Petitioner himself admitted on cross examination that Kyle Hansen was at the plant when his shift ended at 12:09 a.m. on October 5, 2018. In addition, Mr. Clevenger testified there is a phone in the cooler "that we call Kyle Hansen to the cooler, and, boom, he is right there." Furthermore, the Arbitrator notes that Petitioner signed that he received and reviewed the "Safety Rules" that he was to report any accident to his supervisor before the end of his work day. (RX14).

The witness testimony further reveals that there were supervisors at the plant before Petitioner's shift began at 1:59 p.m. on October 5, 2018, that there were supervisors at the plant when Petitioner's shift began at 1:59 p.m. on October 5, 2018, and that there were supervisors present for at least two hours while Petitioner was working at the plant before he claims he reported this incident to Kyle Hansen at approximately 4:00 p.m. on October 5, 2018. Despite all of these supervisors being available to report this incident to at these times, the Arbitrator notes that Petitioner failed to report this incident until *after* he was terminated. That said, the Arbitrator has great difficulty believing Petitioner's reasons for not reporting this incident when it occurred, before, or at the end of his shift at 12:09 a.m. on October 5, 2018, before the start of his shift at 1:59 p.m. on October 5, 2018, at the start of his shift at 1:59 p.m. on October 5, 2018, or at any point between 1:59 p.m. and 4:00 p.m. or 5:00 p.m. on October 5, 2018.

The Arbitrator also finds the records from Petitioner's subsequent employment with Sheehy Mail Contractors to also be of significance in calling into question his credibility. Petitioner appears to be adamant he did not work anywhere after October 5, 2018 besides at Sheehy but, if so, the Arbitrator finds no plausible explanation as to why Petitioner would claim to Sheehy that he worked 10 hours on October 9, 2018, 10 hours on October 11, 2018, 10 hours on October 12, 2018, and 10 hours on October 13, 2018 – for a total of 40 hours those 4 days. (RX10). The Arbitrator places little, if any, weight upon Petitioner's assertion that he meant to write "zero" instead of 10 each time and that he meant to write "zero" instead of 40. In addition, Petitioner claims he did nothing for Sheehy besides drive a truck. However, the records from Sheehy show, at minimum, the "road test" given by Sheehy would have required him to do more than just drive a truck. (RX10). More significantly, Petitioner even wrote in the training documents he could suffer a "shoulder injury from pulling the pin" to release the 5th wheel. (*Id.*).

Finally, Petitioner asserted at the time of arbitration that he called Dr. Ramirez's office sometime between October 5, 2018 and October 17, 2018, but both parties submitted a significant number of records from Dr. Ramirez's office which included phone messages, and the records are devoid of any contact between Petitioner and Dr. Ramirez's office between those dates. (RX5; PX6). This, when coupled with Petitioner's apparent failure to disclose an accurate employment history on his post-accident application in the Sheehy Mail Contractors Employment Records as evidenced on the Application for Employment dated October 9, 2018 (*see* RX10), causes the Arbitrator to admittedly place little weight upon Petitioner's testimony in this matter.

Having reviewed and considered the entirety of the evidence in this matter, the Arbitrator finds that Petitioner failed to prove that he sustained an accidental injury on October 4, 2018 that arose out of and in the course of his employment with Respondent. In light of the Arbitrator's findings with disputed issue (C), the Arbitrator makes no findings with respect to disputed issues (F), (J), (K) and (L), as those issues are rendered moot. The claim is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MIROSLAWA KAMINSKA,

Petitioner,

vs. NO: 19 WC 20310

TWIN CLEANING PROFESSIONALS, INC.,

Respondent.

20IWCC0307

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §§19(b-1) and 8(a) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, prospective medical care, and temporary total disability, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below. The Commission specifically does this to clarify and dispassionately address the facts and issues raised by the parties, which are obscured by the tone of the arbitration decision. The Commission otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings including a determination of permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill. 2d 327 (1980).

I. FINDINGS OF FACT

A. Background and Accident

Petitioner testified through an interpreter. She testified that in April 2019, she worked for Respondent cleaning floors and bathrooms at O'Hare Airport's Terminal 1C. She stated that at that time, she had been working for Respondent for approximately five years. She also stated that she normally worked from 6:00 a.m. to 2:30 p.m. five days per week. Petitioner was 63 years old.

On April 4, 2019, Petitioner testified that at approximately 7:30 a.m., she was performing her normal work duties as a cleaning person. She stated that she was in a supply room near a bathroom, a room from which employees also obtained water. Petitioner stated that she slipped due to soapy water on the floor. She also stated that she fell backwards, striking a cast iron sink, mostly with the left side of her body. She further stated that she then fell to the floor, landing on her whole back.

Petitioner testified that she felt very hard pain in her left rib. She added that she was able to lift herself from the floor fairly quickly, attributing it to shock. She stated that she reported the injury to her supervisor on that date and was taken by ambulance to Resurrection Medical Center.

The City of Chicago Fire Department's report indicates that when EMS arrived, Petitioner appeared to be in some discomfort. Petitioner stated that she struck her left side on the corner of a sink and landed on her left buttock. Petitioner denied striking her head or experiencing neck or back pain. No bruising, deformity or crepitus was noted during an assessment of Petitioner's rib cage. Petitioner was able to place weight on both legs equally during transfer to the stretcher. Petitioner also denied any loss of consciousness and was able to get herself up and walk out to the corridor without assistance. She remained stable and alert during transport.

B. Medical Treatment

On April 4, 2019, Petitioner presented at Resurrection Medical Center (Resurrection), complaining of left rib and shoulder pain. Dr. Marc Dorfman, using an interpreter, took the following history:

> "63-year-old female presents with complaints of left shoulder left rib and left hip pain. Mechanical fall while at work. Denies head trauma, neck pain, amnesia to the event, blood thinners, nausea, vomiting, cough, sciatica, incontinence. Pain in left shoulder worse with movement, pain in ribs with deep breathing. Patient was able to bear weight post event. Patient did not take pain medication prior to arrival. Patient denies previous rib fracture."

A physical examination of the neck revealed "no JVD, no posterior tenderness." The examination of the chest found "left-sided tenderness, no ecchymosis:, [sic] Lacerations." The left shoulder showed "[d]eltoid tenderness, deltoid sensation intact, full active range of motion with pain distal grip strength intact." The left hip showed "[n]o shortening or external [sic], distal cap refill and touch intact." The examination of the back showed "no CVA tenderness, no midline tenderness."

After obtaining X-rays of Petitioner's left hip, left shoulder, and left ribs (with chest), Dr. Dorfman assessed Petitioner with contusions of the shoulder, rib, and hip. Dr. Dorfman prescribed pain management (including Tramadol), with heat and ice treatments. Petitioner was released for work without restrictions as of April 6, 2019.

On April 5, 2019, Petitioner sought further treatment at Union Health Center (Union). Petitioner testified that her most significant pain was in her left rib, and she could not feel anything else. She described the pain as prevailing over all the other pains because she could not swallow or breathe. The medical record for this visit indicates that Petitioner informed Dr. Petya Chalakova that she had fallen at work on a wet and slippery floor, hit her left side on the sink and then the floor. X-rays taken at Resurrection's emergency department were negative for fracture of the ribs, hip and shoulder. Petitioner reported left rib cage and left shoulder pain, rating her pain at 8/10 and worse at the rib cage, but improved in the hip. A physical examination disclosed a bruise of the left ribcage and left shoulder pain with range of motion; the examination does not appear to have included Petitioner's neck or back. Petitioner was directed to rest at home for 10 days and take the prescribed Tramadol. The medical record also reflects that the doctor also recommended that Petitioner follow up with her primary care physician, and obtain follow-up X-rays because sometimes injuries take time to manifest.

Union's medical records indicate that Petitioner underwent X-rays of the left shoulder, chest, and cervical spine, as well as a CT brain scan, on April 11, 2019. Regarding the left shoulder, the interpreting radiologist found no acute fractures, stable mild degenerative changes, and a re-demonstration rotator cuff impingement pattern. The radiologist also found an acute fracture of the left ninth rib. Regarding the cervical spine, the interpreting radiologist found multilevel degenerative disc disease, moderate spondylitic changes in the mid and lower cervical spine, and cervical ribs. There were no acute findings on the non-infusion CT brain scan.

On April 12, 2009, a Union nurse noted, per Dr. Chalakova, that Petitioner had telephoned to inform them that an X-ray taken the prior week disclosed a left ninth rib fracture. The note states that such a fracture takes between six and eight weeks to heal. Petitioner was advised to keep an appointment with her primary care physician next week. The note also indicates that Petitioner had time off work until that appointment.

On April 15 and 27, 2019, Petitioner visited Union to request extensions of time off work; the latter note indicates that Petitioner had been off for three weeks. On April 15, Petitioner complained of pain in the affected area and denied any improvement. With regard to this visit, Petitioner testified that the pain in her rib was a bit less and she had started feeling pain in the back of her neck and head. She also testified that over the next week to 10 days, it became easier for her to breathe and she felt the most pain in her neck. During her April 27 visit, the medical record reflects that Petitioner complained of neck pain and left shoulder pain, rating both at 4/10. She also reported being unable to sleep. Dr. Tipbhrapa Jaojaroenkul noted that he discussed the six- to eight-week healing timeframe for the rib fracture with Petitioner's daughter,

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adding: "She is better, anticipate uneventful recovery." The doctor prescribed cyclobenzaprine and Trazodone HCL.

On May 13, 2019, Petitioner returned to Union, complaining of headaches, frequent vomiting, left shoulder and left chest wall pain, as well as insomnia. Dr. Ewa Osolkowski's examination of Petitioner's neck found it supple, without lymphadenopathy. Petitioner was prescribed Ambien, and was ordered off work for another week.

On May 20, 2019, Petitioner followed up at Union, complaining of continuing pain from her work injury, a bad headache, and back pain. Petitioner reported that her left rib pain had improved, but still had a headache, left shoulder pain, and recently left lower back pain with leg pain (though with no radicular symptoms). Dr. Alex Buder assessed an unremarkable examination but ordered Petitioner off work until a visit with her primary care physician scheduled for June 4, 2019.

Union's records indicate that Petitioner then underwent a CT brain scan on May 30, 2019. The interpreting radiologist's impressions were: (1) no acute findings from the non-infusion scan; (2) chronic ethmoid sinusitis; and (3) bilateral chronic mastoiditis.

On June 4, 2019, Petitioner followed up with Dr. Osolkowski, continuing to report persistent chest wall pain, headaches, insomnia and anxiety, further stating that she cannot work. Petitioner was assessed with a work-related stress disorder, chest wall pain and headache. Petitioner also was advised to remain off work.

On July 1, 2019, Petitioner saw Dr. Osolkowski again due to difficulty sleeping. However, Petitioner reported her back pain was improved. An examination of Petitioner's neck found it supple, without lymphadenopathy. The doctor noted that Petitioner generally appeared to be in no distress. The doctor also noted that Petitioner could return to work as soon as her insomnia was controlled, a condition to be followed by psychiatry. The doctor further scheduled a follow-up visit in three months' time.

On July 15, 2019, Petitioner followed up with Dr. Osolkowski, complaining of persistent neck pain and headaches. Dr. Osolkowski ordered X-rays of the cervical spine and referred Petitioner to Dr. Mark Sokolowski at Petitioner's request. Petitioner testified that she was referred to Dr. Sokolowski by her counsel.

Union's records indicate that Petitioner obtained X-rays of the cervical spine on July 16, 2019. The interpreting radiologist found that the soft tissues were normal, the bones were demineralized, there was a slight straightening of normal lordosis, and no evidence of acute fracture, collapse or slippage. However, the radiologist found a marked loss of disc height at the C4-7 levels, with moderate arthritic changes including bone spur impingement of the foramina, more marked on the right side of C4-5 and C5-6. The radiologist further found bilateral cervical

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ribs, larger on the left side. The radiologist's impressions were: (1) multilevel degenerate disc disease; (2) moderate spondylitic changes mid and lower cervical spine; and (3) cervical ribs.

On July 23, 2019, Petitioner visited Dr. Sokolowski, complaining of neck pain with radiation to trapezial regions and headaches, left posterior rib pain, left upper extremity numbness and tingling, and left lower extremity numbness. After Petitioner recounted falling on the wet floor, the doctor noted the following history:

> "As a result of the fall, she developed the above symptoms. Rib pain has been slowly improving with time. Neck pain and left upper and lower extremity numbness and tingling have not. She has undergone plain radiographs, but no advanced imaging to date. She has not undergone physical therapy. She is frustrated with her persistent symptoms and eager to make some incremental improvement."

After taking a medical history, Dr. Sokolowski further recorded the following:

> "On physical examination, [Petitioner] is a 63-year-old female. Gait pattern is mildly antalgic on the left. She has considerable neck pain with extension and palpable bilateral trapezial muscle spasm. Spurling's test reproduces bilateral periscapular and left radicular pain in a C6 and C7 distribution. Shoulder range of motion is full bilaterally, but left-sided impingement signs are positive. Strength is intact throughout both arms in all muscle groups, but sensation is altered in her left C6 and C7 dermatomes. She is tender over her posterior left chest, from approximately the eighth rib to the thoracolumbar junction. Pain increases with deep inspiration. Left-sided straight leg raise reproduces L5 and S1 pain and numbness. Manipulation of her hips does not. Strength is intact throughout both legs in all muscle groups with altered sensation in her left L5 and S1 dermatomes. She is grossly normoreflexic distally."

Dr. Sokolowski diagnosed Petitioner with: (1) cervical pain; (2) cervical radiculopathy; (3) left posterior rib pain; and (4) features of lumbar radiculopathy. The doctor noted that the diagnoses were "causally related to work injury." The doctor recommended obtaining cervical and lumbar spine MRIs and physical therapy. Dr. Sokolowski also restricted Petitioner to sedentary work duty, avoiding bending, squatting, and lifting more than 10 pounds. Petitioner testified that she provided Respondent with a copy of these work restrictions but was not offered work accommodating them.

Petitioner underwent a physical therapy evaluation at Mark Sokolowski MD, SC Physical Therapy on July 29, 2019. Derick Russell, MPT, recorded that Petitioner slipped at work and hit her head on a metal sink. Petitioner rated her neck pain, headache, and intermittent low back pain at 5/10, while the pain from her fractured posterior rib was rated at 10/10. Petitioner also

reported being able to sleep through the night. Petitioner was assessed with pain, decreased range of motion, soft tissue tenderness, and difficulty performing all activities of daily life. The therapist recommended therapy twice or three times per week for four to six weeks.

Petitioner underwent cervical and lumbar spine MRIs at Edgebrook Radiology on July 30, 2019. Both MRI reports refer to a clinical history of "MVA, trauma with back pain." Regarding the cervical spine MRI, the interpreting radiologist's impression was that at the C4-C5, C5-C6, and C6-C7 levels, there were 3-4 mm subligamentous posterior disk herniations with extruded nuclei pulposi, which indent the ventral surfaces of the thecal sac with generalized spinal stenosis and bilateral neuroforaminal narrowing, exacerbated by uncovertebral and facet arthrosis, appearing slightly greater on the left at the C6-C7 level. The radiologist also found there was a 2-3 mm posterior broad-based disk herniation at the C3-C4 level, which indents the thecal sac with mild generalized spinal stenosis and bilateral neuroforaminal narrowing.

Regarding the lumbar spine MRI, the interpreting radiologist's impression was of abnormal straightening and reversal of the usual lumbar curvature, presumably representing significant post-traumatic muscular spasm, with mild thoracolumbar scoliosis. The radiologist also found that at the L4-L5 level, there was a 3-4 mm broad-based subligamentous posterior disk herniation with an extruded nuclei pulposis which indents the thecal sac with generalized spinal stenosis and bilateral neuroforaminal narrowing, exacerbated by facet arthrosis and ligamenta flava hypertrophy. At the L5-S1 level, the radiologist found some loss of normal height with a 3-4 mm broad-based subligamentous posterior disk herniation with an extruded nuclei pulposis which indents the ventral surface of the thecal sac with generalized spinal stenosis and bilateral neuroforaminal narrowing. At the L2-L3 level, the radiologist found a 3-4 mm posterior and left-sided disk herniation which indents the left side of the thecal sac with left-sided stenosis and left lateral recess narrowing. At the L3-L4 level, the radiologist found a 2-3 mm posterior and left-sided disk herniation which indents the ventral and left side of the thecal sac with mild left-sided stenosis and left neuroforaminal narrowing.

On September 4, 2019, Derick Russell, MPT, prepared a physical therapy evaluation summary regarding Petitioner's treatment, indicating that Petitioner had completed 10 sessions since her initial evaluation. Petitioner rated her neck pain and headaches at 4/10, with continuing numbness in the left hand and fingers. Petitioner rated her intermittent low back pain at 3/10. She also reported negative radiculopathy and rated her positive numbness in the left foot at 5/10. However, Petitioner further reported the pain from her fractured posterior rib at 3/10. Petitioner was assessed as making slow overall improvement. Mr. Russell recommended another course of therapy twice or three times per week for four to six weeks. Petitioner testified that she saw significant improvement in her symptoms as she proceeded with the therapy.

On September 5, 2019, Petitioner followed up with Dr. Sokolowski, who reviewed the therapy notes and the MRI results. Reviewing the actual images and the lumbar MRI report from July 30, Dr. Sokolowski noted that Petitioner had disc herniations at L4-5 and L5-S1 with central and foraminal stenosis bilaterally. The doctor also noted that Petitioner had a left-sided

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disc herniation at L2-3. Dr. Sokolowski further noted that the cervical MRI from the same date demonstrated disc herniations at C4-5, C5-6, and C6-7 with central and foraminal stenosis at all three levels.

Dr. Sokolowski diagnosed Petitioner with: (1) cervical pain; (2) cervical radiculopathy; (3) left ninth rib pain; and (4) lumbar radiculopathy. The doctor again noted that the diagnoses were "causally related to work injury." The doctor recommended a continuation of the physical therapy and current work restrictions. Dr. Sokolowski also advised a re-evaluation in four to six weeks to consider cervical or lumbar epidural steroid injections if progress was unsatisfactory.

Petitioner returned to visit Dr. Sokolowski on October 9, 2019, reporting some additional functional progress in physical therapy. Petitioner rated her neck pain at 5/10, her back pain at 4/10, left arm pain and numbness at 5/10, and left leg pain at 5/10. Petitioner also reported that Respondent had not called her back to work. After reviewing the therapy records, the doctor again recommended continuing physical therapy and Petitioner's work restrictions, with another re-evaluation in four to six weeks. Dr. Sokolowski also discussed the possibility of cervical or lumbar epidural steroid injections with Petitioner, who stated that she would give them some thought.

On November 13, 2019, Petitioner followed up with Dr. Sokolowski, whose notes were substantially similar to those for the October 9, 2019 visit. The doctor again discussed administering epidural steroid injections. Petitioner expressed concern regarding the potential side effects, but was open to the procedures if necessary.

C. Section 12 Examinations and Deposition Testimony by Dr. Lawrence Lieber

On July 11, 2019, Petitioner underwent an independent medical examination by Dr. Lawrence Lieber at Respondent's request. Dr. Lieber took a history of the work incident, noting that Petitioner was taken to Resurrection, then sought treatment with her primary care physician. Petitioner complained of pain in her left chest area upon lifting, pain in the ribs with twisting, and headaches. Petitioner also complained of "some neck pain" along with numbness in her fingers and toes. Petitioner denied any shortness of breath or night pain.

Dr. Lieber's brief summary of his physical examination showed Petitioner to be nontender to palpation throughout the left ribs, about the ninth rib in particular. The doctor also noted pain in the left chest wall upon overhead motion of the shoulders. No other abnormalities were noted. Dr. Lieber further reviewed Petitioner's job duty requirements, as well as medical records from Resurrection, Dr. Osolkowski, Dr. Chalakova, Dr. Buder, and a nurse's record dated April 27, 2019.

Regarding the April 4, 2019 injury, Dr. Lieber's diagnosis was of a healed left ninth rib fracture. Dr. Lieber opined that Petitioner's complaints of left-sided chest wall pain with twisting appeared to be related to that injury but there were no objective abnormalities within the

left chest wall that should cause those symptoms. He also opined that no further treatment was necessary for the April 4, 2019 incident. He further opined that Petitioner's treatment to date had been necessary and reasonable, based on the subjective complaints and objective findings noted upon his record review. Dr. Lieber additionally opined that Petitioner could return to full-duty employment with no restrictions as of July 11, 2019. Dr. Lieber concluded that Petitioner had reached maximum medical improvement (MMI) regarding the April 4, 2019 incident. He stated that these opinions were given with a reasonable degree of medical and surgical surgery.

On October 3, 2019, Petitioner underwent a second independent medical examination by Dr. Lieber at Respondent's request. Dr. Lieber noted that Petitioner "at this time complains of cervical, lumbar, left hip, left shoulder, and thoracic pain in association with the alleged April 4, 2019, work event." Dr. Lieber also noted Petitioner had received physical therapy and MRIs through Dr. Sokolowski.

Petitioner reported some improvement in her symptoms but continued to experience some discomfort. She complained of lower lumbar pain with ambulation as well as using stairs and bending. She also complained of left leg pain and associated numbness, which bothered her more than her lumbar spine. Petitioner further reported consistent neck pain that bothers her at night as well as with motion. She additionally complained of numbness in her left forearm and hand which bothered her more than her neck. Petitioner stated that she had occasional left hip pain that bothered her at night as well as when using stairs. She also stated her left shoulder bothered her at times with motion and overhead activity.

Dr. Lieber conducted a physical examination of Petitioner's back, hip, cervical spine, and left shoulder. The back examination indicated 90 degrees of flexion and 30 degrees of extension, with a lateral bend and lateral rotation of 30 degrees bilaterally. The straight leg raise tests were negative. The cervical spine examination found that tenderness to palpation was positive for the left paracervical muscle areas, as well as around the occiput of the head. The range of motion for the cervical spine was decreased at the extremes secondary to pain. Flexion and extension were both 45 degrees. The lateral bend left and right were both 45 degrees. Lateral rotation of the cervical spine was 80 degrees left and right.

Dr. Lieber also updated his review of Petitioner's medical records. His own review of the July 30, 2019 lumbar spine MRI confirmed evidence of degenerative lumbar disk disease at L2-L3, L3-L4, and L4-L5 with associated disk herniations. He also summarized the formal report by the interpreting radiologist. Dr. Lieber's review of the cervical spine MRI confirmed evidence of degenerative cervical disk disease at C4-C5, C5-C6, and C6-C7 "with associated degenerative disk disease." He then summarized the formal report of the interpreting radiologist. In addition to the records Dr. Lieber reviewed for his initial report, he further noted specifically reviewing: the emergency department record from Resurrection; a March 20, 2017 record in which Petitioner was evaluated for hypertension and severe left flank pain; and Dr. Sokolowski's July 23, 2019 evaluation.

Dr. Lieber diagnosed Petitioner with: degenerative cervical disk disease; degenerative lumbar disk disease; a normal left shoulder; and a healed rib fracture. He opined that Petitioner's left shoulder, left hip, thoracic spine, trunk, and cervical spine reached MMI as of April 5, 2019 and that Petitioner could return to full-duty work without restrictions as of that date.

Dr. Lieber also opined that Petitioner showed no evidence of cervical radiculopathy related to the April 4, 2019 incident, concluding that Petitioner's underlying cervical abnormalities were preexisting and degenerative in nature, unrelated to the work incident. He offered similar opinions disagreeing with Dr. Sokolowski's diagnosis of lumbar radiculopathy. Dr. Lieber additionally opined that Petitioner's headaches were related to her underlying degenerative cervical spine abnormalities and have no relationship to the April 4, 2019 incident.

Dr. Lieber further opined that Petitioner's subjective complaints appeared to correlate with her underlying objective abnormalities of degenerative lumbar and cervical disk disease, though her subjective complaints concerning the hip area did not correlate to any objective findings. He also found no evidence of symptom magnification or malingering relating to the cervical and lumbar spine, but some evidence of symptom magnification relating to her posterior hip complaints.

On January 15, 2020, Dr. Lieber, a board-certified orthopedic surgeon with fellowship training sports medicine and arthritis surgery, testified by deposition on behalf of Respondent. Dr. Lieber testified consistently with his reports of July 11 and October 3, 2019.

Dr. Lieber testified on cross-examination that regarding his first examination, he was only asked to evaluate Petitioner's rib fracture. He agreed that degenerative disk disease can be completely asymptomatic in some people. He also agreed that degenerative disk disease that is otherwise asymptomatic can become symptomatic following a traumatic injury. Dr. Lieber testified that he had assumed Petitioner's baseline cervical condition was asymptomatic based on the lack of prior history of problems. He further acknowledged that 99 percent of his work of this type was at the request of the defense or insurance companies.

D. Utilization Review and Telephonic Deposition Testimony by Dr. Nitin Kukkar

On September 20, 2019, at Respondent's request, Dr. Nitin Kukkar conducted a utilization review of the MRIs and physical therapy ordered by Dr. Sokolowski. Dr. Kukkar's report contains a summary of a series of Petitioner's medical records, beginning with a March 20, 2017 progress note by Dr. Jachimowicz in which Petitioner complained of severe left flank pain, through a physical therapy report dated August 27, 2019.

Dr. Kukkar opined that the cervical and lumbar spine MRIs were not medically necessary. He explained that according to ODG guidelines, MRIs are recommended following six weeks of conservative treatments such as physical therapy. He noted that the July 23, 2019 examination note indicated that Petitioner had not had any physical therapy at that time.

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Dr. Kukkar also asserted that the first mention of cervical and lumbar spine pain following the injury was May 20, 2019, approximately 1 month and 16 days after the injury. He wrote that research indicates that symptoms can have a delayed onset of usually no more than two weeks post injury. The doctor opined that because there was no mention of cervical or lumbar spine pain prior to May 20, 2019, it would be difficult to correlate the pain to Petitioner's injury. However, the doctor also stated in the report that Petitioner had a previous history of lumbar pain, cervical pain and headaches.

Dr. Kukkar further noted that the MRIs indicated some degenerative findings, which would be expected given Petitioner's age. He opined that it was more likely that Petitioner's lumbar pain, cervical pain and headaches were a result of degenerative processes than that they would be related to the injury. Accordingly, Dr. Kukkar concluded that the MRIs were not medically necessary and unrelated to the April 4, 2019 injury.

Regarding the physical therapy, Dr. Kukkar noted that the ODG guidelines allow for such therapy for cervical and lumbar pain at a maximum rate of 10 visits over 8 weeks. Therefore, he concluded that visits in excess of this guideline were not medically necessary. He further asserted that the first mention of cervical and lumbar spine pain was approximately 1 month and 16 days after the injury and therefore, a causal connection could not reasonably be made between the injury and the onset of symptoms. He added that Petitioner had a past medical history of treatment for back pain, and that the independent medical examiner felt that Petitioner was at MMI. Dr. Kukkar opined that for these reasons, the symptoms Petitioner reported on July 23, 2019 were not related to the injury.

Dr. Kukkar further opined that the work restrictions continued on July 23, 2019 were not related to the April 4, 2019 injury. He also wrote that the re-evaluation in four to six weeks was medically necessary, but unrelated to the April 4, 2019 injury.

On December 3, 2019, Dr. Kukkar, an orthopedic surgeon specializing in spine surgery, testified by telephonic deposition on behalf of Respondent. Dr. Kukkar testified that he usually used "Office of Director General, or ODG guidelines," to conduct utilization reviews. He also testified that his report contained a summary of the records he reviewed, but the summary itself was prepared by the company for whom he worked as an independent contractor. He stated that he reviewed both the medical records and the summary. Dr. Kukkar testified regarding his opinions of the MRIs and physical therapy prescribed by Dr. Sokolowski, consistent with his utilization review report.

During cross-examination, Dr. Kukkar testified that he began performing utilization reviews in July or August of 2019. He stated that he tried to follow the ODG guidelines in his own practice, but he does not refer to them for everything he prescribes. He acknowledged that in his practice, his recommendations are based on the examination of the patient and that he had not examined or spoken to Petitioner.

Introduction

Dr. Kukkar acknowledged that he was asked to opine on Petitioner's MRIs taken on May 30, 2019, though the MRIs were in fact taken on July 30, 2019 (as noted in the answers in the report). He agreed that his report stated that Petitioner first mentioned cervical spine pain on May 20, 2019 but also summarizes the record for Petitioner's April 27, 2019 visit to Union, in which she complained of neck pain. He also agreed that the April 27, 2019 visit was 23 days after Petitioner's injury, not 1 month and 16 days. He further acknowledged that Petitioner's subjective complaints seem to correlate with the MRI findings. He additionally agreed that while his report indicated that Petitioner had a history of cervical pain and headaches, the summary of medical records in the report did not refer to a complaint of neck pain prior to April 4, 2019. Dr. Kukkar testified that Petitioner did have lumbar complaints in October 2017, while agreeing that there was no further mention of back pain in the records until May 2019.

On redirect examination, Dr. Kukkar acknowledged that he misspoke in referring to the ODG guidelines as the Office of Director General guidelines instead of the Official Disability Guidelines.

E. Prior and Current Condition

Petitioner testified that prior to April 4, 2019, she had not sustained any injuries to her neck, left shoulder, ribs, or left hip requiring medical treatment. She also testified that she had not sustained any injuries to her neck, left shoulder, ribs, or left hip requiring medical treatment since April 4, 2019.

On cross-examination, Petitioner did not recall whether she injured her back in March 2011 or prior to April 2019. Petitioner also did not remember receiving treatment for her lower back prior to April 2019. Respondent introduced as an exhibit a physical therapy evaluation by Accelerated Rehabilitation Centers, dated April 27, 2011, on referral from Dr. Michael Kornblatt, in which Petitioner reported pain in her right low back and lateral thigh after lifting a bucket of water. Petitioner testified that she did not remember receiving treatment for her left shoulder in October 2017. Respondent introduced as an exhibit a medical record indicating that on October 24, 2017, Petitioner was referred to physical therapy by Dr. Ewa Jachimowicz based on a complaint of left shoulder pain. Petitioner further testified that after April 4, 2019, she had no other slips, trips, falls, or motor vehicle accidents.

Regarding her current condition of ill-being, Petitioner testified that she was continuing to proceed with the physical therapy as Dr. Sokolowski recommended. She stated that she was continuing to see improvement in her symptoms with the therapy. She also stated that on an average day, she did not feel any pain from her rib. She further testified that she did not have any ongoing problems with her left shoulder or left hip. According to Petitioner, she only has pain in her neck and experiences pain turning her head in any direction. She added that she takes Tramadol at night for her pain. Petitioner testified that she still wanted to proceed with the injections recommended by Dr. Sokolowski.

II. CONCLUSIONS OF LAW

The Commission modifies the Decision of the Arbitrator regarding the issues of causal connection and temporary total disability benefits.

A. Causal Connection

The Arbitrator ruled that Petitioner's current condition of ill-being was not causally connected to her injury at work. In order to obtain compensation under the Act, a claimant must prove that some act or phase of his employment was a causative factor in his ensuing injuries. *Land & Lakes Co. v. Industrial Comm'n*, 359 Ill. App. 3d 582, 592 (2005). Recovery will depend on the employee's ability to show that the employee's current condition of ill-being can be said to have been causally connected to the work-related injury and not simply the result of a normal degenerative process of a preexisting condition. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 204-05 (2003). "Accidental injury need not be the sole causative factor, nor even the primary causative factor, as long as it was *a* causative factor in the resulting condition of ill-being." (Emphasis in original.) *Id.* at 205. It is the function of the Commission to resolve conflicts in medical testimony. The Commission may give more weight to a treating physician's opinion, but it is not obligated to do so. See *Prairie Farms Dairy v. Industrial Comm'n*, 279 Ill. App. 3d 546, 550-51 (1996).

In this case, the Arbitrator preferred the opinions of Dr. Lieber and Dr. Kukkar to those of Dr. Sokolowski or Petitioner's testimony. Petitioner maintains that Dr. Kukkar's utilization review was incompetent, misstated the date on which Petitioner initially complained of neck pain, and incorrectly stated that Petitioner had a history of cervical pain and headaches. At the outset, the Commission notes that the Arbitrator's Decision does not discuss Dr. Kukkar's review or testimony in its Findings of Fact. Regarding the issue of causal connection, the Decision's Conclusions of Law refer to Dr. Kukkar's opinions that the MRIs were not medically necessary and that the physical therapy sessions were excessive to explain, in part, why the Arbitrator rejected Dr. Sokolowski's opinions. Thus, while Petitioner takes exception to the qualifications and opinions of Dr. Kukkar, the Arbitrator did not specifically rely on Dr. Kukkar's opinions that the MRIs and therapy were not related to the April 4, 2019 injury.

Petitioner then relies upon Dr. Kukkar's observation that symptoms can have a delayed onset of usually no more than two weeks post injury. Petitioner testified that between April 15, 2019 and April 27, 2019, she began to feel the most pain in her neck. Nevertheless, following her complaint of neck pain on April 27, 2019, the medical records reflect no complaint of neck pain on May 13, May 20, June 4, or July 1, 2019. Indeed, as late as July 1, 2019, Dr. Osolkowski noted that Petitioner generally appeared to be in no distress and could return to work as soon as her insomnia was controlled. The lack of any complaint of neck pain for over two and one-half months after April 27, 2019, combined with the general assessments recorded by her treating physician during those months devoid of neck-related symptoms or pathology during

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various physical examinations, support Dr. Lieber's opinion that the condition of Petitioner's cervical spine is the result of a normal degenerative process rather than caused by trauma suffered during the work-related accident.

Petitioner asserts that Dr. Lieber's opinions make no sense because he saw no evidence of malingering or symptom magnification regarding the cervical spine and her complaints correlated to the objective findings, yet concluded that Petitioner returned to baseline by April 5, 2019. However, Petitioner must establish that her accident at work was a causative factor in the development of symptoms in the neck. *Sisbro, Inc.*, 207 Ill. 2d at 205. Given that the initial treatment records reflect an isolated complaint of neck pain on April 27, 2019 and Petitioner did not complain of persistent neck pain until July 15, 2019, it is not inconsistent for Dr. Lieber to opine that any condition of Petitioner's neck related to the accident resolved almost immediately, while also concluding that her current condition as honestly expressed is the result of degenerative disk disease in a 63-year-old. Notwithstanding Dr. Lieber's assessments regarding symptom magnification or malingering, it is notable that Petitioner's testimony at the hearing was that her neck pain became predominant between April 15 and April 27, 2019. It is not lost on the Commission that Petitioner was being evaluated primarily by generalists in the initial months of treatment as opposed to Dr. Sokolowski, but contemporaneous medical records from Petitioner's own physicians fail to corroborate her testimony about the onset and predominance of symptoms in her neck through April 27, and further fail to corroborate Petitioner's report to Dr. Sokolowski on July 15, 2019 of having experienced persistent neck pain since her accident. To the contrary, as noted above, as of July 1, 2019, the medical records indicate that Petitioner generally appeared to be in no distress.

Petitioner also disputes the Arbitrator's rejection of Dr. Sokolowski's opinions. However, there is little evidence to support Dr. Sokolowski's opinions. The medical record for July 23, 2019 does not indicate that Dr. Sokolowski reviewed Petitioner's post-accident treatment records. Dr. Sokolowski recorded that Petitioner's symptoms, including neck pain, were "subsequent to fall at work." However, there is no indication in Dr. Sokolowski's records that he was aware that Petitioner made an isolated complaint of neck pain on April 27, 2019 or that she was assessed by her prior treating physician to be in no distress beyond insomnia earlier that month with no neck complaints or positive findings despite physical examinations of the neck for over six weeks thereafter. This gap in Dr. Sokolowski's knowledge undermines his opinion that Petitioner's cervical pain and radiculopathy were causally related to her accident. Similarly, the fact that the physical therapist who evaluated Petitioner for Dr. Sokolowski's office recorded that Petitioner struck her head on the sink raises doubts about the information the doctor and his colleagues may have received from Petitioner.[1]

[1] Respondent also argues that Petitioner did not sustain her burden of proving a causal connection regarding the lumbar spine, but Petitioner concedes this point in her Statement of Exceptions, confining her argument to the cervical spine and left rib injury. Notably, Petitioner testified that on an average day, she did not feel any pain from her rib and only has pain in her neck.

Footnotes

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Given the record as a whole, the Commission concludes that the Decision of the Arbitrator regarding the lack of causal connection is not contrary to the weight of the evidence.

B. Temporary Total Disability

The Arbitrator awarded temporary total disability (TTD) benefits for a period from April 5, 2019 through June 22, 2019. The dispositive test for awarding TTD benefits is "whether the claimant's condition has stabilized, that is, whether the claimant has reached maximum medical improvement." *Mechanical Devices v. Industrial Comm'n*, 344 Ill. App. 3d 752, 759 (2003). The Arbitrator determined that Petitioner recovered from her injury by June 22, 2019, prior to Dr. Lieber's July 11, 2019 determination that Petitioner had reached maximum medical improvement.

Petitioner notes that in the Request for Hearing, Respondent claimed a TTD period of April 7, 2019 through June 29, 2019, further asserting no liability beyond amounts Respondent already paid. Petitioner argues that "a party may not argue for a suspension of TTD benefits effective on a date prior to a date it has previously asserted was an appropriate date for suspension of benefits." *Walker v. Industrial Comm'n*, 345 Ill. App. 3d 1084, 1088 (2004). In *Walker*, the court determined that the Commission did not have the power to modify TTD benefits to a period any less than 84 weeks because the statement on the Request for Hearing was in effect a stipulation by employer. *Id.* at 1087.

In this case, Respondent effectively stipulated that it owed TTD benefits for the period of April 7, 2019 through June 29, 2019. Accordingly, the Commission modifies the Arbitrator's award to require payment of TTD benefits for the 12-week period from April 7, 2019 through June 29, 2019.

In all other respects, including the issues of medical expenses and prospective medical care, the Commission affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE FOUND BY THE COMMISSION that Petitioner's current condition of ill-being, except for a resolved rib fracture and contusions to the left shoulder and left hip, is not causally connected to the April 4, 2019 accident.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $458.89 per week for a period of 12 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall be awarded a credit of $5,320.80 for temporary total disability benefits that have been paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay City of Chicago Fire Department of $1,152.00 for reasonable and necessary medical expenses.

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Respondent also shall pay Union Health Services, pursuant to the fee schedule, for expenses incurred (excluding psychiatric services) for the dates of service as specified in the Decision of the Arbitrator, pursuant to §§8(a) and 8.2 of the Act.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $2,400. 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 5 - 2020
d: 6/4/20
BNF/kcb
045

Barbara N. Flores

Deborah L. Simpson

Concurring in part, Dissenting in part

I respectfully dissent from the opinion of the majority and would have reversed the arbitrator's decision, the tone of which – and the speculative accusations upon which it seems to have been founded – inspire no confidence in its conclusions. While I concur with the adjusted temporary total disability benefits calculation conforming with the parties' stipulations, and find the majority's independent review to be measured, I ultimately disagree with the remaining conclusions.

This is a routine slip-and-fall case. Petitioner's work-related accident occurred on April 4, 2019. One week later, Petitioner obtained X-rays of the cervical spine, after receiving medical advice from Dr. Petya Chalakova on April 5, 2019, regarding the possibility of delayed

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symptoms. The clear inference to be drawn from the fact that the cervical spine X-ray was sought is that Petitioner complained of neck pain or that her treating physician suspected a cervical spine injury in making the recommendation. Petitioner testified that she had started feeling pain in the back of her neck and head by the time of her April 15, 2019 medical appointment. She also testified that she began to feel the most pain in her neck over the next week to 10 days. Given that Petitioner sought diagnostics regarding her cervical spine within a week of the injury, I find her testimony credible.

Moreover, while Petitioner's critiques of Respondent's utilization review expert, Dr. Kukkar, are entirely correct, even Dr. Kukkar acknowledged that medical research indicates that symptoms of the type at issue in this case can have a delayed onset of as long as two weeks after an injury. In this case, the record suggests that Petitioner's neck condition was a known concern within one week, and culminating with Petitioner's April 27, 2019 visit, in which she complained of neck pain and left shoulder pain, rating both at 4/10. The record thus establishes that Petitioner's cervical spine injuries promptly manifested within the period defined by Dr. Kukkar and were caused, at least in part, by Petitioner's work-related accident. Therefore, I respectfully dissent from the decision of the majority.

Marc Parker

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19 (b-1) ARBITRATOR DECISION

KAMINSKA, MIROSLAWA Case# **19WC020310**
Employee/Petitioner

TWIN CLEANING PROFESSIONALS INC
Employer/Respondent

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On 2/13/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

Unless a party does the following, this decision shall be entered as the decision of the Commission:

1) Files a Petition for Review within 30 days after receipt of this decision; and

2) Certifies that he or she has paid the court reporter $ 479.40 for the final cost of the arbitration transcript and attaches a copy of the check to the Petition; and
3) Perfects a review in accordance with the Act and Rules.

If the Commission reviews this award, interest of 1.51% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1938 ALEKSY BELCHER
JASON CARROLL
350 N LASALLE ST SUITE 750
CHICAGO, IL 60654

2337 INMAN & FITZGIBBONS LTD
SCOTT McCAIN
33 N DEARBORN ST SUITE 1825
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b-1)

Miroslawa Kaminska
Employee/Petitioner
v.
Twin Cleaning Professionals, Inc.
Employer/Respondent

Case # **19** WC **20310**

Consolidated cases: _____

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An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. Petitioner filed a *Petition for an Immediate Hearing Under Section 19(b-1) of the Act* on **December 10, 2019**. Respondent filed a *Response* on **December 26, 2019**. The Honorable **Thomas L. Ciecko**, Arbitrator of the Commission, held a pretrial conference on **December 18, 2019**, and a trial on **January 2, 2020 and January 24, 2020**, in the City of **Chicago**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

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On the date of accident, **April 4, 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 except for a rib fracture and contusions to the left shoulder and left hip ***is not*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**35,793.68**; the average weekly wage was $**688.34**.

On the date of accident, Petitioner was **63** years of age, **married** with **0** dependent children.

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

Respondent shall be given a credit of $**5,320.80** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**5,320.80**.

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

ORDER

Medical benefits

Respondent shall pay reasonable and necessary medical services to the City of Chicago Fire Department of $1,152.00 and Union Health Service for services prior to July 11, 2019, except for psychiatry treatment, if not already paid, pursuant to the fee schedule. No further medical benefits are awarded.

Temporary total disability

Respondent shall pay Petitioner temporary total disability benefits of $458.89/week for 11 1/7 weeks, commencing April 5, 2019 through June 22, 2019, as provided in Section 8(b) of the Act.

Prospective medical care

No prospective medical care is awarded.

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

RULES REGARDING APPEALS Unless a party 1) files a *Petition for Review* within 30 days after receipt of this decision; and 2) certifies that he or she has paid the court reporter the ***final*** cost of the arbitration transcript and attaches a copy of the check to the *Petition*; and 3) perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

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

Signature of Arbitrator

2/13/2020
Date

FEB 13 2020

Miroslawa Kaminska v. Twin Cleaning Professionals, Inc., No. 19 WC 20310

Preface

The parties proceeded to hearing January 2, 2020, recessed to secure testimony by means of evidence depositions, and resumed and concluded the hearing January 24, 2020, on a Request for Hearing and Petition for Immediate Hearing under Section 19(b-1) of the Act indicating the following disputed issues: whether Petitioner's current condition of ill-being is causally connected to an injury that occurred April 4, 2019; what is Petitioner's average weekly wage; whether Respondent is responsible for unpaid medical bills; whether Petitioner is entitled to prospective medical treatment; and whether Petitioner is entitled to a period of temporary total disability. Miroslawa Kaminska v. Twin Cleaning Professionals, Inc., No. 19 WC 20310 Transcript of Evidence on Arbitration at 4; Arbitrator's Exhibit 1.

Petitioner testified with the aid of an interpreter. Dr. Nitin Kukkar and Dr. Lawrence Lieber testified for Respondent by means of an evidence deposition. Petitioner offered no medical testimony.

Findings of Fact

Miroslawa Kaminska (Petitioner), a 63 year old female, testified that on April 4, 2019, she was working for Twin Cleaning (Respondent) cleaning floors and bathrooms at O'Hare Airport. She was in a supply room by a bathroom, slipped on a wet floor, and hit the left side of her body on a sink and fell to the floor. She felt pain in her left rib, stood up quickly and reported the fall to her supervisor. Kaminska at 12-16.

Petitioner testified she was taken by ambulance to Resurrection Hospital. The records of the City of Chicago Fire Department indicate Petitioner said she slipped and fell while mopping a restroom floor. She said she struck her left side on the corner of a sink and landed on her left buttock. She complained of left flank and left buttock pain and denied striking her head. She denied neck and back pain. She walked out without assistance. That crew took her to Resurrection's Emergency Room. Kaminska at 16; Petitioner's Exhibit 5.

Petitioner testified she was treated at Resurrection Hospital. The records of Resurrection Medical Center indicate she arrived via the Chicago Fire Department and complained of left rib pain and left shoulder pain. She denied neck pain and head trauma. Petitioner had x-rays of the left hip, left rib, and left shoulder. There were no fractures or acute abnormality of the hip; no evidence of a rib fracture; and no fracture or bony abnormality of the shoulder. Petitioner's assessment was: shoulder contusion; rib contusion; and hip contusion. She was given medication and a Work Status Report indicated Return to Work without Restrictions. She was discharged home. Kaminska at 16; Petitioner's Exhibit 1 at 4, 7, 8-10, 5, 27.

Petitioner testified she followed up with Union Health; she said she had gone there previously. Records of Union Health Service indicate that in 2017 Petitioner had complained of pain in her left shoulder, and lower back pain without trauma, with radiation into the right hip. She told providers at Union Health she had similar backaches in the past. Petitioner also

complained of lumbar pain in 2011. A Dr. Michael Kornblatt indicated she had lumbar disc syndrome, right sciatica, and a possible herniated disc. An x-ray done April 1, 2011, indicated disc disease and degenerative changes in Petitioner's lower lumbar spine. Kaminska at 17-18; Respondent's Exhibit 6; Respondent's Exhibit 5.

The records of United Health Service indicate Petitioner was seen April 5, 2019, and three more times in April 2019. She complained only of left rib pain and left shoulder pain. She was assessed with a contusion of the trunk. The records indicate an x-ray showed a hairline fracture of the left 9th rib. It is not at all clear why, or where, the x-ray was taken. There is reference of unknown origin, on April 12, 2019, of x-rays of the left shoulder, left ribs, chest, and cervical spine, as well as a CT scan of the brain. The left shoulder x-ray indicated no acute fracture and mild degenerative arthritic changes. The left rib x-ray indicated a fracture involving the posterior aspect of the 9th rib with no significant separation. The chest x-ray indicated an acute fracture of the left 9th rib and underlying changes of obstructive lung disease. The CT scan of the brain indicated no acute findings, chronic ethmoid sinusitis, and a bilateral chronic infection of the bone behind the ear. An x-ray of the cervical spine indicated multilevel degenerative disc disease and moderate spondylitic changes in the mid and lower cervical spine. With the exception of the CT scan, done because of Petitioner's complaints of headache and nausea, there is no indication who ordered these diagnostics or why, or where they were done. Yet they are referenced in the records of United Health. Petitioner's Exhibit 2 at 11-20, 60-64.

On April 27, 2019, three weeks after the fall, Petitioner first complained of neck pain. By the next visit, May 13, 2019, she had no neck complaints at all. Petitioner repeatedly requested to be off work. By May 20, 2019, almost two months post fall, Petitioner had no neck complaints. There is evidence the records are just parroting whatever Petitioner tells the providers. By June 4, 2019, Petitioner complains of insomnia and anxiety, saying she cannot work. The records indicate her physical examination was normal and she was in no distress. She was sent to psychiatry, and was about to start psychotherapy. It appears that was triggered by Petitioner's difficult in sleeping. On July 1, 2019, the records indicate Petitioner could return to work as soon as her insomnia was controlled. Petitioner's Exhibit 2 at 20, 21, 15, 215, 27, 24, 27-31.

Petitioner's testimony, that after her April 15, 2019, follow-up at Union Health, most of her pain was in the neck is unsupported in her medical records. Kaminska at 21.

Petitioner testified she submitted to an independent medical examination with Dr. Lawrence Lieber on July 11, 2019. Kaminska at 31.

Dr. Lieber, a board certified orthopedic surgeon, testified he examined Petitioner July 11, 2019, and prepared a report. Lieber said Petitioner told him she slipped and fell on a closet floor, landing on her left rib area. She said she had a headache, but there was no indication of head trauma. Petitioner complained to Lieber of pain in the left chest, headaches, some neck pain with numbness in her fingers and toes. He performed a physical examination of Petitioner and reviewed her medical records. His diagnosis, which he relates to the fall, was status post left 9th rib fracture, healed. He believed her symptoms were not related to the accident, as there were no objective abnormalities that would cause those symptoms. Lieber found Petitioner at MMI with

no further treatment necessary, indicating she could return to full duty. Respondent's Exhibit 6, 7, 8, 9, 10.

Despite Lieber's examination, Petitioner followed up with Union Health on July 15, 2019, complaining of neck pain and headaches. Petitioner requested a referral to Dr. Mark Sokolowski. Petitioner testified she was referred to Sokolowski by her attorney. Petitioner's Exhibit 2 at 33; Kaminska at 33. There is no evidence of the education, qualifications, or experience of Sokolowski. It is arguable that, since Lieber placed Petitioner at MMI, full duty, and Petitioner's attorney sent her to Sokolowski, considering the contents of Sokolowski's records, they were prepared for use in litigation and not admissible within the context of 820 ILCS 305/16. In any event, they are not conclusive proof of the contents, by statute and for good reason.

Petitioner testified she first saw Sokolowski July 23, 2019, over three months post fall. The records of Sokolowski indicate Petitioner was first seen July 23, 2019. Kaminska at 25; Petitioner's Exhibit 3 at 3.

The records of the hand picked doctor of Petitioner's attorney, Mark Sokolowski, indicate Petitioner was seen July 23, 2019, almost four months post fall. He indicates Petitioner complained of neck pain with radiation to the trapezial region and headaches, left posterior rib pain, left extremity numbness, and that those symptoms occurred subsequent to the fall at work. This is a radical expansion of Petitioner's initial complaints. Sokolowski indicated Petitioner was a self referral, which was fiction. Sokolowski indicated Petitioner had not had advanced imaging. That was a misrepresentation, as the records of United Health Service clearly indicate. Sokolowski's assessment merely parroted Petitioner's complaints. He wanted an MRI of the cervical and lumbar spine and, without indication what they were, wanted to continue Petitioner's restrictions. At the same time, he recited restrictions on bending, squatting, lifting, with sedentary duty. He took no history, recognized no prior treatment, and indicated no familiarity with Petitioner's job. A Work Status Report of July 23, 2019, while much is illegible, has restrictions on standing, walking, bending, squatting, and favors a sedentary job. This stands in stark contrast to Union Health Service physicians who indicated three weeks prior, that Petitioner could return to work as soon as her insomnia was controlled. Petitioner's Exhibit 3 at 3; Petitioner's Exhibit 2 at 61-64; Petitioner's Exhibit 3 at 4, 5; Petitioner's Exhibit 2 at 31.

Petitioner testified Sokolowski recommended physical therapy and that therapy took place at his office. Kaminska at 25, 26. The physical therapy Evaluation Summary of July 29, 219, indicates Petitioner it her head on a metal sink. That is a complete fabrication. Petitioner's Exhibit 3 at 24; Kaminska at 15; Petitioner's Exhibit 5 at 2; Petitioner's Exhibit 1 at 7; Petitioner's Exhibit 2 at 12. That summary indicates Petitioner is able to sleep through the night. Petitioner's Exhibit 3 at 24. That is also complete fabrication. Petitioner's Exhibit 2 at 27, 30, 31. The physical therapy plan had all available interventions checked, including functional retraining, posture education, cardiovascular conditioning. Petitioner's Exhibit 3 at 24. The integrity of the treatment of Petitioner, as well as the records of Sokolowski, are severely compromised. Those therapy notes remained essentially the same for three months.

Petitioner testified that with physical therapy she saw significant improvements in her symptoms. Kaminska at 27. The physical therapy records suggest that testimony is dishonest. Petitioner's Exhibit 3 at 27, 38, 39, 51.

A little over a month after her initial visit, Petitioner followed up with Sokolowski. He indicated he had reviewed MRIs from Edgebrook Radiology of July 30, 2019. Incredibly, the clinical history for both MRIs, cervical and lumbar, indicate Petitioner was in a motor vehicle accident, with trauma with neck pain and with back pain. Petitioner's Exhibit 3 at 9, 87, 89. They are not trustworthy. It is noteworthy that Sokolowski noted the review of the MRIs, without comment, noting the same assessment of Petitioner from July 23, 2019, and continuing physical therapy. This despite after ten sessions, Petitioner said she felt the same. Petitioner's Exhibit 3 at 9, 3, 37. Sokolowski issued a Work Status Report of September 5, 2019, for modified duty. Petitioner's Exhibit 3 at 10.

Sokolowski's records indicate he saw Petitioner October 9, 2019. Her complaints continued to expand from her initial visit. Sokolowski's assessment is merely an echo of Petitioner's expansive complaints. He indicates if progress, predictably left unexplained, is unsatisfactory, he would consider injections as appropriate. An equivocation if ever there was one. Petitioner's Exhibit 3 at 14.

Petitioner submitted to a follow up, independent medical examination with Dr. Lieber on October 3, 2019. Lieber testified Petitioner had significant other complaints from his first examination, which Petitioner felt were associate with her April 2019 fall. He conducted an extensive physical examination. He reviewed medical records and MRI films of the cervical and lumbar spine. Lieber testified his diagnosis was degenerative cervical disc disease, degenerative lumbar disc disease, a normal left shoulder, status post rib fracture healed. He found no evidence the left shoulder was associated with a work event, or the left hip, or thoracic spine. Lieber testified he found no objective evidence of Petitioner's having sustained a trunk contusion or cervical spine injury connected with her work event. He found no evidence of acute injury in the MRI findings that could be related to the April 2019 event. He disagreed with Sokolowski that Petitioner has cervical radiculopathy related to the fall, based on Petitioner's MRI. Lieber testified the work injury did not cause or aggravate Petitioner's lumbar spine, there was no evidence of any injury. Lieber said he disagreed with Sokolowski's diagnosis of lumbar radiculopathy being related, as Petitioner showed significant preexisting degenerative lumbar disc disease having no relationship to the work injury. There was no evidence, Lieber said, of acute injury to Petitioner's cervical area that would cause her headaches. Petitioner, said Lieber, had reached MMI and could return to full duty from the fall. Respondent's Exhibit 1 at 12, 13, 15, 16-19, Exhibit 3.

Subsequent to the follow up MRI, Petitioner made an unscheduled visit to Sokolowski, seven months post fall. His notes indicate Petitioner was open to epidural injections if necessary. Sokolowski recommended further the physical therapy. Petitioner testified this was her last visit. Petitioner's Exhibit 3 at 19; Kaminska at 28.

At the hearing, Petitioner testified her rib was without pain and she had no problem with her left shoulder or hip. She said her only problem is with her neck when turning her head in any direction. She did not recall any prior back or shoulder treatment. Kaminska at 31-32.

Conclusions of Law

Disputed issue **F** is, is Petitioner's current condition of ill-being causally connected to the fall, April 4, 2019. To obtain compensation under the Act, an employee must establish by a preponderance of the evidence, a causal connection between a work related injury and the employee's condition of ill-being. Vogel v. Illinois Workers' Compensation Commission, 354 Ill. App. 3d 780, 786 (2005).

The evidence in this case indicates that at most Petitioner suffered a fracture of the left 9th rib. Even that evidence is conflicting. Petitioner's Exhibit at 9; Petitioner's Exhibit 2 at 61. I believe she also suffered a contusion to her left shoulder and left hip. Petitioner's Exhibit 1 at 4. I rely on the records of the City of Chicago Fire Department; the records of Resurrection Medical Center; and United Health Center. Petitioner's Exhibit 5 at 2; Petitioner's Exhibit 1 at 4, 10; Petitioner's Exhibit 2 at 11-13.

I further rely on the testimony of Dr. Lawrence Lieber, the only medical testimony offered. By the look of the examinations, he conducted an extensive examination of Petitioner and her diagnostic tests and medical records. His testimony is supported by medical records and radiographic and diagnostic testing. I reject and find untrustworthy, the records of Dr. Sokolowski as a combination of fiction, gaps in knowledge, and equivocation. I give its contents little if any weight. I note the MRI scans he ordered were thought to be not medically necessary by Dr. Nitin Kukkar. Kukkar also thought the physical therapy recommended for Petitioner was excessive. Respondent's Exhibit 2 at 13 14. I note the recommended therapy was done in Sokolowski's office, not a separate facility.

I find, as a conclusion of law, Petitioner's current condition of ill-being, other than her healed rib fracture and resolved soft tissue injuries to her hip and shoulder not causally connected to her fall April 4, 2019.

Disputed issue **G** is what was Petitioner's Average Weekly Wage. Petitioner offered no evidence or testimony on this issue. Based on the evidence submitted by Respondent, I find as a conclusion of law, Petitioner's Average Weekly Wage $688.34. Respondent's Exhibit 4; 820 ILCS 305/10.

Disputed issue **J** is, whether Respondent is liable for unpaid medical bills. An employer shall pay according to a fee schedule or negotiated rate, all necessary first aid, medical services and hospital services incurred, reasonably required to cure or relieve from the effects of an accidental injury. 820 ILCS 305/8a.

Petitioner claims Respondent is liable for $1,152.00 to the City of Chicago Fire Department. I agree Respondent is liable and rely on the records of the fire department and Resurrection Medical Center. Petitioner's Exhibit 5 at 2, 5; Petitioner's Exhibit 1 at 4.

Petitioner claims Respondent is liable for $26,710.00 to Dr. Mark Sokolowski. Respondent is not liable because none of the things he did, which primarily consisted of physical therapy at his own facility, concerned the accidental injury. The recommended therapy was excessive, and the MRIs he required were not medically necessary. Respondent's Exhibit 2 at 13-14. Dr. Lieber placed Petitioner at MMI from the injury with a return to full duty prior to Petitioner's first visit to Sokolowski.

Petitioner claims Respondent is liable for $4,294.00 to Edgebrook Radiology. Respondent is not liable because, similar to Sokolowski, their services did not concern the accidental injury, and also not medically necessary. They are also suspect and unreliable, indicating Petitioner was in a motor vehicle accident. Petitioner's Exhibit 3 at 87, 89.

Petitioner claims Respondent is liable for $947.44 to Union Health Service. Respondent is liable for this amount if incurred before July 11, 2019, and not already paid. If, however, that amount is for Petitioner's psychiatry treatment, Respondent is not liable as that is in no way related to the accidental injury.

Disputed issue **K** is, is Petitioner entitled to prospective medical care. Specific procedures that have been prescribed by a medical service provider are incurred within the meaning of Section 8(a), even if they have not been performed or paid for. Dye v. Illinois Workers' Compensation Commission, 2012 Ill. App. (3d) 100907 WC.

Petitioner seeks a cervical injection and further physical therapy. Petitioner was placed at MMI months before the equivocal notes of Dr. Sokolowski. Such injection and physical therapy would not be related to the accidental injury. Moreover, any suggestion of injections being prescribed by Sokolowski is, by the fact of his notes, hypothetical. Petitioner is not entitled to prospective medical care.

Disputed issue **L** is whether Petitioner is entitled to Temporary Total Disability from April 5, 2019, to hearing.

A claimant is temporarily totally disabled from the time an injury incapacitates her from work until such time as she is recovered or restored as the permanent character of her injury will permit. The dispositive inquiry is whether the claimant's condition has stabilized, reached maximum medical improvement as an example. Considerations are given to a release to return to work, medical testimony, and evidence concerning the injury and extent of the injury. Interstate Scaffolding, Inc. v. Workers' Compensation Commission (Urban), 385 Ill. App. 3d 1040, 1043 (2008).

While Petitioner was released to return to work without restrictions by the emergency room providers at Resurrection Medical Center that day of the accident, she was promptly told to rest at home for 10 days by Union Health Service the next day. That barely qualifies as an "off work" status. Petitioner promptly began requesting extensions of being off work from Union Health, on April 15, 2019, April 27, 2019, and May 20, 2019. On April 27, 2019, providers at Union Health indicated Petitioner would heal in six to eight weeks and they anticipated an

uneventful recovery. By June 4, 2019, Petitioner told the providers at Union Health that she could not work. By July 1, 2019, Union Health providers indicated Petitioner could return to work when a bout of unrelated insomnia was controlled. An examination by Dr. Lieber found Petitioner healed and at MMI able to return to full duty when he examined her July 11, 2019.

I find, based on the observations at Union Health, the medical testimony of Dr. Lieber, and the injury itself, Petitioner recovered from the injury sustained in the fall by June 22, 2019. I find Petitioner entitled to temporary total disability benefits of $458.89 per week from April 5, 2019, to June 22, 2019 (11-1/2 weeks).

Arbitrator

2/13/2020
Date

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Linda Bruno-Brockman,
Petitioner,

vs. No. 12 WC 40368

Provena St. Mary's Hospital,
Respondent.

20IWCC0309

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 temporary total disability, casual connection, medical expenses, prospective medical expense, and penalties and attorney's fees under §19(l), §19(k) and §16, of the Act, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 18, 2018, is hereby affirmed and adopted.

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

20IWCC0309

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 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: JUN 8 - 2020

Marc Parker

Deborah L. Simpson

Deborah L. Simpson

Stephen Mathis

Stephen Mathis

mp/wj
05/21/20
68

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

BRUNO-BROCKMAN, LINDA
Employee/Petitioner

Case# **12WC040368**

PROVENA ST MARY'S
Employer/Respondent

20IWCC0309

On 7/18/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

4070 CHARLES A FANUCCHI LAW OFFICES
2069 CHESHIRE DR
HOFFMAN ESTATES, IL 60192

2461 NYHAN BAMBRICK KINZIE & LOWRY
AMY BILTON
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF WILL)

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

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

Linda Bruno-Brockman
Employee/Petitioner

v.

Provena St. Mary's
Employer/Respondent

Case # **12** WC **40368**

Consolidated cases: **N/A**

20IWCC0309

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Barbara N. Flores**, Arbitrator of the Commission, in the city of **New Lenox** on **April 9, 2018** in the city of **Ottawa** on **May 25, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, May 7, 2012, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $73,096.44; the average weekly wage was $1,414.81.

On the date of accident, Petitioner was 45 years of age, *married* with 2 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 $278,289.99 for TTD, $0 for TPD, $0 for maintenance, and $22,902.33 for other benefits, for a total credit of $301,192.32. *See* AX1.

Respondent is entitled to a credit reflected in Respondent's Exhibit 1 under Section 8(j) of the Act. *See* AX1.

ORDER

As explained in the Arbitration Decision Addendum, Petitioner has failed to establish a causal connection between her accident at work or subsequent medical treatment and current condition of ill-being beyond a left shoulder strain.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $943.21/week for 6 & 3/7th weeks, commencing May 8, 2012 through June 21, 2012, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from May 7, 2012 through May 25, 2018, and shall pay the remainder of the award, if any, in weekly payments.

As stipulated by the parties, Respondent shall receive credit of $278,289.99 for temporary total disability benefits paid. *See* AX1.

Medical Benefits

Respondent shall pay reasonable and necessary medical services as reflected in Petitioner's Exhibits incurred through June 21, 2012 that remain unpaid pursuant to the medical fee schedule as provided in Sections 8(a) and 8.2 of the Act. Petitioner's claim for payment of additional medical bills for treatment thereafter is denied.

Prospective Medical Treatment

Petitioner's claim for prospective medical treatment is denied.

Penalties

Petitioner's claim for penalties and attorneys' fees pursuant to Sections 16, 19(k) and 19(l) of the Act is denied.

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

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

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

Signature of Arbitrator

July 17, 2018
Date

ICArbDec19(b) p.3

JUL 18 2018

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

Linda Bruno-Brockman
Employee/Petitioner

v.

Provena St. Mary's
Employer/Respondent

Case # **12** WC **40368**

Consolidated cases: **N/A**

FINDINGS OF FACT

The issues in dispute include causal connection, Respondent's liability for certain unpaid medical bills, Petitioner's entitlement[1] to temporary total disability benefits from May 7, 2012 through May 25, 2018, whether she is entitled to prospective medical care, and Respondent's liability for penalties and attorneys' fees. Arbitrator's Exhibit[2] ("AX") 1. The parties have stipulated to all other issues. *Id.*

Employment & Background

Linda Bruno-Brockman (Petitioner) testified that she was employed in May of 2012 as a Surgical Nurse by Presence St. Mary's Hospital (Respondent) for approximately 23 years. Tr. at 18. She has a B.S.N. in nursing and is certified as a trauma nurse specialist, ACLS certified, as a mobile intensive care nurse, and explained that she has a lot of certifications. *Id.* At the time of her accident, Petitioner testified that she was taking various medications including one baby aspirin daily, Dyazide which is a water pill, Verapamil, Micardis and Verapamil, which are blood pressure medications for hypertension. Tr. at 19-20. Dr. Long prescribed these medications for her. Tr. at 20. Petitioner explained that she could work her full duties at St. Mary's as a surgical nurse and engage in activities of daily living even taking those medications. Tr. at 20-21.

Medical Treatment Prior to May 7, 2012

The records reflect that Petitioner underwent treatment for various conditions and symptoms prior to her accident at work including orthostasis, postural hypotension, dizziness, urinary issues, exercise intolerance, tremors, hearing loss and neck pain.

On November 20, 1996, she was seen by her primary care physician because her blood pressure was "too low" and she was orthostatic while standing. PX5A at 262. On December 22, 1997, Petitioner was treated at St. Mary's Hospital with symptoms of dizziness, arrhythmia and postural hypotension. PX5A at 247. Petitioner was ordered to hold her blood pressure medications until she was seen by the doctor. *Id.*

On cross-examination, Petitioner denied ever having postural orthostatic tachycardia or treatment for it before her accident at work. Tr. at 125-126. On December 22, 1997, Petitioner was treated for dizziness and diagnosed with postural hypotension and told to change positions and her blood pressure medications because it

[1] Respondent stipulated that Petitioner is entitled to temporary total disability benefits commencing on November 16, 2012 through June 7, 2013. AX1.

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

was causing her blood pressure to crash. Tr. at 126.

On February 16, 1999, Petitioner treated with Dr. Long, her primary care physician, for bilateral hand tremors. PX5A at 268. On cross-examination, Petitioner testified that she was going through a horrible divorce in 1999 for which she was prescribed Xanax due to anxiety, and she denied that was prescribed Xanax for tremors. Tr. at 139-140.

On February 17, 2000, Petitioner was seen for complaints of urge and stress incontinence over the past year, which were treated with medication. PX5A at 337.

On June 2, 2000, Petitioner was seen at Provena St. Mary's emergency room with a recent history of postural tachycardia of unclear etiology. PX5A at 246-247. An electrocardiogram demonstrated the presence of sinus tachycardia, which was reportedly a new finding since prior tracing done in 1996. PX5A at 226-228. Dr. Philip Hays saw Petitioner in consultation and opined the tachycardia was a result of mild orthostasis induced by her blood pressure medication, Trandate, resulting in her heart rate being inadequately controlled by the medication. PX5A at 251-252. Dr. Long discontinued Trandate and placed Petitioner on Toprol-XL. PX5A at 270. On cross-examination, Petitioner testified that she did not know whether on June 2, 2000, she was seen in the emergency room for complaints of tachycardia that were postural in nature. Tr. at 127. Petitioner acknowledged that the medical records reveal a "recent history of postural tachycardia of unclear etiology" and diagnosis of "postural tachycardia in the absence of dehydration or cardiac arrhythmia that was due to the result of mild orthostasis[.]" Tr. at 127-128; *see also* RX5 at 251.

On June 5, 2000, Petitioner followed-up with Dr. Long for her positional tachycardia, but despite the medication change Petitioner claimed she still felt tachycardic. PX5A at 270. Her heart rate increased by 20 beats per minute when changing position from lying to standing. *Id.* Dr. Long again adjusted her medications. *Id.*; Tr. at 125. On June 19, 2000, Petitioner followed-up with Dr. Hays for her complaints of unexplained postural tachycardia and dizziness. PX5A at 339. She underwent a stress echocardiogram which was normal. *Id.*

On July 17, 2000, Petitioner sought treatment with Dr. David Wilber at the University of Chicago for her complaints of postural tachycardia associated with dizziness. PX5A at 340-341. Dr. Wilber adjusted her medication. *Id.* On cross-examination, Petitioner testified that she did not remember seeing another doctor at the University of Chicago on July 17, 2000, for the same condition with recurrent palpitations that were of unclear etiology with associated dizziness and tachycardia. Tr. at 129-130.

On October 14, 2002, Petitioner again sought treatment for palpitations/tachycardia, as well as a new complaint of exercise intolerance. PX5A at 275. She also voiced complaints of exercise intolerance and fatigue on April 22, 2003. *Id.* On cross-examination, Petitioner testified that she had seen a doctor for urinary issues before her accident for stress incontinence. Tr. at 146-147. Petitioner denied that she experienced exercise intolerance from her beta blocker medications in 2002 and 2003. Tr. at 130. Petitioner then testified that she told them that the beta blockers were inhibiting her from doing a lot of the things she wanted to do. Tr. at 131. She explained that her medications were changed as a result. *Id.*

On November 9, 2005, Petitioner returned to Dr. Long with after a recent bout of tachycardia. PX5A at 414-415. She reported two spells of tachycardia over the prior year. *Id.* Dr. Long referred Petitioner to Dr. Suprenant. *Id.* However, Petitioner did not avail herself of this referral for some time. *See* PX8. On cross-examination, Petitioner did not remember receiving treatment from Dr. Long on November 9, 2005 for tachycardia. Tr. at 131. Petitioner also did not remember whether Dr. Long referred her to Dr. Suprenant in 2005 for her condition.

Tr. at 132.

On cross-examination, Petitioner denied a history of headaches, vertigo and hearing loss dating back many years before May 7, 2012. Tr. at 120. Petitioner testified that she underwent an MRI in 2007 for hearing loss, but not vertigo or headache. Tr. at 120. Petitioner denied that the MRI was of the brain and testified that it was for a certain part of her ear to determine why she had hearing loss in her left ear. Tr. at 120-121.

On June 29, 2011, Petitioner sought treatment from Dr. Long for a stiff neck, worst on the left. PX5A at 397-398. On exam, Petitioner's neck range of motion was decreased with side flexion and rotation in either direction. *Id.* On cross-examination, Petitioner acknowledged that she underwent treatment on June 29, 2011 with Dr. Roland for left-sided neck pain. Tr. at 118-119.

On October 7, 2011, Petitioner underwent an MRI of the brain given complaints of progressive hearing loss. PX5A at 107.

On February 29, 2012, Petitioner underwent an MRI of the cervical spine without contrast at the request of Dr. Paul Roland due to complaints of pain radiating to the right shoulder. PX5A at 183. The MRI revealed disc protrusions at C4-C5, C5-6 and C6-C7, causing spinal canal stenosis. *Id.* The findings were most significant at C6-C7 where a right paracentral disc protrusion caused flattening of the cord and was likely abutting the adjacent nerve root. *Id.*

On March 1, 2012, Petitioner followed-up with Dr. Roland for complaints of constant and sharp lower cervical and right shoulder pain, numbness and tingling in the right and little finger and right triceps area, and pain in the right scapular area that had been present off-and-on over the previous two years. PX4A at 9-10; Tr. at 111. Dr. Roland recommended cervical epidural steroid injections and suggested Petitioner obtain an opinion from a neurosurgeon. Petitioner then underwent the cervical epidural steroid injection at C5-6 on March 15, 2012. PX4A at 11-12.

Petitioner acknowledged that she had right-sided cervical radiculopathy and saw Dr. Roland on March 1, 2012. Tr. at 105-106. Petitioner also acknowledged that Dr. Roland's records from March 1, 2012 reflect her history of pain in the right scapular area on and off over the last two years. Tr. at 106. However, Petitioner could not recall whether Dr. Roland referred her to a neurosurgeon based on a disk protrusion at C6-7. Tr. at 109-110.

On cross-examination, Petitioner acknowledged that she had hypertension that she had been addressing with medication for years and years predating her injury at work. Tr. at 101. She testified that her medications had been adjusted over the years, but explained that she was consistently on two different medications as of 2005 and one additional medication was added in 2007. Tr. at 101. Petitioner could not recall whether her doctor added or subtracted medications based on how her body was responding to them before that time. Tr. at 101-102. On extended questioning, Petitioner denied that she was the person "day-to-day deciding how much medication to take" and testified that she took her medications within parameters set by Dr. Long. Tr. at 103-105. Petitioner also testified that she was taking Diazide, a water pill, which she had been taking prior to her accident. Tr. at 130. She acknowledged that dehydration can cause postural tachycardia. *Id.*

On cross-examination, Petitioner admitted that she underwent an epidural steroid injection on March 15, 2012, for a herniated disk at C6-7. Tr. at 110.

Accident

Petitioner testified that on May 7, 2012, she was working in what was called the "clean room" where the cases are readied for the next day and where instrumentation from the previous day is put away. Tr. at 21. Petitioner explained that she was putting away one of the surgical trays from the previous day up on a top shelf, but it got stuck and she injured her shoulder and her neck. Tr. at 21-22. Petitioner's accident is not in dispute. AX1. Petitioner described the tray as a large orthopedic tray weighing about 30-40 pounds with instruments. Tr. at 22. She explained that she had one hand on the bottom and one hand on the handle and it was the last tray to be stored. *Id.* When she went to slide it into the top shelf and it kind of got wedged cockeyed and it did not slide as she was pushing it and she felt a tweak in her shoulder that hurt pretty substantially; enough that she was not able to hold the tray up there and had to let it go. Tr. at 22-23. Petitioner testified that she thought the tray was going to come down on her head so she jerked her head to the right and let go of the tray, which never did fall down on top of her and stayed up in its position. Tr. at 23. Afterward, Petitioner testified that she did not use her left arm again and used her right arm to correct the tray and finish pushing it up in its spot. *Id.* She described the tray to be approximately two feet by one and a half feet and explained that placement of the tray was at or above head level. Tr. at 23-24.

Petitioner testified that she had pain and some slight numbness to the posterior (rear) part of the left shoulder. Tr. at 24. Petitioner reported the injury to her direct supervisor, Karen Cherry (phonetic) within 30 minutes of the injury and she was instructed to told her to go see the corporate health physician, Dr. Michael Panuska, which she did. Tr. at 25.

On cross-examination, Petitioner testified that her left arm was overhead, on the side of the tray, and her right arm was holding the handle. Tr. at 95-96. Petitioner did not recall whether her left arm was completely extended. Tr. at 96.

Medical Treatment

Petitioner testified that she then went to see her primary care physician, Dr. Long, who she had been seeing for a very long period of time. Tr. at 28. Petitioner testified that while she was at Dr. Long's office her arm started sweating. *Id.* He then referred her to a neurosurgeon, Dr. Jimenez, who she saw within 24 hours. Tr. at 29-30. Petitioner testified that her arm was hot to the touch, mottled, and sweaty. Tr. at 30. Petitioner testified that she had shoulder pain radiating down into the arm and pain in the neck that went all back into the left posterior shoulder area. Tr. at 31. Petitioner described her mottled arm to have red and purplish blotches, which she explained she also had when she saw Dr. Panuska and Dr. Long. *Id.*

On cross-examination, Petitioner testified that she knew, as a nurse, that it was important to give a good medical history to a treating physician when being diagnosed and for the doctors to be educated about the work-up and treatment. Tr. at 110-111. However, Petitioner could not say whether she told Dr. Long on May 7, 2012 that she was being treated by Dr. Roland for a cervical disk. Tr. at 111.

The records reflect that on May 9, 2012, Petitioner presented to Dr. Juan Jimenez, a neurosurgeon, at the referral of Dr. Long. PX2 at 24-26. She reported bilateral upper extremity, left greater than right, radicular symptoms and scapular pain after an occupational injury. *Id.* She also complained of posterior upper thorax pain on the left, and intermittent left shoulder pain. *Id.* Petitioner further reported the cold sensation followed by a pins-and-needles sensation that she experienced on the date of accident had improved. *Id.* She denied cervical spine pain, but did demonstrate cervical paraspinal tenderness. *Id.* Her physical examination was significant for a

positive Phalen's test on the left and a positive Tinel's test at the left elbow. *Id.* Dr. Jimenez reviewed Petitioner's May 7, 2012 cervical MRI showing the right-sided disc herniation and opined it consistent with cervical disc disease, and also diagnosed a likely traction-type injury and some peripheral nerve involvement. *Id.*

On cross-examination, Petitioner testified that she told Dr. Jimenez how she was injured when she saw him on May 9, 2012, but she could not recall all the information that she gave him. Tr. at 97. Petitioner testified that she did not know what was in her record from five years ago. Tr. at 98. Petitioner denied telling Dr. Jimenez that she was having bilateral upper extremity symptoms and scapular pain after the work injury. Tr. at 111-113. Petitioner acknowledged that Dr. Jimenez's records reflect that she had bilateral upper extremity radicular symptoms, left greater than right, and scapular pain after her accident, but she testified that it was incorrect. Tr. at 112-113. Petitioner could not recall whether Dr. Jimenez told her that she had a right-sided cervical disk herniation, cervical disk disease, a likely traction type injury and peripheral nerve involvement. Tr. at 113.

On cross-examination, Petitioner testified that at the first visit with Dr. Jimenez two days after her accident she had a cold sensation that changed to hot and back to cold again, but then testified that she could not recall. Tr. at 114. She testified that she had numbness and tingling in her left arm as well and that she reported her discoloration and mottling as well. Tr. at 114-115. When asked whether she reported to Dr. Jimenez that she had been treated by Dr. Roland, Petitioner recalled that "[h]e does not have it documented in there but I'm sure I discussed it with him." Tr. at 115. Petitioner also testified that she and Dr. Jimenez compared her February 29, 2012 MRI with her post-injury MRI in his office contrary to his deposition testimony that he could not recall seeing Petitioner's pre-injury MRI. Tr. at 115-117. Petitioner admitted that there was no change between the two MRIs. Tr. at 116. Petitioner testified that she told every physician with which she treated that she had already seen Dr. Roland and had an epidural steroid injection. Tr. at 117.

The records reflect that Petitioner also saw Dr. Panuska on May 9, 2012 and reported that she had cervical disc problems in the past, including an epidural steroid injection by Dr. Roland. PX1A at 359-360. Petitioner reported that this episode was different because, usually, her right side was affected, but now she complained of a warm and burning sensation and her left arm was sweaty. *Id.* Dr. Panuska diagnosed Petitioner with traction injury with injury to the brachial plexus and, possibly, complex regional pain syndrome. *Id.*

Petitioner testified that she had to go back and see Dr. Panuska who discharged her from his care and told her to stay with Dr. Jimenez and Dr. Roland who was a pain management doctor. Tr. at 32. Petitioner testified that Dr. Panuska gave her work restrictions that she was not able to use her left arm. Tr. at 36. She then went back to work and testified that she presented them to her manager in the surgical department, but they would not allow her to come back to work in the operating room. Tr. at 36-37.

Petitioner testified that when she first saw Dr. Roland she explained how her injury occurred, the immediate symptoms that had happened to her arm, and the results of the MRI. Tr. at 33. She explained that he administered some cervical epidural steroid injections. *Id.*

The records reflect that Petitioner returned to Dr. Roland on June 18, 2012, with complaints of left scapular pain, left upper extremity pain and coldness and discoloration to the extremity. PX4A at 82-83. She now also reported neck pain. *Id.* Dr. Roland noted that he had previously treated Petitioner for pain in her neck and in the scapular region, for which she underwent a series of cervical epidural steroid injections secondary to cervical disc protrusions at C5-6, C4-5, and C6-7 causing radiculopathy. *Id.* Dr. Roland opined Petitioner had signs and symptoms consistent with cervical radiculopathy and recommended another cervical epidural steroid injection

since the pre-accident injection had been successful. *Id.*

On cross-examination, Petitioner testified that when she saw Dr. Roland on June 18, 2012, she told him the complete story of how she was injured, but when asked why his records do not mention the neck she testified that she did not know what he documented in his records and she could not recall what she told him. Tr. at 99.

The records reflect that on June 25, 2012, Petitioner returned to Dr. Jimenez for evaluation of bilateral upper extremity radicular-type symptoms, left greater than right, and scapular pain. PX5A at 156-158. Dr. Jimenez recommended a C6-C7 disc arthroplasty given single-level disc disease. *Id.*

On July 9, 2012, Petitioner underwent the cervical epidural steroid injection with Dr. Roland. PX4A at 80. She returned for treatment with Dr. Long on July 10, 2012, when he cleared her for surgery. PX5A at 391-393.

Petitioner testified that Dr. Jimenez prescribed surgery to the cervical spine and in August of 2012 he replaced a cervical disk in her neck at C6-C7. Tr. at 33-34. Petitioner testified that when she went in for the surgery she was limited as to what she could do due to the sympathetic issues with her left arm including pain, discoloration, sweating and tremors throughout the body. Tr. at 34-35, 38 (*but see* PX5A). Petitioner testified that the tremors started right after the initial injury. Tr. at 35 (*but see* PX5A at 268)

The records reflect that Petitioner underwent a C6-C7 cervical disc arthroplasty on August 3, 2012. PX5A at 156-158. The procedure was uneventful other than a complication of post-operative urinary retention. *Id.* Petitioner underwent a follow-up cervical x-ray on August 16, 2012 which showed the disc prosthesis to be appropriately positioned. PX5A at 175.

Petitioner returned to Dr. Jimenez on August 27, 2012. PX5A. Her complaints of pain radiating to her posterior left upper extremity and bicep remained. PX5A at 64-66. Petitioner's urinary retention was noted to have resolved. *Id.* Dr. Long recommended another cervical MRI to exclude new pathology. *Id.*

The updated MRI on August 28, 2012 showed no evidence of canal stenosis or cord compression. PX5A at 158-159. Given the blooming of the metal artifacts on the imaging, Petitioner was recommended for further assessment using a CT myelogram. *Id.*

Petitioner was then hospitalized on August 28, 2012 due to complaints of progressive sensory symptoms in her left, followed by right, upper extremities. PX5A at 145-147. She was seen in consultation by Dr. Daniel Orozco, who noted Petitioner had already seen a pain management physician, and was already experiencing what sounded like symptoms compatible with RSD – reflex sympathetic dystrophy – prior to May, 2012. *Id.* Upon physical examination, Dr. Orozco did not note any such symptoms. *Id.*

Petitioner was also worked-up for the possibility of residual neurological compromise. PX5A at 137-139. A myelogram ruled out any cause for her ongoing upper extremity symptoms. *Id.* Petitioner was also treated for urinary symptoms during her hospitalization. *Id.* Dr. Frye mentioned Petitioner had a history of chronic bowel issues. *Id.* Dr. Frye opined Petitioner had high sympathetic discharge which was probably related to reflex sympathetic dystrophy and recommended intermittent catheterization. *Id.*

On August 30, 2012, also during her hospitalization, Petitioner stood to use the restroom and experienced postural tachycardia despite minimal exertion, accompanied by hypertension. *Id.* A brain MRI was normal. PX5A at 172. She was subsequently transferred to the intensive care unit. *Id.* The postural tachycardic

symptoms were felt unrelated to any acute coronary syndrome, but rather related to sympathetic overdrive. *Id.* Dr. Long started Petitioner on Lopressor for the tachycardia. *Id.* The discharge diagnosis from August 30, 2012 was apparent reflex sympathetic dystrophy with symptoms including bilateral upper extremity pain and urinary retention. *Id.* Dr. Roland opined all the symptoms were a manifestation of chronic regional pain syndrome (CRPS, formerly known as reflex sympathetic dystrophy, or RSD) and suggested Petitioner transfer to Rush to seek treatment with Dr. Timothy Lubenow. *Id.*

Petitioner testified regarding this hospitalization and testified that it was for nausea, vomiting, headache, and mainly numbness and tingling to both of her arms and hands. Tr. at 38-39. She explained that she underwent a myelogram and an MRI, which she admitted were both normal. Tr. at 39-40. Petitioner testified that the following morning she woke up and while walking to the bathroom she started getting chest pain, shortness of breath, palpitations, and nausea, which she reported to someone at the hospital. Tr. at 40. She then underwent an EKG and was examined by a team of physicians including a cardiologist, a neurologist, and a pain specialist because she had a multitude of complaints. Tr. at 40-42. After three days in the hospital, Petitioner was released to see Dr. Roland and Dr. Lubenow at Rush University. Tr. at 43. Dr. Long remained her primary care physician. *Id.*

The records reflect that on September 12, 2012, Petitioner saw Dr. Lubenow and reported that she "was injured in a work-related accident and developed left shoulder pain after she was lifting an orthopedic tray at work. Since the accident in May, 2012, [she] notes persistent left posterior neck and shoulder pain that radiates across the anterior shoulder, down the posterior left arm, to the elbow, and then anteriorly into the left forearm, as well as numbness in the left fourth and fifth digits. [Petitioner] underwent a C6-C7 discectomy on August 3, 2012, however, she continues to have symptoms in the distribution noted above." PX7 at 22-23. At her next visit on September 26, 2012, Dr. Lubenow diagnosed Petitioner with neuropathic pain and an atypical presentation of RSD or CRPS of the left upper extremity and shoulder status post work-related injury. *Id.* Then, Dr. Lubenow recommended and administered a diagnostic sweat test and stellate ganglion blocks. PX7. Petitioner underwent the series of stellate ganglion blocks, on the right and left sides, from September 26, 2012 through December 20, 2012, and a trigger point injection on December 27, 2012. *Id.* Petitioner testified that she understood that these blocks were to "reset the sympathetic nervous system." Tr. at 43-44.

On September 28, 2012, Petitioner underwent a cardiac catheterization which ruled out atherosclerotic cardiovascular disease. PX5A at 27-29. Petitioner testified that she saw Dr. Masullo[3], a cardiologist, who performed an echocardiogram and cardiac catheterization, which were admittedly normal. Tr. at 44.

Petitioner testified that she also came under the care of Dr. Suprenant, a cardiac electrophysiologist, who diagnosed her with "POTS" (i.e., postural orthostatic tachycardia syndrome), prescribed medications for her, and helped her get in to see a POTS specialist in Toledo, Ohio, Dr. Blair Grubb. Tr. at 45-46. Petitioner explained that Dr. Suprenant "helped with the medications" that she was on such that he would decrease her water pill when she was starting to feel dehydrated and he allowed her to decrease her Dyazide and manage her Lopressor depending on her symptoms. Tr. at 46. She explained that if she was more tachycardic or she wanted to be more active during the day, she could take more medication so it would allow her to be more active. Tr. at 47. Petitioner testified that she had a team of physicians, but Dr. Long prescribed the medications and she understood that the other physicians conferred with Dr. Long. Tr. at 47, 62-63.

The records reflect that Petitioner saw Dr. Brad Suprenant at Kankakee Arrhythmia Consultants on October 4,

[3] At the hearing, Dr. Masullo was sometimes, erroneously, referenced as Dr. Masuda.

2012. PX9 at 2-6. Dr. Suprenant assessed Petitioner with POTS secondary to her cervical disk surgery. *Id.* Petitioner began occupational therapy after her neck surgery on October 17, 2012. PX5B at 1183-1185. She followed-up with Dr. Jimenez on October 31, 2012 when Dr. Jimenez opined the recent diagnosis of Postural Orthostatic Tachycardia Syndrome "clearly explained (her) multiple symptoms." PX2 at 7-8.

On cross-examination, Petitioner admitted that she did not tell Dr. Suprenant about any of her symptoms of postural tachycardia, workup history for postural tachycardia, history of orthostasis when standing, dizziness, or postural hypertension prior to May of 2012. Tr. at 137-138.

The records reflect that on October 30, 2012, Petitioner underwent a repeat electrocardiogram that showed no tachycardia. PX1A at 265.

Petitioner testified that she saw Dr. Hayes (a cardiologist) who facilitated her appointment with Dr. Grubb who she understood to be a world-renown specialist in POTS, and it took a year or more to see him and she was desperate and she was going to do anything to get in. Tr. at 48. Unfortunately, Petitioner understood that Dr. Grubb's wife was dying of cancer and she could not get in any sooner to see him. *Id.*

Before seeing Dr. Grubb, Petitioner testified that she saw Dr. Swale because she was having problems with on-and-off-again blurriness in her vision. Tr. at 49. Petitioner explained that Dr. Swale advised her to buy several different types of cheater glasses and put them over her prescription glasses to see which one corrects the vision problem. Tr. at 50.

Petitioner came under the care of Dr. Shital Mehta, a psychiatrist, as referred by Dr. Long. Tr. at 50. Petitioner testified that she was having problems with depression because she was not even able to go out and do the stuff she used to do. *Id.* Dr. Mehta prescribed Xanax, but Petitioner testified that she was already taking Xanax for her tremors, as well as Cymbalta. Tr. at 51. However, Petitioner testified that Dr. Long ultimately prescribed the medications for her. Tr. at 52.

Petitioner came under the care of Dr. Faris Sibai, a rheumatologist, as referred by Dr. Long. Tr. at 52-53. Petitioner testified that Dr. Sibai ordered a battery of tests to rule out auto-immune diseases. *Id.*

Petitioner testified that she saw Dr. Grubb twice. Tr. at 55-56. Petitioner testified that Dr. Grubb changed her Lopressor to Vistolic, added a nausea medication as well as one more medication. Tr. at 58.

On June 30, 2016, Petitioner testified that she passed out in the shower. Tr. at 59. Petitioner testified that she had multiple occasions where she passed out after her accident at work. *Id.* After the fall on June 30, 2016, Petitioner testified that she fractured her left shoulder and scraped her toe. Tr. at 60. Petitioner went to the emergency room initially and then she went to see Dr. Corcoran, an orthopedic surgeon, the following day as referred by the hospital. Tr. at 60-61.

The records reflect that Dr. Corcoran saw Petitioner relating to a left shoulder injury from a fall in the shower. PX20 at 34-35; PX1C at 271. Petitioner reported that she fell secondary to POTS. *Id.* Dr. Corcoran examined Petitioner and ordered an MRI that was performed on July 1, 2016. PX20 at 28-36. The interpreting radiologist noted a nondisplaced greater tuberosity fracture with trabecular fracture extending inferiorly with adjacent periosteal edema and no evidence of a rotator cuff tear. *Id.* Dr. Corcoran diagnosed Petitioner with a fractured non-displaced greater tuberosity fracture with trabecular fracture extending inferiorly. *Id.* He also ordered physical therapy and use of a sling. *Id.* The discharge note from June 30, 2016 shows a diagnosis of a syncopal

event secondary to POTS syndrome, abrasions to the left toe, and left shoulder pain. *Id.*

Petitioner testified that she also sought treatment with chiropractors and physical therapists. Tr. at 62.

Petitioner testified that she last saw Dr. Suprenant sometime around January of 2018. Tr. at 78-79. She explained that she was having breakthrough tachycardia issues and increased heart rate issues. Tr. at 79.

Petitioner testified that she took Zofran while she was there because she was vomiting in his garbage can in his exam room. Tr. at 81. Petitioner denied taking any Lopressor. *Id.* She testified that Dr. Zelby was not in the room while she was vomiting, and he had to step out from some reason. *Id.* On cross-examination, Petitioner again denied taking a beta blocker during Dr. Zelby's examination and testified that she took Zofran. Tr. at 138-139.

Petitioner testified that she has been off work since her accident in May of 2012 and no medical provider, or Respondent, has advised her to return to work. Tr. at 83. Petitioner testified that she is on social security disability and has not attempted to go back to work. Tr. at 86-87. Other than the notes from Dr. Panuska, Petitioner testified that she has not presented a note saying that she could return to work. Tr. at 142.

Second Section 12 Examination – Dr. Zelby

On April 17, 2013, Petitioner submitted to a medical evaluation with Andrew Zelby, M.D. (Dr. Zelby) at Respondent's request. RX9 (Dep. Ex. 2). Dr. Zelby's report reflects that he took a history from Petitioner, examined her, reviewed various treating medical records, and rendered opinions regarding her physical condition and their relation, if any, to Petitioner's accident at work. *Id.*

Dr. Zelby diagnosed Petitioner with cervical spondylosis and a history of anterior cervical discectomy and arthroplasty. *Id.* Dr. Zelby noted the following in pertinent part:

> [Petitioner] was found to have a herniated disc at C6-7, but this disc abnormality was to the right, and would not have result[ed] in any constellation of symptoms into the left upper extremity, including the symptoms that [she] describes. Her diagnostic studies since surgery demonstrate a satisfactory postoperative appearance of her disc arthroplasty, making the symptoms in her left upper extremity even more perplexing to relate any condition or abnormality in the spine or nervous system. [Petitioner] also has no convincing objective evidence for a complex regional pain syndrome (reflex sympathetic dystrophy). She has no significant temperature change between her upper extremities on exam, and has no mottling, atrophic change, allodynia or any other features suggestive of a complex regional pain syndrome. [Petitioner] also indicated she has been diagnosed with postural orthostatic tachycardia syndrome and believes this is related to her work injury. There is no objective medical evidence to suggest she has any abnormality as a consequence of her work injury that would result in such a condition. I have a strong clinical concern that her diagnosis of POTS is related to her polypharmacy, as opposed to any infirmity in her autonomic nervous system. Near the end of her examination with me, [Petitioner] spontaneously took a Lopressor tablet for reasons that were completely unclear. This desultory use of these medications, particularly ones with potentially profound cardiovascular effects, may actually be exacerbating, not ameliorating her problem. [Petitioner] has no identifiable objective abnormality associated with her spine or nervous system that requires any additional diagnostic studies or further directed treatment, irrespective of cause. Unfortunately, her exam today reveals a constellation of symptoms and a history of findings that cannot be identified on exam and cannot be ascribed to any identifiable abnormality on her diagnostic studies or any abnormality in her nervous system. Despite her constellation of complaints, I cannot identify any abnormality that can be treated to give [Petitioner] any

> reasonable expectation to see a subjective improvement in her constellation of complaints. Her exam today also reveals a completely normal neurologic exam. Because [Petitioner] has no identifiable abnormality that can be improved with treatment and she has a normal neurologic exam, without convincing findings of a complex regional pain syndrome, she has reached maximum medical improvement. Based on the objective medical evidence, including a normal neurologic exam, an absence of neural impingement and an absence of any convincing findings consistent with a complex regional pain syndrome, there is no medical basis to suggest that [Petitioner] is not qualified to work in at least a medium physical demand level. Because her constellation of subjective complaints cannot be correlated with any identifiable objective abnormality, there is no objective medical evidence to suggest any permanent disability or impairment, irrespective of cause. It would be in [Petitioner's] best interests to be weaned off her medications in a controlled and careful fashion, probably with a cardiologist, and gradually make a return to normal activities. Otherwise, I do not think she has any reasonable expectation to find improvement in her constellation of symptoms. The weaning of her medications should be done through her own health insurance, since the condition forward she reports that she is taking these medications is completely unrelated to her reported work injury. ....

PX9 (Dep. Ex. 2).

Continued Medical Treatment

On April 4, 2014, Petitioner presented for treatment with Dr. Blair Grubb at the University of Toledo. PX18. Petitioner reported her work accident and he reviewed limited medical records for treatment after the date of accident. *Id.* Dr. Grubb's records do not reflect that Petitioner reported any symptoms of postural orthostatic tachycardia prior to May 7, 2012. *Id.* He concurred with Petitioner's previous diagnosis of POTS and ordered a slow program of reconditioning. *Id.*, at 8-10. Dr. Grubb did not opine that Petitioner's work accident or cervical surgery caused her POTS. *Id.* Rather, he noted that the "current knowledge of these disorders is many of these are secondary to some autoimmune disorder or chronic inflammatory state." *Id.*

After several questions on cross-examination, Petitioner gave conflicting or effusive testimony regarding whether she told Dr. Grubb about any of her episodes of tachycardia dating back to 1996 occurring before her accident at work. Tr. at 135-137. Ultimately, she testified that she did tell him about her pre-accident symptoms, but also admitted that she only authorized a release of her medical records to Dr. Grubb beginning on May 7, 2012 and that she did not allow Dr. Grubb to see her medical records for treatment occurring before her accident at work. Tr. at 136-137, 133-135; PX18. The following exchange occurred during Petitioner's cross-examination:

> Q: Did you tell [Dr. Grubb] about the tachycardia that you had had dating back to 1996, 1997, 2000, 2005?
> A: Those episodes were limited and POTS has to be for 6 months straight.

Tr. at 135.

The medical records reflect that Petitioner continued symptomatic treatment with Dr. Long throughout the year 2014, and received another "maintenance" cervical epidural steroid injection from Dr. Roland on May 17, 2014, which she reported gave good relief. PX4B at 228-229. Petitioner was released from Dr. Roland's care on September 11, 2014. PX4B at 220-225.

Petitioner underwent another MRI of the cervical spine with and without contrast on November 18, 2014 due to

her ongoing complaints of right arm numbness. There was essentially no change when compared to the August 23, 2013 MRI.

Petitioner returned to Dr. Roland and underwent yet another cervical epidural steroid injection on February 9, 2015. PX4B at 211-214.

Dr. Grubb saw Petitioner in follow-up on March 18, 2015, at which point he recommended that she exercise and made a medication change. PX5A at 567-569.

During 2015, Dr. Long continued to adjust Petitioner's medications and she began experiencing dehydration and constipation due to POTS, which was treated with administration of IV fluids. PX5A at 724-725. She also experienced recurrent infections which were treated with antibiotics. *Id.*

On June 30, 2016, Petitioner presented to Presence St. Mary's Hospital's emergency room after reportedly becoming dizzy and passing out in the shower, injuring her left shoulder. PX1C at 36-39. Imaging failed to reveal any fractures. *Id.* The discharge note from June 30, 2016 shows a diagnosis of a syncopal event secondary to POTS syndrome, abrasions to the left toe, and left shoulder pain. *Id.*

Petitioner followed up with Dr. Michael Corcoran for her shoulder. PX20. On July 20, 2016, x-rays showed a greater tuberosity fracture of the left shoulder. *Id.* She underwent a course of physical therapy and had full range of motion with strength limited by pain by December 8, 2016. *Id.* She started developing adhesive capsulitis in mid-2017, causing Dr. Corcoran to recommend further physical therapy. *Id.*

On March 20, 2017, Dr. Kirk Packo opined Petitioner's visual complaints were likely "unassociated with any definite pathology." PX5B at 1523-1524.

Since mid-2017, Dr. Long continues to adjust Petitioner's medications and continues to complain of symptoms associated with POTS. PX5B. However, Dr. Long has not provided any work status reports in years. *Id.*

Petitioner returned to Dr. Suprenant on December 11, 2017, claiming she had POTS symptoms three times per week. PX5B at 1402-1405. Dr. Suprenant discussed the use of Propranolol cocktail therapy, and Petitioner requested a prescription for the off-label use of Corlanor, which Dr. Suprenant told her to discuss with Dr. Grubb. *Id.* She has not returned to Dr. Grubb since 2015.

Petitioner last saw Dr. Long on January 30, 2018 at which time her POTS condition had not appreciably changed. PX5B at 1588-1591.

Deposition Testimony – Dr. Jimenez

Petitioner called Juan Jimenez, M.D. (Dr. Jimenez) as a witness and he provided testimony at an evidence deposition on February 10, 2014. PX13. Dr. Jimenez testified that he is a certified neurosurgeon specializing in the treatment of neurological conditions involving the brain, spine, and in some instances the peripheral nerves. PX13 at 3-4.

Dr. Jimenez first saw Petitioner on May 9, 2012. PX13 at 4-5. He took a history from her, performed a physical examination, and diagnosed her with displacement of cervical intervertebral disc without myelopathy, carpal tunnel syndrome, and ulnar neuropathy. *Id.*, at 5-7. He opined that Petitioner's C6-C7 disc herniation resulted

from a combination of cervical disc disease as well as a traction-type injury to her peripheral nerve related to her described work injury. *Id.*, at 7. As of May 30, 2012, Dr. Jimenez diagnosed Petitioner with reflex sympathetic dystrophy (RSD) of the upper limb. *Id.*, at 7-9. He referred Petitioner to local pain consultant, Dr. Roland. *Id.*, at 9. On June 25, 2012, Dr. Jimenez diagnosed Petitioner with displacement of cervical intervertebral disc without myelopathy and explained that he removed the RSD diagnosis because he wanted to focus the diagnosis although her other "diagnoses were still evident." *Id.* at 10.

Later, on August 3, 2012, Dr. Jimenez performed the disc replacement surgery at C6-C7. *Id.*, at 12-13. Intraoperatively, he noted evidence of an annular tear along the midline. *Id.*, at 14. Dr. Jimenez testified that Petitioner's condition was "dynamic process in which the disc findings at times intraoperatively are more impressive than what one sees on the static preoperative image." *Id.*, at 15-16.

Dr. Jimenez testified that he does not treat patients with chronic regional pain syndrome or conditions such as POTS. PX13 at 21. He typically works with our pain colleagues who are better equipped and have a greater experience and knowledge base on those conditions, such as Dr. Roland and Dr. Lubenow. *Id.*, at 26-27.

Dr. Jimenez opined that Petitioner's disc herniation at C6-C7 was temporally related to the tray lifting incident that she described on May 7, 2012 and that the disc replacement surgery and associated medical treatment was reasonable and related. PX13 at 27-28.

On cross-examination, Dr. Jimenez testified that he did not recall receiving any medical records pre-dating May 7, 2012, and usually a referral (in this case from Dr. Long) normally only included the referral sheet and imaging study. *Id.*, at 29-30. He was not aware of any medical treatment to the cervical spine prior to May 9, 2012. *Id.*, at 30.

While Dr. Jimenez testified that he does not treat sympathetic dystrophy, RSD, or CRPS, he typically looks for skin changes, temperature changes, distribution of a particular nerve distribution, as well as a history of these symptoms, etc. when making a referral out for such a diagnosis. *Id.*, at 31.

Based on Petitioner's August 28, 2012 CT myelogram, Dr. Jimenez acknowledged that there was no evidence of neural element compression or compression of nerve root impingement. *Id.*, at 35-36.

Dr. Jimenez testified that he referred Petitioner to Dr. Roland because he thought she had a sympathetic neuropathy of some sort and to address her pain at C6-C7, which was 2-3/10 at the time of her first visit, but significant enough in the context of all her symptoms to warrant further investigation. PX13 at 36-37.

On cross-examination, Dr. Jimenez acknowledged that he does not treat POTS and he has not rendered any opinions related to Petitioner's POTS condition and the accident at work. PX13 at 39.

Deposition Testimony – Dr. Roland

Petitioner called Donald Roland, M.D. (Dr. Roland) as a witness and he provided testimony at an evidence deposition on February 10, 2014. PX14. Dr. Roland testified that he is board-certified in anesthesiology and pain management. PX14 at 4-5, 34-35.

Dr. Roland testified that he first saw Petitioner on March 1, 2012 at which time he took a history from her, performed a physical examination, reviewed her February of 2012 MRI, and ultimately recommended and

administered epidural steroid injections. PX14 at 5-7. After a physical examination, Dr. Roland diagnosed Petitioner with cervical radiculopathy, which he opined caused her left side neck and arm condition. *Id.*, at 9-10. Dr. Roland continued to provide medical treatment to Petitioner through the fall of 2013 including injections and conservative treatment modalities. *Id.*, at 10-32. He added a diagnosis of RSD/CRPS as of June 18, 2012. *Id.*, at 39-40.

Dr. Roland testified that Petitioner's post-cervical surgical condition and CRPS are related to her injury in May of 2012. PX14 at 32. He opined that after having an injury, she has a disc dysfunction, which was not uncommon for patients with disc problems that had undergone surgery. *Id.*, at 32-33. Dr. Roland did not have an opinion regarding the cause of Petitioner's POTS condition. *Id.*, at 34, 63.

On cross-examination, Dr. Roland testified that he agreed with Petitioner's referral to Dr. Lubenow at Rush. PX14 at 35. He acknowledged that he did not receive any chart notes from Dr. Lubenow. *Id.* Dr. Roland also acknowledged that he was not aware of Petitioner's prior medical history. *Id.*, at 36.

Dr. Roland testified that Petitioner's complaints were initially right-sided when he first evaluated her on March 1, 2012. PX14 at 37. When Petitioner returned on June 18, 2012, she'd had this new incident and left-sided complaints. *Id.*, at 38. Petitioner also described several different symptoms including coldness, which Dr. Roland testified he palpated including coldness, moistness, and he observed mottling. *Id.*, at 38-39. However, Petitioner did not report pain on palpation. *Id.*, at 39-40. Dr. Roland testified that there are stages to CRPS and it would be inaccurate to assign timelines to a patient's development from mild to severe (i.e., one month, six months, etc.), but a patient would not go from stage one to stage four overnight. *Id.*, at 40-41. When asked about the typical symptoms that one would see in the first stage of CRPS, Dr. Roland testified that patients typically demonstrate pain, which could be upon touch or in general, and there could be discoloration, but those symptoms could wax and wane. *Id.*, at 41-42. He also testified that patients may have hyperalgesia where you can squeeze the hand which would normally be uncomfortable, but they react more profoundly to that. *Id.*, at 42. Dr. Roland did not categorize Petitioner at any particular stage of CRPS at the time that he saw her on June 18, 2012, but testified that he would place her in the "early stages." *Id.*

On cross-examination, Dr. Roland testified that Petitioner's tenderness in the cervical and left trapezius muscles could be related to her cervical spine condition. PX14 at 42-43. He acknowledged that other diseases, such as vascular diseases including fibromyalgia, could also cause temperature changes. *Id.*, at 43. Hypertension and high blood pressure also involve the vasculature. *Id.* Dr. Roland acknowledged that patients with other diseases also demonstrate mottling, but he did not know whether hypertension was one of those. *Id.*, at 44.

Dr. Roland testified that he did not have Petitioner's pre-accident February 29, 2012 MRI. PX14 at 47. He also acknowledged that there were no facet changes at C6-C7 noted at the time of Petitioner's post-accident, post-operative MRI on August 23, 2013. *Id.*, at 47-48. Dr. Roland further acknowledged that if the work accident caused Petitioner's need for the C6-C7 disc replacement, he would expect to see degenerative changes at that level. *Id.*, at 48. He testified that although the area impacted by the accident was C6-C7, Petitioner could have developed facet pathology from C2-C5 over time and that such pathology does not necessarily develop because of trauma. *Id.*, at 48-49.

On cross-examination, Dr. Roland testified that he did not manage Petitioner's medications as a matter of course. PX14 at 52-53. Although he is a pain management physician, he explained that he would defer medication management to another physician depending on what the patient wants. *Id.*, at 53.

Dr. Roland acknowledged that there are other diagnostic tests which can be performed to confirm or deny CRPS, such as a thermogram and bone scan, but that were not done in Petitioner's case. PX14 at 56. He also testified that Petitioner's CRPS symptoms were all exhibited in the left upper extremity. *Id.*, at 57.

On cross-examination, Dr. Roland admitted that he does not have any records from any other physician providing Petitioner with medical treatment. PX14 at 64.

Deposition Testimony – Dr. Long

Petitioner called Jeffrey Long, M.D. (Dr. Long) as a witness and he provided testimony at an evidence deposition on February 11, 2014. PX12. Dr. Long testified that he is a board-certified physician in family practice. *Id.*, at 3-5; *Id.*, (Dep Ex. 1).

Dr. Long testified that Petitioner has been his patient since 1993. PX12 at 5. He became aware of an incident that occurred in May of 2012 while she was at work. *Id.* By way of history, Dr. Long testified that Petitioner reported that she was hurt at work mainly complaining of a lot of pain in her left shoulder precipitated by some kind of overhead lifting event at work. *Id.*, at 5-6. After taking a history, performing a physical examination, and reviewing a cervical MRI, Dr. Long referred Petitioner to Dr. Jimenez, a neurosurgeon. *Id.*, at 5-8.

Dr. Long continued to see Petitioner, and noted her hospitalization August 28-30, 2012. PX12 at 10-11. It was during this stay that Petitioner's tachycardia, her worsening arm symptoms, progressive difficulty when she got up and moved and her symptoms when up and moving really became very obvious and apparent to him. *Id.*, at 12-13. Petitioner consulted with another neurologist, Dr. Orozco, a neurologist who provided an opinion to Dr. Long that Petitioner had a severe and complex case of parasympathetic dystrophy with bladder and bowel involvement. *Id.*, at 13-14. Dr. Long testified that Dr. Orozco was consulted because he was concerned that Petitioner had some kind of problem with her sympathetic nervous system. *Id.*, at 13.

As of October, of 2012, Dr. Long noted his referral of Petitioner for pain management, and diagnosis of tachycardia NOS and POTS as he was getting suspicious that maybe she had postural tachycardia syndrome. PX12 at 18-19. Dr. Long testified that he only had one other patient with POTS, but he believed that Petitioner's symptoms may fall into that diagnosis given her tachycardia, blood pressure changes, etc. *Id.*, at 19-20. Petitioner did see Dr. Suprenant, but he did not have any of those records. *Id.*, at 21.

Dr. Long also testified that Petitioner and her husband provided him with several articles and information regarding Dr. Grubb, a physician specializing in POTS that she was trying to get in to see. PX12 at 21-22. Petitioner continued to see the pain specialist, Dr. Roland, as well. *Id.*, at 22. Given that Petitioner was yet unable to see Dr. Grubb, after the January 23, 2013 visit, Dr. Long referred Petitioner to a cardiologist, Dr. Hays, to provide more input and Dr. Hays knew Dr. Grubb, so Dr. Long understood that Dr. Hays tried to get Petitioner in to see Dr. Grubb. *Id.*, at 26-27.

As of September 24, 2013, Dr. Long testified that Petitioner has completed an examination per workers' comp and she was really tearful and upset at that visit. PX12 at 36. He referred Petitioner to a rheumatologist, Dr. Sibai, as well as a psychiatrist, Dr. Mehta. *Id.*, at 36-37. Dr. Long understood from Dr. Sibai that Petitioner had polyarthralgia with no clinical inflammatory arthritis like rheumatoid or lupus, fatigue, myalgia, and suspect fibromyalgia as a cause of her issues as well as a Vitamin D deficiency and a skin lump on her arm. *Id.* at 37. Dr. Long understood from Dr. Mehta that Petitioner had major depressive disorder with some generalized anxiety disorder. *Id.*, at 38.

Dr. Long opined throughout the course of his treatment of Petitioner beginning in May of 2012 through November of 2013, Petitioner remained off work and could not have tolerated it. PX12 at 41, 59-60. He also opined that Petitioner's symptoms were related to Petitioner's CRPS or POTS diagnoses. *Id.* at 41-42. Dr. Long opined that Petitioner's POTS diagnosis was appropriate given her symptoms, and that she was not suffering from symptoms because of polypharmacy reactions. *Id.*, at 42-43.

On cross-examination, Dr. Long testified that he was not aware that Petitioner had been treating with Dr. Roland for neck symptoms prior to the May 7, 2012 accident, and he did not see any such medical records. PX12 at 46-47. He testified that he was aware that the May 7, 2012 MRI was the same as one performed on February 29, 2012 because the report notes that there was a comparison. *Id.*, at 47. Dr. Long testified that he was not aware that Petitioner had fibromyalgia or myofascial pain diagnoses prior to May 7, 2012. *Id.*, at 49.

Dr. Long testified that he is the physician in charge of Petitioner's medication regimen, but with input from her other physicians, experts in their fields. *Id.*, at 47-48. He was aware that Petitioner's husband was providing prescriptions for medications for nausea and the like, but he was not aware whether he was administering trigger point injections. *Id.*, at 48.

Dr. Long testified that Petitioner and her husband came to him with the research from Dr. Grubb. PX12 at 53. He also testified that he diagnosed Petitioner with POTS, but has only had one other patient with the condition. *Id.*, at 56. Dr. Long testified that both Petitioner and that other patient were referred to Dr. Suprenant. *Id.*

Dr. Long testified that he is confident that he has performed all the necessary tests to diagnose Petitioner with POTS and, although he has never performed a tilt table test, he does not believe that Petitioner could tolerate it. PX12 at 56-57. Dr. Long testified that he would be happy to share his chart notes with other physicians, but he is not aware that any other physicians requested them. *Id.*, at 61.

Deposition Testimony – Dr. Zelby

Respondent called Andrew Zelby, M.D. (Dr. Zelby) as a witness and he provided testimony at an evidence deposition on February 27, 2014. RX9. Dr. Zelby testified that he is a board-certified neurosurgeon specializing in the spine, brain and peripheral nervous system. RX9 at 4-6; *Id.*, at (Dep. Ex. 1).

Dr. Zelby testified consistently with the opinions contained in his report. *See generally* RX9. He also testified that based on his review of Petitioner's medical records and her symptoms, the surgery performed by Dr. Jimenez was "[n]ot at all[]" going to be helpful because the "radiographic abnormality at C6-7 had absolutely nothing to do with any of [Petitioner]'s symptoms. It was on the wrong side. ...." RX9 at 24-25. Dr. Zelby went on to explain that "[t]he fact that she had no right-sided symptoms following her work injury is pretty clear evidence that the herniated disc on MRI had nothing to do with her work injury." *Id.*, at 26. Ultimately, Dr. Zelby opined that Petitioner's cervical spondylosis and history of an anterior cervical discectomy and arthroplasty were unrelated to the accident at work. *Id.*, at 28. In so opining, Dr. Zelby explained that Petitioner had a constellation of symptoms, including neck pain and a feeling of coldness and mottling in the left upper extremity as well as a right-sided herniated disc at C6-7 that would not result in any constellation of symptoms on the left side. *Id.*, at 28-29, 51-52.

Dr. Zelby further opined that there was no convincing objective medical evidence to support a CRPS diagnosis including "no significant temperature change between her upper extremities, no mottling, trophic change, allodynia, or any other features suggestive of a complex regional pain syndrome." RX9 at 29.

Dr. Zelby acknowledged that he did not perform any lying and sitting blood pressure tests to determine if Petitioner was orthostatic. *Id.*, at 31. However, he testified that near the end of Petitioner's exam, she spontaneously took a Lopressor for reasons that were completely unclear. *Id.* He explained that she was sitting in the exam and "nothing had changed, she hadn't stood up, and suddenly she takes a blood pressure medication. It was my feeling that this desultory use of these medications, particularly ones with potentially profound cardiovascular effects, may be actually exacerbating, not ameliorating her problem." *Id.*, at 31-32.

Dr. Zelby opined that Petitioner could work based on her normal neurologic exam, lack of neural impingement, and lack of any convincing findings consistent with CRPS. RX9 at 32.

On cross-examination, Dr. Zelby testified that this opinion was based on his evaluation of Petitioner. RX9 at 42. He also testified that Petitioner's alleged CRPS would not be generalized because her reported symptoms were in the left upper extremity, and that the symptoms of CRPS (a diagnosis reached by exclusion) do not come and go particularly where the patient reports ineffective treatment as Petitioner did. *Id.*, at 42-44. Dr. Zelby also acknowledged that he did not review records from Dr. Lubenow, Dr. Suprenant, Dr. Frye, or Dr. Hays from before or after his examination of Petitioner. RX9 at 46-47.

Deposition Testimony – Dr. Candido

Respondent called Kenneth Candido, M.D. (Dr. Candido) as a witness and he provided testimony at an evidence deposition on March 11, 2014. RX10. Dr. Candido testified that he is board-certified in anesthesiology specializing in anesthesiology and pain management. RX10 at 4-5; *Id.*, (Dep. Ex. 1). In his practice, Dr. Candido sees patients with CRPS or RSD. *Id.*

Dr. Candido examined Petitioner at Respondent's request on September 17, 2013. RX10 at 5. He testified that Petitioner refused to answer his questions regarding her injury, telling him that he should be able to get all that history and information from the medical records. *Id.*, at 7-8. Dr. Candido described Petitioner as obstructionist because when he sought information regarding her past medical treatments or history or anything except how she was feeling on that given day, she refused. *Id.*, at 8.

Dr. Candido explained that five of the eight Budapest criteria, comprised of objectively tested subjectively reported signs and symptoms, must be present to diagnose CRPS, and half of those criteria must be objectively positive. RX10 at 21-23. Dr. Candido explained that he did not diagnose Petitioner with CRPS because from Petitioner's history she had zero of the eight criteria subjectively reported and no physical examination findings to support the diagnosis. *Id.*, at 23-24. He also disagreed with Dr. Roland's CRPS diagnosis noting that he "essentially regurgitated some of [Petitioner's] subjective complaints" and his records did not reveal "due diligence" in objective evaluation of Petitioner's condition to make the CRPS diagnosis. *Id.*, at 24-25.

Dr. Candido opined that Petitioner's diagnosis of fibromyalgia and status post cervical anterior discectomy and fusion surgery did not require any additional treatment in the form of pain management. *Id.*, at 26-28. He testified that POTS is a rare disease and he has treated between 1-3 patients with the condition in 15 years. *Id.*, at 30-31. However, he testified that the "table tilt" test is the gold standard for making a POTS diagnosis and that standard blood work would also reveal whether a patient had elevated catecholamine or metanephrine

levels. *Id.*, at 31-32. After reviewing Petitioner's September 20, 2012 lab results from Provena St. Mary's Hospital, Dr. Candido noted that Petitioner's metanephrine levels were not elevated and were, in fact, in the low at 48 in the normal range being 58 to 203, her norepinephrine levels were normal at 140 in the range of 88 to 649 micrograms, and her total metanephrine level was normal at 188 in the range of 182 to 739 micrograms. *Id.*, at 32-33. Dr. Candido opined that Petitioner's values in these objective tests were normal and inconsistent with a POTS diagnosis. *Id.*

Ultimately, Dr. Candido opined that Petitioner's symptomatology at the time of his evaluation was not related to her accident at work. RX10 at 33. He also opined that Petitioner had reached maximum medical improvement and she could have returned to regular duty work. *Id.*, at 34.

On cross-examination, Dr. Candido testified that he did not have the benefit of reviewing Petitioner's functional capacity evaluation which was performed less than 24 hours before he examined her. RX10 at 35. Regarding CRPS, Dr. Candido maintained that while subjectively reported symptoms could change with time, objective findings do not change with time. *Id.*, at 37-38. He also maintained that if a patient did not meet the objective findings strictly required per the Budapest criteria that individual did not have CRPS. *Id.*, at 38-39.

Dr. Candido noted that Dr. Suprenant did not perform a table tilt test or reference any norepinephrine or circulating catecholamine levels in making Petitioner's POTS diagnosis, so he believed that the diagnosis was not based on factual information. RX10 at 46. He maintained that POTS cannot be diagnosed without performing a tilt table test. *Id.*, at 47. Dr. Candido also maintained that, after a review of all the medical records provided to him, he found no clinical objective evidence to support a POTS diagnosis. *Id.*, at 69.

Deposition Testimony – Dr. Suprenant

Petitioner called Brad Suprenant, D.O. (Dr. Suprenant) as a witness and he provided testimony at an evidence deposition on August 17, 2015. PX8. Dr. Suprenant testified that he is a certified electrophysiologist, which involves the study of arrhythmias of the heart. PX8 at 3-5; *Id.*, (Dep. Ex. 1).

Dr. Suprenant testified that he first saw Petitioner on October 4, 2012 when she presented for palpitations and chest discomfort as referred by Dr. Long. PX8 at 5-6. He examined Petitioner, took a history from her, and reviewed various records including her EKGs. *Id.*, at 6-8; *Id.*, (Dep. Ex. 2). Petitioner underwent an angiogram for her chest pain, and the results were normal. *Id.*, at 8. She also underwent an electrocardiogram to evaluate for arrhythmias or underlying cardiac abnormalities, which was unremarkable. *Id.*, at 8-9.

Dr. Suprenant diagnosed Petitioner with postural orthostatic tachycardia syndrome or POTS. PX8 at 9-10. He explained that the condition is an autonomic dysfunction that when the patient stands upright, they begin to immediately have rapid palpitations and drop in blood pressure due to inadequate vasomotor tone. *Id.*, at 10. He explained that Petitioner's condition was "more historical than on physical examination." *Id.* Dr. Suprenant testified that POTS can stem from acute viral syndromes, infectious upper etiologies, or trauma. *Id.* On cross-examination, Dr. Suprenant testified that POTS can also stem from "emotion." *Id.*, at 28. Dr. Suprenant also testified that he did not have any records or history from Petitioner to indicate she had any type of viral infections or upper respiratory problems that could have led to POTS, but Petitioner reported that she sustained a traumatic injury to the cervical spine for which she underwent surgery. *Id.*, at 10-11, 13.

Dr. Suprenant testified that either the trauma or the surgery could have potentially triggered POTS. PX8 at 11. He did not have any opinion as to the cause of Petitioner's reflex sympathetic dystrophy and he was not aware with whom she was treating for the condition. *Id.*, at 11-12.

In addition to his diagnoses, Dr. Suprenant referred Petitioner to "consider another opinion from an authority figure [Dr. Blair Grubb]." PX8 at 14. Dr. Suprenant described Dr. Grubb as one of the foremost authorities in POTS, treatment and evaluation of POTS. *Id.*

On cross-examination, Dr. Suprenant testified that he did not have any independent recollection of Petitioner or review of medical records beyond what is indicated in his report. PX8 at 15-16. His examination of the neck from a heart specialist's perspective showing no evidence of jugular venous distension, carotid upstrokes, carotid bruits or thrills. *Id.*, at 18-19. Petitioner's heart rate, rhythm and PMI were normal showing no enlargement of the heart, hyperdynamic function of the heart, any valvular heart disease, that sort of thing. *Id.*, at 19-20. Dr. Suprenant testified that Petitioner's physical examination was normal. *Id.*, at 20-21.

Ultimately, Dr. Suprenant testified that he did not find anything on his examination or testing to support the diagnosis of POTS; "[i]t was all historical. [He] did no provocative testing for POTS." PX8 at 23. He testified that he would defer to Dr. Grubb regarding causal connection between Petitioner's POTS and either the work injury or the cervical surgery. *Id.*, at 24. On a yearly basis, Dr. Suprenant testified that his office sees about five POTS patients. *Id.*, at 25. He acknowledged that he has not seen any objective testing and is not aware of any objective testing that would support Petitioner's POTS diagnosis other than what she or her husband told him. *Id.*, at 25. He also acknowledged that tachycardia is part of POTS, which means a rapid heart rate, which can be caused by "[v]olume depletion, heart rhythm abnormalities, fever, anxiety, a multitude of things." *Id.*, at 25-26. Dr. Suprenant testified that the POTS diagnosis that he made is because when Petitioner stands up and exerts, her heart rate increases, which is the "postural" part of POTS. *Id.*, at 27. He further admitted that he was not aware of Petitioner's medical history before the alleged work incident in May of 2012 or summer of 2012. *Id.*, at 27. He assumed, based on Petitioner's history, that she did not have heart palpitations until after her cervical surgery. *Id.*

Dr. Suprenant acknowledged that it is difficult to determine the cause and effect relationship of POTS at this stage of scientific development. PX8 at 28. It is not very well understood by the cardiology community at this point in time. *Id.*, at 28-29. Dr. Suprenant did not impose any work restrictions on Petitioner. *Id.*, at 29.

Surveillance

Respondent called several witnesses and offered into evidence surveillance video footage of Petitioner taken or attempted on June 21, 2016, July 1, 2016, July 9, 2016, August 4, 2016, August 6, 2016, August 9, 2016, August 18, 2016, August 22, 2016, August 23, 2016, August 24, 2016, August 31, 2016, September 1, 2016, September 2, 2016, September 3, 2016, October 8, 2016, May 25, 2017, May 27, 2017, and June 27, 2017. RX12-RX14. The surveillance video footage reflects Petitioner in various activities including walking to and from her car, in and out of restaurants, walking or working in and around her home, and engaged in other daily activities. *Id.* On some occasions Petitioner is shown wearing a sling on her arm. *Id.* Otherwise, Petitioner is does not appear to have any difficulty while engaged in activities of daily living on the days in which she was recorded. *Id.*

ISSUES AND CONCLUSIONS

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

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

Petitioner claims injury to various body parts as a result of her accident at work. Specifically, she asserts sustaining an injury to the cervical spine and thereafter developing various diseases including CRPS and POTS. In light of the record as a whole, the Arbitrator finds that Petitioner has failed to establish a causal connection between her current condition of ill-being, including conditions in the cervical spine or POTS and CRPS, and her accident at work. In so concluding, the Arbitrator finds the medical opinions of Respondent's Section 12 examiners, Dr. Zelby and Dr. Candido, to be persuasive given the totality of this record.

As an initial matter, Petitioner's testimony is unreliable and controverted by the medical records. While contemporaneous medical records generally corroborate Petitioner's recitation of the mechanism of injury at the hearing, which is not in dispute, the records do not corroborate Petitioner's recitation of symptoms post-accident. Petitioner testified with specificity on direct examination using medical references presumably from her training as a nurse to explain her symptoms and reports to physicians over decades with clarity. However, on cross-examination, Petitioner disputed the accuracy of her own physicians' charting, done contemporaneously over years of treatment. She testified that any inconsistencies between her testimony and the charts were errors on the part of her doctors. Petitioner also could not recall what she reported to her physicians when it controverted her testimony. Petitioner also answered direct questions with conclusory or effusive responses. The Arbitrator finds that Petitioner's testimony is not credible.

However, Petitioner's testimony it is by no means the only evidence in this case. Voluminous medical records and physicians' testimony via evidence deposition were submitted into evidence. As explained below, the remainder of the extensive evidence does not establish that Petitioner's cervical spine, CRPS or POTS conditions are causally related to her accident at work as claimed.

Cervical Spine

Approximately two months before her accident, Petitioner underwent a cervical MRI on February 29, 2012 at the direction of Dr. Roland, her pain management physician. It revealed protrusions at C4-C5, C5-6 and C6-C7, causing spinal canal stenosis, most significantly at C6-C7 where a right paracentral disc protrusion caused flattening of the cord and was likely abutting the adjacent nerve root. Petitioner followed up on March 1, 2012 with complaints of right-sided neck and shoulder pain. She then underwent an epidural steroid injection on March 15, 2012 to address the right-sided herniated disk at C6-C7.

The undisputed accident occurred on May 7, 2012. Petitioner testified that she was injured while putting away a surgical tray overhead that weighed 30-to-40 pounds. The tray slipped toward Petitioner such that she jerked her head to the right and felt a tweak in her shoulder that was "pretty substantial." Petitioner explained that she felt pain in the posterior left shoulder. She began treatment almost immediately and underwent another MRI on May 7, 2012 that revealed the same right-sided disc herniation and pathology at C6-C7.

Additional Information

Regarding her current condition, Petitioner testified that she has tachycardia, hypertension, nausea, vomiting, chest pain, constipation, occasional diarrhea, "mental fog," chronic pain issues, depression, urinary retention issues, and breakthrough urinary tract infections. Tr. at 86-87. She explained that heat can sometimes worsen her symptoms, but she counteracts that with icepacks and adapting to the issues. Tr. at 89. Petitioner explained that she has good days and bad days, and cannot predict how the results of participating in activities such as taking out the garbage, pulling weeds, playing with her grandchildren, etc. Tr. at 89-90.

Petitioner testified that her treating physicians advised her to exercise for her POTS condition at least 3 to 4 days per week at least 30 to 40 minutes of cardio exercise per day. Tr. at 91. Petitioner testified that she continues to maintain her nursing license, but none of her certifications. Tr. at 94-95.

On cross-examination, Petitioner testified that she faces the debilitating symptoms related to her POTS sometimes two or three days a week and sometimes she is good for a week, which she estimated was probably as long as she had gone without symptoms. Tr. at 148-149.

On cross-examination Petitioner testified that she received long term disability benefits, but she could not recall what benefits she received. Tr. at 99-100. Petitioner also testified that she received social security disability benefits at some point as well as another disability check of approximately $200 per week from a different policy. *Id.*

At the referral of her primary care physician, Dr. Long, Petitioner saw Dr. Jimenez on May 9, 2012. He reviewed her MRI confirming the right-sided herniation at C6-C7. He noted her bilateral complaints primarily on the left side with positive testing on the left side. At that visit, Dr. Jimenez immediately opined that Petitioner's traction-like injury at work contributed to her condition. Petitioner's pain management physician, Dr. Roland, later also opined that Petitioner's left-sided neck and arm complaints were causally related to her accident at work. However, "[e]xpert opinions must be supported by facts and are only as valid as the facts underlying them." *Gross v. Ill. Workers' Comp. Comm'n*, 2011 IL App (4th) 100615WC, *16-17, 960 N.E.2d 587, 594 (4th Dist. 2011) (*citing In re Joseph S.*, 339 Ill. App. 3d 599, 607, 791 N.E.2d 80, 87, 274 Ill. Dec. 284 (2003)).

At their depositions, Dr. Jimenez and Dr. Roland admitted that they were not aware that Petitioner had treatment to the neck before May 9, 2012, much less that an MRI taken two months earlier revealed the same disc pathology. Regardless, neither Dr. Jimenez or Dr. Roland explained how the accident could have caused left-sided neck symptoms when the diagnostic tests revealed only right-sided pathology. In contrast, Respondent's Section 12 examiner, Dr. Zelby, testified that Petitioner's cervical spine condition was not causally related to the accident at work. He noted that Petitioner's post-accident MRI revealed a disc herniation on the right side, the same as the disc herniation reflected in Petitioner's pre-accident MRI two months earlier. Dr. Zelby also highlighted that Petitioner's complaints were on the left side whereas the pathology was located on the right side. Petitioner's pre- and post-accident MRIs and Dr. Jimenez's operative report further confirm pathology on the right side whereas Petitioner's subjective symptomatology was on the left. The opinions of Petitioner's physicians are simply not persuasive given their lack of understanding of Petitioner's prior medical history. The Arbitrator finds the opinions of Dr. Zelby to be persuasive in this case as he provided a more plausible opinion given the totality of this record and which was based on a more complete understanding of Petitioner's medical history.

Thus, the Arbitrator finds that Petitioner has failed to establish a causal connection between her accident at work and her cervical spine condition of ill-being.

CRPS & POTS

Several physicians provided opinions regarding the relatedness, if any, of Petitioner's CRPS and POTS conditions to her accident at work. Again, expert opinions must be supported by facts and are only as valid as those facts. *Gross*, 2011 IL App (4th) 100615WC, *16-17. Based on the totality of this record, the Arbitrator finds the opinions of Respondent's Section 12 examiners, Dr. Candido and Dr. Zelby, to be more persuasive than those of Petitioner's treating physicians.

Dr. Long, Petitioner's primary care physician, testified that he referred Petitioner to neurologists, a psychiatrist, cardiologists, and a pain management specialist to obtain their opinions regarding Petitioner's conditions. While he suspected that Petitioner had POTS and CRPS, he admitted that he is not an expert in making these diagnoses. Thus, the Arbitrator finds that Dr. Long is not qualified to render an opinion on the diagnosis of or relatedness, if any, of Petitioner's POTS or CRPS conditions to her accident at work.

Regarding Petitioner's CRPS, Dr. Suprenant and Dr. Jimenez offered no opinions relative to causation for the CRPS. Dr. Roland diagnosed Petitioner with CRPS, but never opined that a causal connection between that condition and the work accident existed. Indeed, Dr. Roland admitted CRPS does not go from stages one to four so quickly, as would have had to have been the case for Petitioner to have the symptoms with which she presented on May 7, 2012.

On referral from Dr. Long, Petitioner saw Dr. Lubenow. He noted Petitioner's report of left-sided symptoms because of her accident at work and a C6-C7 discectomy and diagnosed her with neuropathic pain, with an atypical presentation of CRPS of the left upper extremity and shoulder status post her work-related injury. Dr. Lubenow's records do not reflect that he reviewed Petitioner's medical records from before her accident at work or any records after her accident at work, including the pre- and post-accident MRIs showing right-sided pathology or Dr. Jimenez's operative report correcting right-sided pathology. Dr. Lubenow was not called as a witness at the hearing and provided no testimony explaining how he arrived at the "atypical" CRPS diagnosis based on the information available to him or how Petitioner's left-sided symptoms related to the right-sided C6-C7 disc pathology either of which resulted in her "atypical" CRPS diagnosis. Dr. Lubenow's records also fail to document objective correlation of any Budapest criteria subjectively reported by Petitioner. Given the foregoing, the Arbitrator does not find the opinion of Dr. Lubenow to be persuasive given the totality of this record.

Regarding Petitioner's POTS condition, Dr. Suprenant, an electrophysiologist, deferred to Dr. Grubb, an expert in the condition, regarding any causal connection opinion relating Petitioner's work incident and her condition of ill-being. Dr. Suprenant is not qualified to correlate Petitioner's POTS condition of ill-being with her accident at work by his own admission. Notwithstanding, Dr. Suprenant also testified that POTS can have many causes, but admitted that his opinion was based on the history relayed by Petitioner as well as the limited medical information at his disposal, which did not include knowledge of Petitioner's pre-accident postural orthostasis or tachycardia. Given that Dr. Suprenant is admittedly not an expert in POTS and he did not have a complete understanding of Petitioner's pre-accident medical history or treatment, his opinions are not persuasive in this case.

Petitioner's other treating physicians, Dr. Jimenez and Dr. Grubb did not opine that Petitioner's POTS condition was related to any accident at work. Dr. Jimenez testified that he does not treat sympathetic dystrophy, RSD, or CRPS and he admitted that he was not aware of Petitioner's medical treatment history prior to May 9, 2012. He also acknowledged that he does not treat POTS. Dr. Jimenez further admitted that he rendered no opinion relating Petitioner's POTS condition to the accident at work. Dr. Grubb, the foremost expert among Petitioner's physicians, not only failed to relate Petitioner's POTS condition to the accident at work, he also expressed that the current state of medical knowledge regarding the etiology of POTS is that "many of these [disorders] are secondary to some autoimmune disorder or chronic inflammatory state." He did not opine that Petitioner's POTS stemmed from her traumatic injury at work. He did not opine that Petitioner's POTS stemmed from any treatment or surgery necessary because of an injury at work. He did not opine that any pre-existing condition that Petitioner had was aggravated by the injury or related medical treatment. He did not opine that any newly developed condition post-accident occurred because of any injury at work or related medical treatment. Dr. Grubb's silence on the matter of causal connection, in addition to his affirmative statement that the etiology of POTS is secondary to other disease, in contrast to a traumatic event whether injury or surgical trauma, is striking.

At the time of her Section 12 examination with Dr. Candido at Respondent's request, Petitioner refused to provide any information regarding her past medical treatments or history indicating that he could rely on her medical records for such information. Notwithstanding, Dr. Candido reviewed Petitioner's medical records and ultimately opined that Petitioner did not have CRPS or POTS and that her condition of ill-being was unrelated to her accident at work or the subsequent medical treatment including surgery to the cervical spine. In so concluding, Dr. Candido noted that Petitioner's treatment records failed to document objective findings to support Petitioner's ongoing subjectively reported complaints supposedly supporting her treating physicians'

diagnoses of CRPS and POTS. He also noted that certain standard tests performed to diagnose CRPS and POTS were either negative, within normal limits, or not performed at all. Dr. Candido found no objective evidence to support either a CRPS or POTS diagnosis or a relationship between such diagnoses and Petitioner's accident at work, or subsequent medical treatment, and such conditions. Similarly, Dr. Zelby concluded that Petitioner's constellation of symptoms and history of findings could not be objectively identified on exam or ascribed to any identifiable abnormality reflected in her diagnostic studies.

Thus, the Arbitrator finds that Petitioner has failed to establish a causal connection between her accident at work or its *sequelae* and her CRPS or POTS conditions of ill-being. There is no credible objective medical evidence contained in Petitioner's treatment records that her CRPS or POTS conditions can be ascribed to her accident at work or the subsequent medical treatment including surgery to the cervical spine. Petitioner's treating physicians' opinions relating her CRPS condition to the accident at work are from admittedly underqualified physicians in this particular area of medical expertise, or the opinions are based on only post-accident medical treatment relying primarily on Petitioner's subjectively reported symptomatology that the physicians were, by and large, unable to objectively correlate clinically or via objective testing or diagnostic studies. Dr. Grubb, Petitioner's foremost expert in POTS, offered no opinion whatsoever relating the condition to her accident at work or the subsequent medical treatment and, indeed, stated that the etiology of the condition is generally related to other diseases as opposed to trauma. The Arbitrator finds the opinions of Dr. Candido and Dr. Zelby to be more persuasive given the entirety of the evidence in this case as they provided more plausible medical opinions based on a more complete understanding of Petitioner's medical history.

The evidence establishes only that Petitioner sustained a left shoulder strain because of her undisputed accident. Petitioner was released to light-duty work for the shoulder strain by Provena St. Mary's Hospital's Occupational Health Center on May 7, 2012, and light-duty was not accommodated. Dr. Jimenez did not address work status when he first saw Petitioner on May 9, 2012. When she followed up with Occupational Health on May 9, 2012, her light-duty restrictions were continued as concerned the left shoulder strain. Dr. Jimenez then authorized Petitioner off work for three weeks for complaints of shoulder achiness and some radiating symptoms. Thereafter, Dr. Jimenez did not comment on work status relating to any left shoulder symptoms until the unrelated cervical surgery for right-sided pathology.

Given the totality of this record, the Arbitrator finds that Petitioner has failed to establish a causal connection between her any of her current conditions of ill-being and accident at work on May 7, 2012 beyond a left shoulder strain.

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

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

As explained above, the Arbitrator finds that Petitioner's current condition of ill-being is not causally related to her accident at work beyond a left shoulder strain given the lack of objective medical evidence to support her claim and in reliance on the opinions of Respondent's Section 12 examiners, Dr. Zelby and Dr. Candido. Thus, the Arbitrator finds that Respondent shall pay reasonable and necessary medical bills for services rendered to Petitioner through June 21, 2012 as reflected in Petitioner's Exhibits that remain unpaid, if any, pursuant to the medical fee schedule as provided in Sections 8(a) and 8.2 of the Act. Petitioner's claim for payment of additional medical bills for treatment thereafter is denied.

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

As explained above, the Arbitrator finds that Petitioner's current condition of ill-being is not causally related to her accident at work beyond a left shoulder strain given the lack of objective medical evidence to support her claim and in reliance on the opinions of Respondent's Section 12 examiners, Dr. Zelby and Dr. Candido. Thus, the Arbitrator denies Petitioner's claim for prospective medical treatment.

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

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

As explained above, the Arbitrator finds that Petitioner's current condition of ill-being is not causally related to her accident at work beyond a left shoulder strain given the lack of objective medical evidence to support her claim and in reliance on the opinions of Respondent's Section 12 examiners, Dr. Zelby and Dr. Candido. Regarding her post-accident condition in the left shoulder, Petitioner was released to light-duty work on May 7, 2012, and light-duty was not accommodated. Dr. Jimenez did not address work status when he first saw Petitioner on May 9, 2012. When she followed up with Occupational Health on May 9, 2012, her light-duty restrictions were continued as concerned the left shoulder strain. Dr. Jimenez then authorized Petitioner off work for three weeks for complaints of shoulder achiness and some radiating symptoms. Thereafter, Dr. Jimenez did not comment on work status relating to any left shoulder symptoms until the unrelated cervical surgery for right-sided pathology.

Thus, the Arbitrator finds that Petitioner is entitled to temporary total disability benefits from May 8, 2012 through June 21, 2012. Petitioner's claim for temporary total disability benefits thereafter is denied. Respondent is entitled to a credit for the temporary total disability benefits paid in the amount of $278,289.99 as stipulated by the parties.

In support of the Arbitrator's decision relating to Issue (M), whether penalties or fees should be imposed upon Respondent, the Arbitrator finds the following:

The Arbitrator finds that no additional compensation is due to Petitioner or shall be imposed upon the Respondent pursuant to Sections 19(l), 19(k) and 16 of the Act. Respondent had a reasonable dispute as to

whether Petitioner's accident at work or the post-accident medical treatment caused any condition of ill-being related to the cervical spine, or caused CRPS or POTS in whole or in part as alleged. Respondent's conduct was not unreasonable, vexatious and/or in bad faith. Thus, Petitioner's claim for penalties and fees under Sections 19(k), 19(l) or 16 of the Act is denied.

STATE OF ILLINOIS)
)SS
COUNTY OF CHAMPAIGN)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

STATE OF ILLINOIS,
ILLINOIS WORKERS'
COMPENSATION COMMISSION
INSURANCE COMPLIANCE DIVISION
Petitioner,

vs. NO. 20WC005395

MICHAEL R. CRAFT,
Individually, and as President of
C&M EXPRESS, Inc., (a dissolved
corporation),
Respondent.

20IWCC0308

DECISION AND OPINION RE: INSURANCE COMPLIANCE

Petitioner, the Illinois Workers' Compensation Commission (the Commission), Insurance Compliance Division, brings this action, by and through the Office of the Illinois Attorney General, against the above-captioned Respondent, alleging violations of Section 4(a) of the Illinois Workers' Compensation Act (the Act) and Section 9100.90 of the Rules Governing Practice Before the Industrial Workers' Compensation Commission (the Rules), codified as Title 50 of the Illinois Administrative Code, Chapter 6. Proper and timely notice was given to all parties.

An Insurance Compliance Hearing on the Merits was held before Commissioner Stephen J. Mathis on October 11, 2017, in Urbana, Illinois. Respondent was not present at the hearing despite being personally served with notice of said hearing on September 22, 2017. (T. 4-5; PX3).

Petitioner has requested penalties for a period of 2,072 days of non-compliance with the Act from July 26, 2006 through March 29, 2012. The Commission, after considering the record in its entirety, and being advised of the applicable law, finds that Respondent MICHAEL CRAFT, individually and as President of C&M EXPRESS, (a dissolved corporation), knowingly and willfully violated Section 4(a) of the Act and Section 9100.90 of the Rules during the period of July 26, 2006 to March 29, 2012.

As a result, Respondent shall be held liable for his non-compliance with the Act and shall pay a penalty in accordance with Section 4(d) of the Act and 9100.90(b) of the Rules. The

Commission hereby assesses the penalty of $1,036,00.00 against the above- named Respondent for the reasons set forth below.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1) On June 22, 2004, Articles of Incorporation were filed on behalf of C&M Express Inc. Michael Craft was listed as President, and James L. Tungate was listed as the Registered Agent. (PX 5).
2) Records from the Illinois Department of Revenue showed that Respondent C&M Express filed no Illinois Corporation Income and Replacement Tax Returns for 2006 through 2012.
3) Records from the Illinois Department of Revenue showed that Respondent C&M Express filed no Illinois Employers' Quarterly Withholding Income Tax Returns for September 2006 through March 2012.
4) The Insurance Non-Compliance Report shows that Respondent C&M Express was incorporated on June 22, 2004 and involuntarily dissolved on November 11, 2011. (PX4).
5) On March 8, 2011 Todd Beatty, Respondent's employee, filed a work injury claim, namely, 11 WC 008721. In this claim, Mr. Beatty named Michael R. Craft/C&M Express/Greg Miller/ G &S Refrigerated Transport as Respondents asserting that he sustained a work accident on January 22, 2011. (PX10).
6) On January 23, 2013 Mr. Beatty filed a second amended Application for Adjustment of Claim adding Dan Rutherford, Treasurer of the State of Illinois, and Ex- Officio Custodian of the Injured Workers' Benefit Fund & Technology Insurance Company as additional Respondents
7) An Arbitration hearing was conducted on March 4, 2013 before Arbitrator Zanotti. Respondent Michael Craft appeared and testified at the arbitration hearing. (PX10)
8) The Arbitrator found that Michael Craft, as owner and sole shareholder of C&M Express, Inc., was operating under and subject to the Illinois Workers' Compensation Act, 820 ILCS 305/1 *et seq.* He further found that Craft had an employment relationship with Mr. Beatty as opposed to an independent contractor relationship. (PX10)
9) Petitioner Todd Beatty prevailed in the action and Arbitrator Zanotti ordered the award against the IWBF to the extent permitted and allowed under Section 4 (d) of the Act in the event of the failure of Respondent- Employers to pay the benefits due and owing to Petitioner. (PX10)
10) The IWBF paid the award in the amount of $101,991.60. The Commission received a disbursement from the Respondent's Chapter 7 bankruptcy in the amount of $3,184.23. This was subtracted from the total benefit fund payout. The net payout to by the IWBF was $98,807.37 (T. 12; PX2)
11) Petitioner presented Michael Cummins, an Investigator for the Commission, as a witness at the Insurance Compliance Hearing before Commissioner Mathis on October 11, 2017. Respondent was not present at the hearing although he was personally served on September 22, 2017. (T. 4; PX3).
12) Mr. Cummins testified he began investigating Respondent after the workers' compensation claim was adjudicated to determine if Respondent was in compliance with the Act. Mr. Cummins requested information from the National Council on Compensation Insurance

(NCCI), the Illinois Secretary of State, the Illinois Department of Employment Securities, and the Self-Insurance Unit of the Commission. (T9-11).

13) On May 4, 2016, Maria Sarli-Dehlin, from the Office of Self Insurance, certified that no certificate of approval to self-insure was issued by the Commission to C&M Express, aka, C&M Transport in Iroquois, Illinois. Mr. Craft was named as "owner" on the certification. (PX7).
14) On October 13, 2016, Esteban Ortiz, Proof of Coverage Analyst for NCCI Holdings, Inc. conducted a thorough search of the NCCI database. The search revealed that Respondents C&M Express, or Michael Craft had no proof of workers' compensation coverage for the period from July 26, 2006 to March 29, 2012. (PX6).
15) The Commission has designated NCCI Holdings, Inc. as its agent for the purpose of collecting proof of coverage information on Illinois employers who have purchased workers' compensation insurance from carriers. (PX6).
16) The Insurance Compliance Department of the Commission sent Respondent a notice of Non-Compliance under Section 4(a) of the Act via certified mail on March 29, 2012. (PX1).
17) As of the October 11, 2017 hearing date, the only amount paid on behalf of Respondent Craft was the Chapter 7 bankruptcy disbursement of $3, 184.23.
18) Mr. Cummins testified that he reviewed information on the NCCI website to determine the cost of workers' compensation insurance during Respondent's non-compliance period. In this case Respondent never had an insurance policy of his own. Therefore, Mr. Cummins based the cost of premium estimate on average premiums of similar sized trucking companies and estimated the yearly premium at $12,000.00. Mr. Cummins multiplied the daily rate by the same 2, 072 days of non-compliance for a total of $68, 127.36.

Pursuant to Section 3 of the Act, certain employers and their employees are automatically subject to the provisions of the Act if they engage in specific businesses, including: "Any enterprise in which electric, gasoline or other power driven equipment is used in the operation thereof. . ." 820 ILCS 305/3(15).

The Commission finds that Respondent's business falls under Section 3(15) of the Act. While there was no direct testimony as to the nature of the business during the period of non-compliance, the Commission takes judicial notice of the findings by the Arbitrator in this regard and as contained in the Decision rendered in 11 WC 008721. By application of Section 3, Respondent was required to maintain workers' compensation insurance. The Respondent has offered no evidence to the contrary.

The Commission's authority and jurisdiction over insurance non-compliance cases is authorized by the Act, as well as the Rules. Under Section 4 of the Act, all employers who come within the auspices of the Act are required to provide workers' compensation insurance, whether this is done through being self-insured, through security, indemnity or bond, or through a purchased policy. Under Section 4(d):

> Upon a finding by the Commission, after reasonable notice and hearing, of the knowing and willful failure or refusal of an

> employer to comply with any of the provisions of paragraph (a) of this Section . . . , the Commission may assess a civil penalty of up to $500 per day for each day of such failure or refusal after the effective date of this amendatory Act of 1989. The minimum penalty under this Section shall be the sum of $10,000. Each day of such failure or refusal shall constitute a separate offense. The Commission may assess the civil penalty personally and individually against the corporate officers and directors of a corporate employer, the partners of an employer partnership, and the members of an employer limited liability company, after a finding of a knowing and willful refusal or failure of each such named corporate officer, director, partner, or member to comply with this Section. The liability for the assessed penalty shall be against the named employer first, and if the named employer refuses to pay the penalty to the Commission within 30 days after the final order of the Commission, then the named corporate officers, directors, partners, or members who have been found to have knowingly and willfully refused or failed to comply with this Section shall be liable for the unpaid penalty or any unpaid portion of the penalty.

Section 9100.90 of the Rules codifies the language of the Act, and additionally describes the notice of non-compliance required, as well as the procedures of the Insurance Compliance Division, and how hearings are to be conducted. Reasonable and proper notice, as noted above, was provided to Respondent. Section 9100.90(d)(3)(D) of the Rules indicates that "A certification from an employee of the National Council on Compensation Insurance stating that no policy information page has been filed in accordance with Section 9100.20 shall be deemed prima facie evidence of that fact." Petitioner's Exhibit 6 contains the certification from NCCI Holdings, Inc. indicating that Respondent did not have workers' compensation insurance from July 26, 2006 to March 29, 2012. Respondent failed to offer any evidence of compliance with the Act.

In *State of Illinois v. Murphy Container Service, et al.*, 2007 Ill.Wrk.Comp.LEXIS 1216, the Commission considered the following factors in assessing penalties against an uninsured employer: 1) the length of time the employer had been violating the Act; 2) the number of workers' compensation claims brought against the employer; 3) whether the employer had been made aware of his conduct in the past; 4) the number of employees working for the employer; 5) the employer's ability to secure and pay for workers' compensation coverage; 6) whether the employer had alleged mitigating circumstances; and, 7) the employer's ability to pay the assessed amount.

In the instant case, the Commission finds that the length of time in which the Respondent had been violating the Act in failing to obtain workers' compensation insurance was significant. The Respondent failed to have insurance for 2,072 days, from July 26, 2006 to March 29, 2012. One of Respondent's employees, Todd Beatty did sustain a grievous work injury.

20IWCC0308

Having reviewed the record, the Commission finds no evidence as to Respondent's inability to secure and pay for workers' compensation coverage and no evidence of mitigating circumstances.

The Commission finds Respondent knowingly and willfully failed to comply with the Act. Based on the significant period of time that Respondent failed to comply with the Act, the Commission assesses a penalty of $ 1,036,000.00 against Respondent, MICHAEL CRAFT, individually, and as President of C&M EXPRESS, Inc. (a dissolved corporation).

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent, MICHAEL CRAFT, individually and as President of C&M Express, Inc. (a dissolved corporation), is found to be an employer who was in non-compliance with the insurance provisions of Section 4(a) of the Act and Section 9100.90 of the Commission Rules, and is hereby ordered to pay the Commission a fine of $1,104,127.30 pursuant to Section 4(d) of the Act and Section 9100.90 of the Commission Rules. This amount represents 2,072 days of non-compliance with the Act, at $500.00 per day, from July 26, 2006 through March 29,2012, and assessment of unpaid premiums in the amount of $68,127.36 for the same time period.

Pursuant to Commission Rule 9100.90(f), once the Commission assesses a penalty against an employer in accordance with Section 4(d) of the Act, payment shall be made according to the following procedure: 1) payment of the penalty shall be made by certified check or money order made payable to the Commission; 2) payment shall be mailed or presented within thirty (30) days of the final order of the Commission or the order of the court of 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: JUN 8 – 2020
SJM/msb
D: 3/25/2020
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Stephen J. Mathis

D. Douglas McCarthy

Douglas D. McCarthy

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

BERNARDO CARDONA,

Petitioner,

vs. NO: 13 WC 16951

A.Q.L., ROBERT CHOI, DREAMBAG, INC., and ILLINOIS STATE TREASURER as *ex officio* custodian of the Injured Workers' Benefit Fund,

Respondents.

ORDER

This matter comes before the Commission on Petitioner's Motion to Reinstate the Proceedings against Respondents A.Q.L. and Dreambag, Inc. For the reasons set forth below, the Commission vacates its decision entered on July 31, 2017 as well as the Arbitrator's decision entered on January 20, 2017 as both decisions are void and without legal effect. The matter is remanded to the Arbitrator for a hearing on the merits to proceed against all named Respondents.

Statement of Facts

On February 5, 2014, Petitioner filed his Second Amended Application for Adjustment of Claim naming four Respondents: A.Q.L.; Robert Choi; Dreambag, Inc.; and the Injured Workers' Benefit Fund (IWBF).

The matter proceeded to hearing on December 19, 2016 before Arbitrator Mason. No one appeared on behalf of A.Q.L., Robert Choi, or Dreambag, Inc. On January 20, 2017, Arbitrator Mason entered her decision finding Petitioner failed to present adequate notice to Respondents A.Q.L. and Dreambag, Inc., and, therefore, no other findings were made. As to Respondent Robert Choi, the Arbitrator awarded benefits as follows: 1) 9 1/7 weeks Temporary Total Disability; 2) medical expenses; and 3) permanent partial disability of 40% loss of use of the left

middle finger. The Arbitrator further found Petitioner failed to prove that Robert Choi lacks insurance coverage, therefore, finding the IWBF was not liable.

Thereafter, Petitioner filed a timely review raising the issues of notice as well as the procedural posture as to Respondents A.Q.L. and Dreambag, Inc. On July 31, 2017, the Commission issued its decision affirming and adopting the decision of the Arbitrator. Within its decision of July 31, 2017, the Commission failed to address Petitioner's claim of error regarding the procedural posture in relation to Respondents A.Q.L. and Dreambag, Inc.

On September 5, 2017, Petitioner filed a review in the Circuit Court of Cook County. On May 2, 2018, the Honorable Daniel J. Kubasiak dismissed the appeal due to lack of subject matter jurisdiction as Petitioner's appeal was filed beyond the 20-day period required by the Illinois Workers' Compensation Act (the Act).

On February 21, 2019, Petitioner filed a Motion to Reinstate the Proceedings against Respondents A.Q.L. and Dreambag, Inc. The matter was fully briefed by the parties, and the matter proceeded to argument before the Commission.

Conclusion of Law

The Commission is an administrative body and only possesses the powers granted to it by the Illinois Workers' Compensation Act. See *Ferris, Thompson & Zweig, Ltd. v. Esposito*, 2015 IL 117443, ¶ 16 ("An administrative agency's powers are limited to those granted by the legislature and any action taken by an agency must be authorized specifically by statute"). Section 6(d) of the Act establishes the time constraints for filing an Application for Adjustment of Claim. *820 ILCS 820/6(d)* (West 2013). Section 9020.20(b) of the Rules Governing Practice before the Illinois Workers' Compensation Commission provides "An Application must be limited to one accident or one claim. After an Application has been filed with the Commission, any other Applications for Adjustment of Claim covering that accident, but naming a different employer, shall be assigned the same docket number as the original Application." 50 Ill. Admin. Code §9020.20(b) (eff. Nov. 9, 2016). Such requirement is necessary as the hearing must address not only all the issues stemming from one claimed accident but also as to all named respondents as the Act does not allow for apportionment. See *Concrete Structures of the Midwest v. Industrial Commission*, 315 Ill. App. 3d 596, 599, 734 N.E.2d 970 (2000) ("More importantly, we have no authority to make such an award. The issue of apportionment of benefits between various employers is a matter for the legislature to address first, not us").

Petitioner filed an Application for Adjustment of Claim alleging an accident occurring on March 14, 2013. Pursuant to the Rules, Petitioner amended the Application for Adjustment of Claim on several occasions in order to name alleged different employers. Once all employers were named, a hearing was conducted on December 19, 2016 before the Arbitrator. The Arbitrator found Petitioner failed to provide adequate notice to two of the four named Respondents- A.Q.L. and Dreambag, Inc. Therefore, no decision was entered concerning A.Q.L. and Dreambag, Inc. The Commission finds the unresolved issues against two named respondents render the decision void: As the Act does not allow for apportionment between respondents, it is incumbent on the Commission to enter a decision which addresses all issues and all respondents

for a claimed date of accident following a duly conducted trial. Multiple hearings against multiple respondents arising out of one date of accident is simply not contemplated by the Act.

As such, the Commission vacates its decision of July 31, 2017 and remands the matter to the Arbitrator for a new trial.

IT IS THEREFORE ORDERED BY THE COMMISSION that the decision of the Commission dated July 31, 2017 is vacated, thereby vacating the decision of the Arbitrator entered on January 20, 2017.

IT IS FURTHER ORDERED BY THE COMMISSION that the matter is remanded for hearing on the merits against all named Respondents.

DATED: JUN 8 - 2020

L. Elizabeth Coppoletti

LEC

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D. Douglas McCarthy

DISSENT

I respectfully dissent. I would affirm and adopt the well-reasoned opinion of the Commission dated July 31, 2017 which affirmed and adopted the decision of the Arbitrator in its entirety.

Stephen Mathis

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

LLOYD FORSON,

Petitioner,

vs.

NO: 17 WC 8725
17 WC 17579 (cons.)

PTO SERVICES, CTC LOGISTICS, and INJURED WORKERS' BENEFIT FUND,

Respondents.

ORDER

This matter coming before the Commission pursuant to a Petition for Review filed by Respondent CTC Logistics, due notice having been given and the Commission being fully apprised in the premises, the Commission hereby dismisses the Petition for Review for the reasons stated below:

Section 19(b) provides that "unless a petition for review is filed by either party within 30 days after the receipt by such party of the copy of the decision and notification of time when filed *** the decision shall become the decision of the Commission and in the absence of fraud shall be conclusive." *820 ILCS 305/19(b)* (West 2000). The Arbitrator's Decision in this matter was filed on April 4, 2018. On June 26, 2018, Respondent CTC Logistics filed a Petition for Review of the arbitration decision "received on April 6, 2018."

"'The Commission, as an administrative, nonjudicial body, has no presumption in favor of jurisdiction.' [citation omitted]. Thus…a party seeking review before the Commission must strictly comply with the statute conferring jurisdiction upon the Commission." *Shafer v. Illinois Workers' Compensation Commission*, 2011 IL App (4th) 100505WC, ¶32, 976 N.E.2d 1. "The 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 Commission*, 286 Ill. App. 3d 963, 966, 677 N.E.2d 438 (1996). Respondent CTC Logistics did not file its Petition for Review until 81 days after its acknowledged receipt of the

Arbitration Decision. As Respondent CTC Logistics failed to comply with the requirements of Section 19(b) of the Act, the Commission lacks jurisdiction to hear this matter. The April 4, 2018 Decision is now final.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent CTC Logistics' Petition for Review filed June 26, 2018 is hereby dismissed.

IT IS FURTHER ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 4, 2018 is final.

DATED: JUN 8 - 2020

L. Elizabeth Coppoletti

LEC/mck

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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 Permanent Disability	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

LISA MARTIN,

Petitioner,

vs.

NO: 16 WC 30728
14 WC 18871 (cons.)

ILLINOIS VETERAN'S HOME - LASALLE,

Respondent.

20IWCC0310

DECISION AND OPINION ON REVIEW

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

The Arbitrator issued two separate decisions for these cases awarding 5% loss of use of the person as a whole pursuant to section 8(d)2 of the Act in the earlier case, and 2% loss of use of the person as a whole pursuant to section 8(d)2 of the Act in the later case. "From and procedural and practical standpoint, where a claimant has sustained two separate and distinct injuries to the same body part and the claims are consolidated for hearing and decision, it is proper for the Commission to consider all of the evidence presented to determine the nature and extent of his permanent disability as of the date of the hearing." *Baumgardner v. Illinois Workers' Compensation Commission*, 409 Ill. App. 3d 274, 279-80, 947 N.E.2d 856 (1st Dist. 2011). The permanent partial disability award in companion case 14 WC 18871 having been vacated, the Commission modifies the PPD award herein to reflect Petitioner sustained a 6% loss of use of the person as a whole pursuant to Section 8(d)2 of the Act as set forth below.

The Commission views the evidence differently with respect to Section 8.1b(b) factor (v). Following each accident, Petitioner underwent a course of conservative care after which, each

20IWCC0310

time, she was released to return to work without restrictions. Petitioner did return to work full duty, and subsequently resigned her position due to an unrelated health condition.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 28, 2017, as modified above, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $537.00 per week for a period for 30 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained in both cases caused 6% loss of use of the person as a whole.

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

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

Pursuant to Section 19(f)(1), this decision is not subject to judicial review.

DATED: JUN 8 - 2020

L. Elizabeth Coppoletti

L. Elizabeth Coppoletti

LEC/cak

O: 4/28/2020

Stephen Mathis

43

D. Douglas McCarthy

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MARTIN, LISA
Employee/Petitioner

Case# **16WC030728**
14WC018871

ILLINOIS VETERAN'S HOME-LaSALLE
Employer/Respondent

20IWCC0310

On 10/2/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.17% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

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

0000 ASSISTANT ATTORNEY GENERAL
JOSEPH P BLEWITT
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

SEP 28 2017

RONALD A. RASCIA, Acting Secretary
Illinois Workers' Compensation Commission

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

Lisa Martin
Employee/Petitioner

v.

Illinois Veteran's Home-LaSalle
Employer/Respondent

Case # **16** WC **30728**

Consolidated cases: **14WC18871**

20IWCC0310

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gregory Dollison**, Arbitrator of the Commission, in the city of **Ottawa, Illinois** on **8/25/2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ 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 **9/7/2016**, Respondent was operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**48,840.00**; the average weekly wage was $**920.00**.

On the date of accident, Petitioner was **59** years of age, ***married*** with **0** dependent children.

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

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

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

Respondent is entitled to a credit of $**12.79** under Section 8(j) of the Act. Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $613.33/week for 3-6/7 weeks, commencing 9/08/2016 through 10/4/2016, as provided in Section 8(b) of the Act. Petitioner received vacation pay from September 13, 2016 through September 18, 2016. Respondent is entitled to receive a credit only to the extent of the compensation that would have been payable during the period covered by such payment, as provided in Section 8(j)2 of the Act,

Respondent shall pay Petitioner permanent partial disability benefits of $552.00/week for 10 weeks, because the injuries sustained caused a 2% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

Respondent shall pay reasonable and necessary medical services of $17,967.32 as provided in Section 8(a) of the Act. Said medical expenses shall be paid consistent with the medical 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.

Signature of Arbitrator

9/27/17
Date

FINDINGS OF FACT:

Lisa Martin, Petitioner in this matter, was employed by Respondent, the LaSalle Veterans Home, as a Certified Nursing Assistant on September 8, 2016. As part of her duties, it was her job to take care of residents, help them get dressed, bathe them, and feed them. Petitioner testified that it is a physical job.

The Arbitrator notes that Petitioner testified she suffers from an early on-set of Alzheimer's Disease. The Arbitrator notes that Petitioner was able to answer all the questions, however, some of her answers took some time to be stated. The Arbitrator also notes Petitioner sustained an undisputed accident on April 7, 2014 (See 14 WC 18871). In that case Petitioner treated for a causally related condition of ill-being, i.e., low back sprain superimposed over pre-existing asymptomatic degenerative condition, which had reached maximum medical improvement by February 10, 2015. Thereafter, she returned to work full duty.

Petitioner testified that she was preforming her regular work duties on September 8, 2016 for Respondent. As she was getting a large resident out of his bed, she was turning and twisted her right leg. Petitioner testified that she was expecting the resident to go to the right but he went to the left instead. Petitioner stated she immediately felt pain in her right leg that radiated down to her feet. Petitioner stated she reported the incident to her supervisor, Jackie, who sent her to the exercise area as same didn't require any heavy lifting.

Petitioner testified that she filled out an Incident Report. The Arbitrator notes that said report was not introduced as evidence at trial. Nevertheless, Petitioner testified as to the contents of said report. Petitioner testified, on cross-examination, that "Melissa" was in the room when the incident occurred. Petitioner was asked if Melissa was in the room at that time. Petitioner replied, "I think so." She stated, "[they] had to have two people because he was a big man to turn." Petitioner indicated she "told my nurse when we finally got him down. [I] told [the] nurse, I think I did something to my leg." Lastly, Petitioner stated, "Melissa went and got the nurse because I had to sit down because it was very painful."

Petitioner testified that on the date of the alleged incident she went to Morris Hospital. Records submitted show Petitioner presented for an evaluation of pain to the right hip. Petitioner provided a history that "...she was at work today when she developed increasing pain to her right hip radiating down the posterior aspect of her right leg to her right foot. The pain was increased with movement and walking..." X-rays were taken of the low back, right hip and pelvis which revealed degenerative disc disease at L5-S1 with minimal facet arthropathy and mild right hip osteoarthritis. Petitioner was diagnosed with right leg pain, taken off work and advised to follow up with her family doctor. (PX 9)

Petitioner followed up with Dr. Cote on September 15, 2016. The doctor's office recorded that Petitioner presented with acute back pain. According to the records Petitioner stated "...This condition occurred following a specific injury. The injury involved the lumbosacral area. This occurred 1 week ago at work. The injury resulted from twisting...She states that the recent twisting incident has caused a flare-up." She complained of pain in the right low back radiating to her right thigh. In addition to an examination it was noted Petitioner was already scheduled for an MRI the following week. Petitioner was assessed with back pain and lumbar radiculopathy. Petitioner was prescribed medication and returned to restricted work of no standing, lifting, bending or stooping. (PX 3)

On September 19, 2016, Petitioner presented to Dr. Becker at the Illinois Valley Community Hospital Pain Clinic. The doctor noted that he last saw Petitioner on August 31, 2016. At that time he had recommended

a MRI of the lumbar spine which had been denied. The doctor recorded that since that time, Petitioner sustained a re-aggravation of pain at work when lifting a patient on September 8, 2016. Dr. Becker assessment was low back pain, herniated lumbar disc and lumbar radiculopathy. The doctor stated that "since [Petitioner] was seen on August 31, 2016, her symptoms had gotten significantly worse also aggravated by lifting a patient at work. The pain is radicular in nature." Dr. Becker recommended an MRI as soon as possible and advised Petitioner to continue her home exercises. (PX 3)

On October 4, 2016, Dr. Cote's physician's assistant, Mr. John Kuzma, completed a CMS physician's statement indicating Petitioner could return to full duty work. (PX 3)

Petitioner testified that thereafter her Alzheimer condition was discovered and that said condition became the primary focus. She has since moved to Wisconsin with her family. Petitioner provided that currently she takes Tramadol for periodic pain. She is no longer working. She indicated that she has periodic right leg and back pain that radiates down to her feet. She indicated that her radiation symptoms did not start until after her September 2016 incident at work.

With respect to Issue C.) Did an accident occur that arose out of the course of Petitioner's employment by Respondent, the Arbitrator finds the following:

The Arbitrator finds that Petitioner sustained an accident on September 8, 2016 while working for Respondent. Petitioner testified specifically regarding the twisting injury that she sustained while attempting to move a large patient on September 8, 2016. Petitioner testified that she reported this to her supervisor, Jackie, and filled out a report. The history in the medical records subsequent to that date are consistent with Petitioner's testimony of sustaining a twisting injury at work on September 8, 2016. The Arbitrator finds Petitioner's testimony credible. Respondent offered no evidence either by testimony or documents to refute any testimony or documents offered by Petitioner.

With respect to Issue F, Is Petitioners current condition of ill being causally related to the injury, the Arbitrator finds the following:

Petitioner's testimony and medical records are consistent with her sustaining a re-injury to her low back on September 8, 2016. The treatment that she had at Morris Hospital, the Peru Medical Clinic with Dr. Cote, and at Illinois Valley Community Hospital with Dr. Becker, are all consistent with her testimony. On September 19, 2016, Dr. Becker recorded that Petitioner sustained a re-aggravation of pain at work when lifting a patient on September 8, 2016. Dr. Becker noted that he had seen Petitioner in August 2016 and her symptoms had gotten significantly worse also aggravated by lifting a patient at work. The pain was radicular in nature. There was no evidence introduced in the record to show any non-work related intervening accident. Respondent did not offer any opinions with respect to causation regarding this second injury. Consequently, the Arbitrator finds that Petitioners condition of ill-being is casually related to her September 8, 2016 accident.

With respect to Issue K.) what temporary total disability benefits (TTD) are in dispute, the Arbitrator finds the following:

Petitioner seeks temporary total disability benefits from September 8, 2016 through September 21, 2016 or a period of 1-6/7th weeks.

The proofs in this matter show Petitioner presented to Morris Hospital on the day of accident. Records show she was taken off work and advised to follow up with her family doctor. Petitioner followed up with Dr. Cote on September 15, 2016. Petitioner was prescribed medication and returned to restricted work of no

standing, lifting, bending or stooping. On October 4, 2016, Dr. Cote's physician's assistant, Mr. John Kuzma, completed a CMS physician's statement indicating Petitioner could return to full duty work.

Based on the above, the Arbitrator finds Petitioner was temporally and totally disabled for work from September 8, 2016 through October 4, 2016, a period of 3-6/7th weeks. Testimony elicited at trial demonstrated that Petitioner took a vacation from September 13, 2016 through September 18, 2016. It appears Petitioner was paid her regular salary during that period. Petitioner stated that she was not receiving any temporary total disability and needed "some money." The Arbitrator finds that consistent Section 8(j)2 of the Act, Respondent is entitled to receive credit only to the extent of the compensation that would have been payable during the period covered by such payment.

With respect to Issue J.) Were the medical services that were provided the Petitioner reasonable and necessary, has Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds the following;

Having found in favor Petitioner regarding accident and causal relationship, the Arbitrator awards the $17,967.32 in unpaid bills enumerated in Petitioner's Exhibit 1. Respondent is entitled to a credit for all medical bills paid through its group medical plan. 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 L.) What is the nature and extent of the injury, the Arbitrator finds the following:

In determining the level of permanent partial disability for injuries incurred on or after September 1, 2011, the Commission shall base its determination on the following factors: (i) the reported level of impairment pursuant to the most current edition of the AMA's "Guides to the Evaluation of Permanent Impairment"; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; (v) evidence of disability corroborated by the treating medical records. (820 ILCS 305/8.1b)

No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order. (820 ILCS 305/8.1b)

Pursuant to Section 8.1b of the Act, the following criteria and factors must be weighed in determining the level of permanent partial disability, for accidental injuries occurring on or after September 1, 2011:

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

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

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

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

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes the record reveals Petitioner was employed as a Certified Nursing Assistant at the time of the accident and although she was able to return to work in her prior capacity, as a result of said injury, Petitioner is no longer working as a CNA due to an unrelated medical condition. The Arbitrator therefore gives lesser weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 59 years old at the time of the accident. Because of Petitioner's advanced age she will live with his permanent disability for a shorter period than a younger individual. Because of this, the Arbitrator therefore gives lesser weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that although Petitioner is no longer working because of an unrelated medical condition, Petitioner was cable of returning to her regular work at her regular pay. The Arbitrator therefore gives no weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes Petitioner sustained a re-aggravation of her low back injury at work on September 8, 2016. Subsequent to the accident, she began having pain in her low back but also pain radiating down into her right thigh, which was a new finding as compared to her first accident (See 14 WC 18871). Petitioner's testimony is that she is still in pain in her low back and leg. She takes Tramadol for periodic pain. The Arbitrator therefore gives greater weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds Petitioner is permanently disabled to the extent of 2% under Section 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 Permanent Disability	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

LISA MARTIN,

Petitioner,

vs.

NO: 14 WC 18871
16 WC 30728 (cons.)

ILLINOIS VETERAN'S HOME - LASALLE,

Respondent.

20IWCC0311

DECISION AND OPINION ON REVIEW

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

The Arbitrator issued two separate decisions for these cases awarding 5% loss of use of the person as a whole pursuant to section 8(d)2 of the Act in the earlier case, and 2% loss of use of the person as a whole pursuant to section 8(d)2 of the Act in the later case. "From and procedural and practical standpoint, where a claimant has sustained two separate and distinct injuries to the same body part and the claims are consolidated for hearing and decision, it is proper for the Commission to consider all of the evidence presented to determine the nature and extent of his permanent disability as of the date of the hearing." *Baumgardner v. Illinois Workers' Compensation Commission*, 409 Ill. App. 3d 274, 279-80, 947 N.E.2d 856 (1st Dist. 2011). The Commission vacates the Arbitrator's permanent partial disability award herein. Permanent partial disability will be addressed in companion case 16 WC 30728.

All else is affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the

20IWCC0311

Arbitrator filed September 28, 2017, as modified above, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $596.67 per week for a period of 44 2/7 weeks, representing April 8, 2014 through February 10, 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 Responent shall pay reasonable and necessary medical services for outstanding medical bills and out-of-pocket medical expenses through February 10, 2015, as provided in Section 8(a), subject to Section 8.2.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of 5% loss of use of the person as a whole is vacated.

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

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

Pursuant to Section 19(f)(1), this decision is not subject to judicial review.

DATED: JUN 8 - 2020

L. Elizabeth Coppoletti

LEC/cak

O: 4/28/2020

Stephen Mathis

43

D. Douglas McCarthy

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MARTIN, LISA
Employee/Petitioner

Case# **14WC018871**
16WC030728

ILLINOIS VETERAN'S HOME-LaSALLE
Employer/Respondent

20IWCC0311

On 9/28/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.17% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

0499 CMS RISK MANAGEMENT
801 S SEVENTH ST 6M
PO BOX 19208
SPRINGFIELD, IL 62794-9208

0000 ASSISTANT ATTORNEY GENERAL
JOSEPH BLEWITT
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

SEP 28 2017

RONALD A.RASCIA, Acting Secretary
Illinois Workers' Compensation Commission

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

Lisa Martin
Employee/Petitioner

v.

Illinois Veteran's Home-LaSalle
Employer/Respondent

Case # **14** WC **18871**

Consolidated cases: **16WC30728**

20IWCC0311

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gregory Dollison**, Arbitrator of the Commission, in the city of **Ottawa, Illinois**, on **8/25/2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **4/07/2014**, 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 $**46,540.00**; the average weekly wage was $**895.00**.

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

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

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

Respondent shall be given a credit of $**10,131.17** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**10,131.17**.

Respondent is entitled to a credit of $**5,215.68** under Section 8(j) of the Act. Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $596.67/week for 44-2/7 weeks, commencing 4/08/2014 through 2/10/2015, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $537.00/week for 25 weeks, because the injuries sustained caused a 5% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

Respondent shall pay reasonable and necessary medical services for outstanding medical bills and out-of-pocket medical expenses through February 10, 2015, as provided in Sections 8(a) and 8.2 of the Act.

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

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

Signature of Arbitrator

9/27/17
Date

SEP 28 2017

FINDINGS OF FACT:

Lisa Martin, Petitioner in this matter, was employed by Respondent, the LaSalle Veterans Home, as a Certified Nursing Assistant on April 7, 2014. As part of her duties, it was her job to take care of residents, help them get dressed, bathe them, and feed them. Petitioner testified that it is a physical job. She testified that as of April 7, 2014 her back was not giving her any problems. She testified that she never had any prior chiropractic treatment to her back.

The Arbitrator notes that Petitioner testified she suffers from an early on-set of Alzheimer's Disease. The Arbitrator notes that Petitioner was able to answer all the questions, however, some of her answers took some time to be stated.

Petitioner sustained in undisputed accident while working for Respondent on April 7, 2014. She was assisting a resident to the bathroom when the resident began falling forward. Petitioner testified that she tried to grab him and then she fell. Petitioner testified she hit the floor and injured her low back. Petitioner testified that she filled out an accident report the same day.

Petitioner sought medical treatment on the date of her accident with Dr. Mario Cote, her family physician, at the Peru Medical Clinic. She reported a consistent history of injuring her low back at work while attempting to prevent a resident from falling. Dr. Cote assessed back pain, prescribed medication, authorized Petitioner off work and ordered physical therapy. (PX 3) Petitioner also underwent an x-ray of her lumbar spine the same day at Illinois Valley Community Hospital. The radiologist interpreted the x-ray as showing degenerative changes from levels L2 thru S1. (PX 6)

Petitioner continued to treat with Dr. Cote and was kept off work. Dr. Cote noted that her therapy as of April 21, 2014 still had not been approved. (PX 3) It was ultimately approved and she began undergoing therapy at Accelerated Physical Therapy/Athletico Physical Therapy on April 28, 2014. (PX 5) By May 28, 2014, Petitioner reported persistent to worsening low back pain. Dr. Cote recommended Petitioner undergo an MRI. (PX 3). Petitioner underwent the MRI on June 19, 2014 at the Community Hospital of Ottawa. The radiologist interpreted the MRI as showing lumbosacral degenerative spondylosis. (PX 8)

Petitioner returned to Dr. Cote on June 27, 2014. The doctor noted that her low back complaints were more located in the right sacroiliac area. Dr. Cote referred her to a pain clinic as well as physiatry. Petitioner was continued off work. (PX 3)

On August 18, 2014, Petitioner underwent a functional capacity evaluation at Newsome Physical Therapy. According to the report, Petitioner had attended thirty-five (35) therapy sessions. She had decreased pain ratings, however her pain was constant. It was noted that she demonstrated instability in her back and pelvis. It was also noted she had audible, crepitus in the lumbar spine with certain movements. The evaluator provided that Petitioner demonstrated the ability to perform within the light physical demand category and was unable to complete all the job demands of a CNA. (PX4)

At Respondent's request, Petitioner underwent a Section 12 examination with Dr. Lawrence Li, an Orthopedic Surgeon, on August 18, 2014. Dr. Li authored a report dated August 21, 2014. According to his report, Dr. Li reviewed the injury report, the notes of Dr. Cote, the MRI of June 14, 2014, the Functional Capacity Evaluation and therapy notes between April 28 and June 20, 2014. Dr. Li preformed an examination and opined Petitioner suffered a lumbar strain related to the April 7, 2014 work accident. He also felt she had

underlying lumbar degenerative disc disease and spondylosis. He felt that due to a lack of objective findings upon examination, her lumbar strain had resolved. The only thing that had not resolved, according to Dr. Li, was Petitioner's discomfort. He stated that no further treatment would be needed for the April7, 2014 work injury, and any additional treatment she may have or need would be due to her pre-existing condition. He further stated that she could return to work full duty and did not require any restrictions on her activities due to any injury of April 7, 2014. He felt that she had reached maximum medical improvement regarding that injury. Lastly, Dr. Li opined that she had sustained impairment of 1% of a whole person based on the AMA Guides for the Evaluation of Permanent Impairment, Sixth Edition. (RX 1)

Upon referral of Dr. Cote, Petitioner was seen by Dr. Thomas Szymke, a physiatrist, on August 28, 2014. Petitioner reported a consistent history of injuring her low back at work of April of 2014. Dr. Szymke reviewed Petitioner's x-rays and her MRI and preformed an examination. He diagnosed Petitioner with facet arthropathy with his greatest concern at the left L5-1 facet. He recommended a bone scan. (PX 2)

Petitioner underwent a bone scan at Illinois Valley Community Hospital on September 5, 2014. The findings were unremarkable with no uptake seen at the left S1 joint. (PX 6)

Petitioner testified that she attempted to return to work on October 9, 2014. Petitioner stated she was only able to work 1 or 1-1/2 hours. Petitioner stated she experienced "burning and hurt real bad." She "couldn't do it."

She subsequently returned to Dr. Szymke on October 9, 2014. According to Dr. Szymke's records, she attempted to return to work pursuant to the review with Dr. Li . She told Dr. Szymke that she only lasted an hour and a half before she was forced to leave work due to pain. Dr. Szymke's exam was identical to the previous visit. Dr. Szymke stated that in spite of the bone scan, he had little doubt that Petitioner had a significant arthropathy at the L5 junction on the left side. He referred her to the Illinois Valley Community Hospital Pain Clinic for the possibility of epidural steroid injections and medial branch blocks. (PX 2)

Petitioner was first seen by Dr. Kloc at the Illinois Valley Community Hospital Pain Clinic on October 10, 2014. She again reported her symptoms had begun from her work injury of April of 2014. She stated that her pain would typically be about 3 out of 10 but would fluctuate between 2 of 10 and 7 out of 10. Dr. Kloc reviewed the MRI noting same was relatively benign. He felt the most obvious thing he saw was a disc bulge at L1-2 paradian right which didn't appear to irritate the central canal or the nerve root. He also reviewed the previous lumbar x-rays which showed arthritis in the lower three joints bilaterally. Dr. Kloc's impression was lumbar facet arthritis with facet mediated pain. The doctor recommended that she undergo a medial branch block. If that was successful, the doctor would further recommend radio frequency lesioning. (PX 6)

Petitioner returned to Dr. Cote on November 12, 2014. Petitioner expressed that she was a little hesitant to undergo the injection. Dr. Cote suggested she be seen by a neurosurgeon. Petitioner was kept off work. (PX 3)

Petitioner underwent a medial branch block of her left lumbar spine by Dr. Kloc at Illinois Valley Community Hospital on November 17, 2014. (PX 6) She returned to Dr. Szymke on December 4, 2014. Petitioner reported that she had approximately 80% diminution of her pain after the block. He recommended a standing lumbosacral spine series with flexion-extension. The doctor also noted he awaited authorization for a Functional Capacity Evaluation. (PX 2) Petitioner underwent the x-rays of her lumbar spine at Illinois Valley Community Hospital on December 4, 2014 which the radiologist interpreted as showing mild to moderate degenerative changes, most pronounced at level L5 S1 facet joints. The radiologist also indicated there was no evidence of spondylolysis, spondylolisthesis or instability. (PX 6)

Petitioner was seen by a spinal surgeon, Dr. Cary Templin on December 9, 2014. Petitioner reported her history of injuring herself at work on April 7, 2014. Petitioner told Dr. Templin that her pain was in her left side over the lumbosacral junction with minimal leg pain. She had no weakness, numbness, bowel or bladder dysfunction. Her pain did go to her posterior buttock more predominately on her left side. She did not have any prior history of back pain of that nature. She did have a popping in her back with flexion/extension. She reported that she was under the care of a pain physician and had an injection of her facet joint which had given her some significant relief. She told the doctor that she had been off work and had tried to return in September of 2014, but had to leave due to pain. Upon examination, Dr. Templin noted that her lumbar flexion was to 70 degrees, and her extension was to 10 degrees, with increasing pain on going from a flexed to an extended position with obvious crepitus or popping in the low back as well. She had a positive fabere exam to the left, negative to the right. The rest of the exam was within normal limits. He reviewed her x-rays and her MRI. He felt that there were degenerative changes including obvious facet degenerative changes at L5 S1 worst to the left side. He felt that the bone scan showed degenerative uptake at the posterior elements on the left side L5 S1, but nothing otherwise. He thought the MRI showed a L1-L2 right sided herniated disc and severe degenerative change to the left side of facet joint of level L5-S1. Dr. Templin recommended that she undergo an additional block to the L5-S1 facet with a potential for an ablation in the future. The doctor added that if she had significant relief, he would recommend she rehabilitate back to work. She was also kept off work. (PX 7)

Petitioner followed up with Dr. Kloc on December 15, 2014. She underwent a radio frequency procedure of her left lumbar spine from level L2 to S1. On December 29, 2014, Dr. Kloc recorded that Petitioner was very pleased with the improvement of her pain on the left side and she was eager to go ahead with treatment on her right side. As a result, Dr. Kloc administered medial branch block injections to her right side between levels L2 and L5. (PX 6)

On January 15, 2015, Petitioner returned to Dr. Szymke. Petitioner reported complete relief of her left side of facet pain after undergoing radio frequency ablation with Dr. Kloc. Petitioner informed Dr. Szymke that she was doing very vigorous stretching exercises on a daily basis at home. She also had been doing transfer work with her husband acting as a patient. Dr. Szymke also noted that Petitioner could undergo an FCE or work conditioning as same was being denied by Respondent. An examination performed that day revealed increase in range of motion in her lumbar spine. The doctor recommended continued home exercises. He also noted Petitioner was scheduled to have the right-sided facets ablated. (PX 2)

Petitioner underwent a right sided radio frequency ablation to her facet joints with Dr. Kloc on January 21, 2015. (PX 6) Petitioner returned to Dr. Cote on January 26, 2015. The doctor noted Petitioner reported that her pain was dramatically to completely resolved. An examination revealed mild tenderness to palpation to the back. Dr. Cote felt Petitioner would be able to return to work with no restrictions effective February 3, 2015. (PX 3)

Petitioner returned to Dr. Szymke on January 29, 2015. The doctor noted she had complete relief of her left-sided facet pain; that her right side had been completed; and that she asymptomatic. The doctor indicated that she had completed her medical plan and released her to return to work without restrictions. (PX 2)

Petitioner followed with Dr. Kloc on February 10, 2015. Petitioner reported that she was doing very well and felt she could return to work without any concerns about chronic low back pain. She rated her pain as 0/10. Dr. Kloc discharged Petitioner from care and was told to return as needed. (PX 6) Petitioner testified that she returned to full duty work thereafter.

At Respondent's request, Petitioner underwent a second Section 12 examination with Dr. Li on June 8, 2015. Dr.Li provided that he reviewed the medical records regarding treatment since his last examination on

August 18, 2014. Per Dr. Li, Petitioner reported that she was working worked 40 to 50 hours a week at full duty. The doctor also noted Petitioner reported she could do all he normal activities as well as hobbies, such as camping. He stated that she complained of low back pain that radiates in her buttocks and rated it at a level of 3 out of 10. Petitioner indicated that she had improved compared to before the radio frequency ablations. Dr. Li preformed an examination and Petitioner fill out a pain disability questionnaire which resulted in a PDQ score of 29. Dr. Li opined Petitioner had pre-existing lumber spondylosis and arthritis as well as degenerative disc disease. He stated that the facet joint arthritis was part of the lumber spondylosis. He stated that the objective findings were evident on the MRI, which she had lumbar spondylosis, worse in the L5-S1 facet joints. The doctor felt she behaved appropriately and expressed her pain appropriately. He diagnosed her current condition of lumbar spondylosis most severe at the L5-S1 facet joints with noticeable relief with the radio frequency ablation. Dr. Li felt there was no cause or relationship between her preexisting facet joint arthritis and her lumbar spondylosis and the reported accident. He reiterated his opinion that she suffered a lumbar sprain because of the accident, but that her current symptoms are not due to that sprain. He felt that all her medical treatment to date had been reasonable and necessary. He did not feel that any additional medical treatment was necessary at that time as there were no current plans by any provider to provide any additional care. He felt her prognosis was good, but that she would most likely continue to have low back pain due to her lumbar spondylosis and facet joint arthritis, which would progress with time. He felt she could work full duty and that she reached maximum medical improvement on February 10, 2015. He again reiterated his opinion that under the AMA Guides to Evaluation of Permanent Impairment, Sixth Edition, Petitioner sustained impairment to 1% loss of a whole person. (RX 2)

Petitioner testified that after being released to return to work she continued to have periodic low back pain. She said it returned gradually onto the right side. On September 30, 2015, she returned to Dr. Cote complaining of right leg pain with internal rotation pain into the groin. The doctor assessed lumbar radiculopathy and referred her to Pain Management at Illinois Valley Community Hospital. (PX 3)

On October 5, 2015, Petitioner presented to the Illinois Valley Community Hospital Pain Clinic where she was seen Dr. Eugene Becker. She reported her consistent history of injuring her low back when she caught a resident from falling. She complained of pain in her low back that was now radiating down her right leg. She also complained of pain on the interior surface of her left thigh. Petitioner reported that her pain was constant at a level of 3 out of 10. Dr. Becker assessed low back pain and lumbar radiculopathy. The doctor recommended trigger point injections which was carried out by Dr. Becker on October 7, 2015. Thereafter, Petitioner followed up with Dr. Becker on October 21, 2015 reporting that she had a very good response to the injections. She was told to follow up as needed. (PX 6)

Petitioner returned to Dr. Becker on December 21, 2015 complaining of low back pain, left worse than right. Additionally, she complained about numbness in both thighs with no weakness in the legs. Dr. Becker noted the trigger point injection provided some relief of her pain. Dr. Becker assessed 1.) low back; 2.) spondylosis lumbar spine; and 3.) degenerative disc disease lumbar spine. The doctor also noted that Petitioner had a good response to the prior radio frequency ablation performed a year prior and that Petitioner indicated similar pain was returning indicating she had tenderness over facet joints on both sides of the lumbar spine. Dr. Becker recommended repeating a series of radio frequency ablation of the medial branches. (PX 6)

On January 13, 2016, Dr. Becker performed the ablations at L4-5, L5-S1 and S1. At return visit on February 3, 2016, Petitioner reported that her pain was not as intense rating same at 1 out of 10. The doctor felt Petitioner responded well and did not recommend any additional intervention. Petitioner was advised to return as needed. She was also advised to continue with her home exercises. (PX 6)

Petitioner testified that she had pain in her back and legs. She indicated that she has learned to live with her condition. Petitioner testified that she has made an appointment for another radio frequency ablation with a

physician in Wisconsin. Petitioner further testified that she earned a higher salary after she returned to work for Respondent and that she received two prior settlements while working for Respondent.

With respect to Issue F.), Is Petitioner's current condition of ill being cause related to the injury, the Arbitrator finds the following:

Petitioner's credibly testified that she had no low back problems prior to the undisputed accident on April 7, 2014. Petitioner's testimony is supported by all treatment records which demonstrate she was asymptomatic until the accident. None of the documents references any prior treatment to her lumbar spine. Petitioner provided consistent histories of experiencing low back pain since the date of accident.

It is also clear Petitioner had an underlying pre-existing degenerative condition. The only doctor to offer an opinion regarding Petitioner's need for back treatment is Dr. Li, who opined that that she sustained lumbar sprain, and that any additional treatment after August 18, 2014 was related to her underlying lumbar degenerative disc disease and spondylosis. He felt that due to a lack of objective findings upon examination, her lumbar strain had resolved. The only thing that had not resolved, according to Dr. Li, was Petitioner's discomfort.

Dr. Li echoed a similar opinion after performing a second IME on June 8, 2015. After reviewing additional records Dr.Li opined Petitioner had pre-existing lumber spondylosis and arthritis as well as degenerative disc disease. He stated that the facet joint arthritis was part of the lumber spondylosis. He stated that the objective findings were evident on the MRI, which she had lumbar spondylosis, worse in the L5-S1 facet joints. The doctor felt she behaved appropriately and expressed her pain appropriately. He diagnosed her current condition of lumbar spondylosis most severe at the L5-S1 facet joints with noticeable relief with the radio frequency ablation. Dr. Li felt there was no cause or relationship between her preexisting facet joint arthritis and her lumbar spondylosis and the reported accident. He reiterated his opinion that she suffered a lumbar sprain because of the accident, but that her current symptoms are not due to that sprain. He felt that all her medical treatment to date had been reasonable and necessary. He did not feel that any additional medical treatment was necessary at that time and that she reached maximum medical improvement on February 10, 2015.

Drs. Cote, Kloc and Li all agree that Petitioner reached MMI as of February 10, 2015 for her diagnoses of facet joint arthritis and lumbar spondylosis. Dr. Cote said her back pain had completely resolved. Dr. Kloc recorded 0/10 pain and discharged her from treatment, and Dr. Li in his second IME found Petitioner to be at MMI as of February 10, 2015. The Arbitrator notes that Petitioner would not treat for her low back for another 8 months after February 2015. This gap is treatment is highly indicative that she had reached MMI.

Based on the above, the Arbitrator finds that Petitioner proved that a causal nexus existed between the accident sustained and her lumbar condition of ill-being through February 10, 2015, the date Drs. Cote, Kloc and Li all agree that Petitioner reached MMI.

With respect to Issue J.) Were medical services that were provided the Petitioner reasonable and necessary and has Respondent paid all appropriate chargers for all reasonable and necessary medical services, the Arbitrator finds the following:

Based on the Arbitrator's finding enumerated in issue (F.), the Arbitrator finds Respondent shall be liable and pay for all medical treatments through February 10, 2015. Respondent shall further hold Petitioner harmless for the $5,215.68 paid by the employers group insurance.

With respect to Issue K, what temporary total disability benefits (TTD) are in dispute, the Arbitrator finds the following:

Petitioner seeks temporary total disability benefits from April 7, 2014 through January 22, 2015, or 41-3/7 weeks.

The proofs in this matter show Petitioner returned to Dr. Cote on January 26, 2015. The doctor noted Petitioner reported that her pain was dramatically to completely resolved. Dr. Cote felt Petitioner would be able to return to work with no restrictions effective February 3, 2015. On January 29, 2015, Petitioner saw Dr. Szymke. The doctor noted she had complete relief of her left-sided facet pain; that her right side had been completed; and that she asymptomatic. The doctor indicated that she had completed her medical plan and released her to return to work without restrictions. Petitioner also followed with Dr. Kloc. She saw the doctor on February 10, 2015. At that time Petitioner reported that she was doing very well and felt she could return to work without any concerns about chronic low back pain. Dr. Kloc discharged Petitioner from care and told her to return as needed. Lastly, Dr. Li, Respondent's Section 12 examiner, felt she could work full duty and that she reached maximum medical improvement on February 10, 2015.

Based on the above, the Arbitrator finds Petitioner was authorized off work by her treating physicians from the date of the accident through February 10, 2015, a total of 44-2/7ths weeks.

With respect to L.) What is the nature and extent of the injury, the Arbitrator finds the following:

In determining the level of permanent partial disability for injuries incurred on or after September 1, 2011, the Commission shall base its determination on the following factors: (i) the reported level of impairment pursuant to the most current edition of the AMA's "Guides to the Evaluation of Permanent Impairment"; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; (v) evidence of disability corroborated by the treating medical records. (820 ILCS 305/8.1b)

No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order. (820 ILCS 305/8.1b)

Pursuant to Section 8.1b of the Act, the following criteria and factors must be weighed in determining the level of permanent partial disability, for accidental injuries occurring on or after September 1, 2011:

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

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

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

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that the record contains an impairment rating of 1% of whole person as determined by Dr. Li, pursuant to the most current edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment. According to Dr. Li, he used a diagnosis of low back pain from facet arthritis which was a class 1 diagnosis. That diagnosis was attained from the MRI obtained by Dr. Kloc. 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. As such, the Arbitrator gives weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as a certified nursing assistant at the time of the accident. Petitioner is no longer working as a CNA due to an unrelated medical condition. The Arbitrator therefore gives lesser weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 56 years old at the time of the accident. Because of Petitioner's advanced age she will live with his permanent disability for a shorter period than a younger individual. Because of this, the Arbitrator therefore gives lesser weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that because of an unrelated medical condition, Petitioner is no longer working. Furthermore, Petitioner testified that she earned a higher salary after she returned to work for Respondent. The Arbitrator therefore gives no weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes Petitioner sustained a low back sprain superimposed over pre-existing, asymptomatic, degenerative condition. All the treating physicians and the IME physician agreed that she had facet joint arthritis which was treated with injections and radio frequency ablation. Petitioner continued to have low back pain subsequent to her treatment and up until the time of the hearing. This is corroborated not only in the treating physician's records, but also in Dr. Li's June 8, 2015 IME report in which Petitioner was still suffering pain in her low back at a level 3 out of 10. The Arbitrator therefore gives greater weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds Petitioner is permanently disabled to the extent of 5% under Section 8(d)2 of the Act.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Roger Craig,

Petitioner,

20IWCC0312

vs. NO: 16 WC 11115

Continental Tire 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 issue of permanent partial disability, being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 26, 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.

20IWCC0312

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $7,600.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUN - 8 2020
d- 4/21/20
KAD/jsf

Kathryn A. Doerries

Maria E. Portela

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CRAIG, ROGER
Employee/Petitioner

Case# **16WC011115**

20IWCC0312

CONTINENTAL TIRE NORTH AMERICA INC
Employer/Respondent

On 9/26/2019, 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:

1167 WOMICK LAW FIRM CHTD
CASEY VANWINKLE
501 RUSHING DR
HERRIN, IL 62948

0299 KEEFE & DePAULI PC
ANDREW J KEEFE
2 EXECUTIVE DR
FAIRVIEW HTS, IL 62208

STATE OF ILLINOIS 20 IWCC0312

)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

Roger Craig
Employee/Petitioner

v.

Continental Tire North America, Inc.
Employer/Respondent

Case # 16 WC 11115

An *Application for Adjustment 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 **Mt. Vernon**, on **07/12/19**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ 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 _____

20IWCC0312

FINDINGS

On **12/03/14**, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner *did* 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 $**40,139.84**; the average weekly wage was $**771.92**.

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

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

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

Respondent shall be given a credit of $**147.03** for TTD, **N/A** for TPD, **N/A** for maintenance, and **N/A** for other benefits, for a total credit of $**147.03**.

Respondent is entitled to a credit of **any amount of medical paid through group** under Section 8(j) of the Act.

ORDER

Petitioner currently has disability to the extent of **27.5% loss of use of the right leg** under Section **8(e)(12)** of the Act. Petitioner previously received an award of 20% loss of use of the right leg in case 94 WC 66230 for which Respondent is entitled to a credit. Thus, Respondent shall pay Petitioner the sum of **$463.15/week** for a further period of **16.125 weeks**, equaling 7.5% loss of use of the right leg, for injuries sustained in the case 16 WC 11115.

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

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

Signature of Arbitrator

9/23/19
Date

SEP 26 2019

The Arbitrator finds the following facts:

Petitioner sustained a right knee injury on December 3, 2014. A co-worker struck him with a buggy and pushed him across an aisle before striking a machine. Petitioner completed his shift and presented to Health Services the following day. He was diagnosed with minor swelling and minor pain to the right knee. Petitioner subsequently undertook two separate courses of physical therapy. He continued working his regular job duties.

Petitioner presented to Dr. George Paletta on July 13, 2015 reporting right knee pain resulting from a December 3, 2014 work injury. Petitioner reported he had not missed any work and continued working without restrictions. Petitioner reported a course of therapy did not alleviate his symptoms. Following x-rays and physical examination, Dr. Paletta diagnosed right knee pain in the setting of mild medial compartment degenerative joint disease and possible associated medial meniscus tear. Dr. Paletta recommended an MRI of the right knee. He opined Petitioner could continue working without restrictions. He opined the work incident might have caused a temporary increase in symptoms as related to Petitioner's underlying degenerative condition.

Petitioner underwent a right knee MRI on July 23, 2015. Dr. Paletta interpreted the study to reveal a complex medial meniscus tear with extrusion of the meniscus into the medial gutter suggestive of possible route avulsion, early medial compartment degenerative joint disease, horizontal cleavage tear of the lateral meniscus, and Grade IV chondrosis of the lateral femoral trochlea. Dr. Paletta opined the femoral trochlear chondrosis was chronic and longstanding. Based on the study, Dr. Paletta recommended arthroscopy with partial medial and lateral meniscectomies and possible debridement and chondroplasty.

Petitioner presented to Dr. Robert Golz at the Orthopaedic Institute on October 16, 2015. Petitioner chose to treat with Dr. Golz for logistical reasons. Dr. Golz reviewed the medical records and performed a physical examination. He diagnosed medial and lateral meniscal tears with moderately advanced medial and patellofemoral gonarthrosis. Dr. Golz opined the medial and lateral meniscal tears were acute and related to the accident. He opined the arthritis was pre-existing and might have been exacerbated by the work incident. Surgery was offered.

On October 27, 2015, Petitioner underwent a right knee arthroscopy, debridement, partial medial meniscectomy and partial lateral meniscectomy without complication.

Dr. Golz reviewed the operative photographs with Petitioner on November 10, 2015, identifying the significance of the degenerative arthritis. Dr. Golz noted Petitioner's pre-operative symptoms associated with the meniscal tears was improved.

Dr. Golz re-evaluated Petitioner on December 8, 2015, documenting the scope had helped Petitioner's symptoms. He noted Petitioner had resumed working light duty. Petitioner complained of continued start up stiffness and swelling in his bilateral legs. Petitioner's right knee was aspirated.

Dr. Golz re-evaluated Petitioner on January 19, 2016. A repeat aspiration and cortisone injection were administered.

In a chart note dated January 22, 2016, Dr. Golz opined Petitioner's ongoing symptoms were attributable to primary osteoarthritis of the knee. He recommended viscosupplementation injections.

Dr. Paletta re-evaluated Petitioner February 12, 2016. Dr. Paletta reviewed Dr. Golz's treatment records. Following examination, Dr. Paletta diagnosed persistent right knee pain status post arthroscopy with partial medial and lateral meniscectomies in the setting of underlying pre-existing moderately advanced osteoarthritis of the knee. Dr. Paletta stated he was in agreement with Dr. Golz that Petitioner's underlying osteoarthritis was pre-existing, long-standing and not caused by the work injury. He opined it was likely Petitioner's continued symptoms were attributable to the underlying condition. Dr. Paletta recommended an updated MRI, a custom unloader brace and consideration to viscosupplementation injections to treat Petitioner's ongoing complaints. Dr. Paletta did not see indication for an EMG/NCS study. He opined that Petitioner should limit activities with respect to squatting, kneeling, climbing and traversing stairs.

Dr. Golz evaluated Petitioner on February 26, 2016, noting he was waiting to review Dr. Paletta's report before making additional recommendations.

In a March 7, 2016 note, Dr. Paletta opined the need for ongoing treatment and restrictions were not causally related to the work accident, but directly related to the underlying, pre-existing osteoarthritis.

Dr. Golz evaluated Petitioner on April 26, 2016 and reviewed Dr. Paletta's independent medical examination report. A treatment plan for Petitioner's underlying primary osteoarthritic symptoms was discussed. An injection was administered on May 16, 2016.

Dr. Paletta drafted a report dated May 26, 2016 reiterating his belief that Petitioner's underlying pre-existing osteoarthritis was not related to the work injury and Petitioner's current condition of ill-being was neither caused nor aggravated by the work incident.

Petitioner followed up at Dr. Golz's office on June 3, 2016, July 14, 2016, and August 16, 2016.

Dr. Paletta re-evaluated Petitioner on September 26, 2016. Following examination, Dr. Paletta diagnosed moderately advanced medial compartment degenerative joint disease with varus alignment. Dr. Paletta opined the majority of Petitioner's symptoms were arthritic, to include achiness, crepitance and intermittent swelling. Dr. Paletta again recommended an unloader brace for the varus alignment of the knee. Dr. Paletta did not recommend repeating viscosupplementation injections. He opined a FCE might be indicated. He recommended Petitioner avoid knee replacement for the time being. Dr. Paletta opined the need for any ongoing treatment would be related to the osteoarthritis. Dr. Paletta opined the restrictions imposed by Dr. Golz were reasonable but would not be attributable to the work incident.

Petitioner returned to Dr. Golz's office on February 21, 2017 reporting he was having no problems with his right knee. He reported that he was essentially back to normal activity at work and was requesting a regular duty work release form. Petitioner denied having pain or stiffness when waking up in the morning. He would have some symptoms after periods of activity.

Physical examination revealed mild swelling, no erythema, no ecchymosis, maintained motion, and maintained strength. Petitioner was placed at maximum medical improvement and instructed to return on an as needed basis.

Dr. Golz' deposition was taken on July 27, 2018. He testified consistent with his office records. Dr. Golz noted the last time he evaluated Petitioner was on July 18, 2017 and Petitioner had not reported any ongoing issues with his right knee since that time.

Dr. Paletta's deposition was taken on December 19, 2018. He testified consistent with his reports. Dr. Paletta maintained the October 27, 2016 meniscal repair was causally related to the work incident and that Petitioner would have reached maximum medical improvement approximately three months after the surgery. He believed that any treatment or restrictions imposed thereafter would not be work related.

Petitioner testified at trial that he resumed working his regular job duties as a press operator without restriction beginning February 21, 2017. He testified that he is able to perform his job duties but would have some difficulty when there is an issue with his machine and he has to climb two steps to fix the issue. He testified this does not occur very often. He usually seeks assistance from co-workers and maintenance to resolve the issue. He testified that some aspects of his job are now easier than before. Petitioner testified he develops knee soreness after driving long periods of time. Petitioner testified he has some difficulty ascending from a toilet or chair. He testified that he has swelling in his legs after a strenuous day. Outside of work, Petitioner testified that he continues to deer hunt and fish. He loads and unloads his fishing boat into and out of the water by himself. He is still capable of playing with his grandchildren and chases his wife around. Petitioner testified he is subject to annual salary increases. He has not reported any ongoing complaints to Health Services and has not been reprimanded for his job performance.

Petitioner previously received an award of 20% loss of use of the right leg in case 94 WC 66230.

A Surveillance Report and Video documents Petitioner's activities outside of work on June 15, 2019. Petitioner was viewed fishing, driving his boat, sitting, standing, walking, bending at the waist, operating/steering the boat with a foot controlled trolling motor with his right foot, squatting, ascending/stepping up and down from the front deck of the boat. After three hours, Petitioner reportedly returned to the boat ramp, climbed up into and out of the boat, pulled the boat up onto the ramp with both hands, pushed the boat off the ramp with both hands, entering and existing his pickup truck, and loaded the boat onto his trailer. No limitations of the right knee were identified with these activities.

Respondent paid two days of temporary total disability benefits covering October 30, 2015 through October 31, 2015. A medical payment printout reflects Respondent paid for medical services up to December 2016. The parties stipulated Respondent is entitled to a credit for those payments. A bill summary reflects there remains a zero balance for remaining medical bills.

Therefore the Arbitrator concludes:

(1) Petitioner's medial and lateral meniscal tears resulting in surgical repair are causally related to the December 3, 2014 work accident. The work related condition reasonably resolved three months after the October 27, 2016 surgery. Petitioner's underlying pre-existing osteoarthritis was not related to the work injury. Petitioner's condition of ill-being as related to the osteoarthritis was neither caused nor aggravated by the work incident. Treatment rendered and charges associated with treatment for the osteoarthritis condition are not causally connected to the work accident.

(2) Petitioner currently has disability to the extent of **27.5% loss of use of the right leg** under Section **8(e)(12)** of the Act. Petitioner previously received an award of 20% loss of use of the right leg in case 94 WC 66230 for which Respondent is entitled to a credit. Thus, Respondent shall pay Petitioner the sum of **$463.15/week** for a further period of **16.125 weeks**, equaling 7.5% loss of use of the right leg, for injuries sustained in case 16 WC 11115.

In determining the level of permanent partial disability, the Arbitrator considers the following factors:

(i) Petitioner did not submit an AMA impairment rating report and this factor is given no weight.
(ii) Petitioner resumed working his regular job on February 21, 2017, and continues working his regular job duties without restriction. He has not been reprimanded for his performance and is capable of continuing his job despite the injury. He continues working his regular hours. This factor is given some weight.
(iii) Petitioner was 53 years at the time of his injury and will not have to live and work with his purported symptoms as long as a younger individual. This factor is given some weight.
(iv) Petitioner's future earning capacity was not diminished by the injury and he is subject to annual cost of living raises. This factor is given some weight.
(v) Petitioner credibly testified that he has some minor residual symptoms following his release from care. This factor is given some weight.

(3) Respondent is entitled to a credit for any medical payments made through the group insurance provider and any advanced permanent partial disability benefit payments.

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

Aja Carpenter,
Petitioner,

vs.

Chicago Transit Authority,
Respondent.

20IWCC0313

NO: 09 WC 15868

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, bills, temporary disability and permanent disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

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

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: JUN 10 2020
o5/21/20
DLS/rm
046

Deborah L. Simpson

Deborah L. Simpson

Barbara N. Flores

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

20IWCC0313

CARPENTER, AJA
Employee/Petitioner

Case# **09WC015868**

CHICAGO TRANSIT AUTHORITY
Employer/Respondent

On 3/14/2019, 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:

2339 CHRISTOPHER FREEMAN LAW OFFICE
155 N MICHIGAN AVE
SUITE 706
CHICAGO, IL 60601

0515 CHICAGO TRANSIT AUTHORITY
J BARRETT LONG
567 W LAKE ST 6TH FL
CHICAGO, IL 60661

20 IWCC0313

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

AJA CARPENTER
Employee/Petitioner

v.

CHICAGO TRANSIT AUTHORITY
Employer/Respondent

Case # **09** WC **15868**

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 **February 14, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **March 14, 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 was but currently ***is not*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**57,574.40**; the average weekly wage was $**1,107.20**.

On the date of accident, Petitioner was **30** 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 $**3,200.00** in non-occupational disability benefits, for a total credit of $**3,200.00**.

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

ORDER

The Arbitrator finds that the Petitioner sustained accidental injury arising out of and in the course of her employment on March 14, 2009. The Arbitrator further finds that her condition and treatment from March 15, 2009 through July 10, 2009 was causally related to the accident. The Petitioner's condition thereafter was no longer causally related to the March 14, 2009 accident.

Respondent shall pay Petitioner temporary total disability benefits of $738.13 per week for 16-4/7 weeks, commencing March 15, 2009 through July 8, 2009, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $3,200.00 for non-occupational indemnity disability benefits that have been paid via Respondent pursuant to Section 8(j) of the Act, and shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay reasonable and necessary medical services of $4,481, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $664.32 per week for 5 weeks, because the injuries sustained caused the loss of use of 1% 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 10, 2009** through **February 14, 2019**, and shall pay the remainder of the award, if any, in weekly payments.

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

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

Signature of Arbitrator

March 13, 2019
Date

STATEMENT OF FACTS

Petitioner testified that she has worked for the CTA as a bus driver since April 2003, mainly on the south side and downtown areas out of the 77th Street garage. On 3/14/09, she was driving the bus on 71st Street between Cottage Grove and King Drive, near St. Calabenas. She started around 9 a.m. that day, a Saturday. Around 3 p.m. while driving westbound on 71st , Petitioner testified she saw a man out of her driver's side window shooting at someone else who was shooting back at him across 71st Street in front of the bus. She testified that the bus was in the crossfire, but no one was physically hurt.

Petitioner testified that she was scared and wanted to jump out of her seat, but she had her seat belt on, so she just kept driving. The bus passengers, maybe 10 to 15 of them, got down to the floor of the bus. She testified that she drove to the next terminal near State and Lafayette, called the CTA control center controller to let them know what happened. She was instructed to discontinue bus service and to remain at the location for further instruction. Petitioner filled out an incident report and the person who interviewed her, who she believed was Ms. Hudson, stopped her from continuing her shift.

Petitioner did not immediately seek treatment. She was not scheduled to work the next two days (Sunday and Monday). She contacted Dr. Kelley, who she heard about from a co-worker, on Sunday and got an appointment for the next day, Monday.

On 3/17/09, Petitioner saw Dr. Kelley, testifying that she was feeling stressed out and worried for "different reasons." She had to do the same route daily, 5 days/week, and there was no way.

Petitioner treated with Dr. Kelley from 3/17/09 to 7/10/09. He would ask her about the job and what happened, and he gave her some types of diagnostic testing. At some point, he had her participate in "exposure therapy", which involved a gradual exposure to buses and bus-related situations. Petitioner testified she also treated with Dr. Beck, who prescribed her medications.

Clinical Psychologist Dr. Kelley's 3/17/09 report notes Petitioner presented after a 3/14/09 incident where her bus was "reportedly caught under gunfire by two gunmen." She reported a prior history of anxiety disorder. Multiple diagnostic tests were performed in addition to the clinical interview. Dr. Kelley indicated Petitioner

stated: ". . . a male jumped out in the middle of the street. He approached the front driver's side window and he then pulled out a gun, pointed it, and started shooting right in front of the bus. We all screamed and everyone jumped down. Then the shooting started coming from the opposite direction. The bus was right in the crossfire. I kept the bus going while I kept my head down. I was afraid I was going to be shot and killed. I was shaking." She reported since experiencing problems sleeping, nightmares, flashbacks, headaches, tremors, social avoidance and agitation. Her affect appeared restricted and her mood anxious. Based on the interview and testing, Dr. Kelley indicated Petitioner had severe levels of depression and anxiety, characterized by somatic complaints and depressed mood. The diagnosis was adjustment disorder. He prescribed psychotherapy, referral for psychiatric consultation for possible medication and continued leave of absence from work. He wanted a transitional work program and anticipated a return to work as a bus driver in 6 to 9 weeks. (Px1).

Minimal records were submitted of Dr. Kelley covering four dates between 3/17/09 to 4/6/09, which provide no information regarding any clinical discussions, and there are no notes between 4/6/09 and 7/10/09 other than a couple of off work notes on 5/21/09 and 6/25/09. Dr. Kelley issued a discharge report on 7/10/09. He reported that Petitioner evidenced significant progress in emotional/psychological functioning, though she reported episodic periods of symptom exacerbation. She had been released to return to four hour shifts on 4/6/09. Techniques included psycho-education, cognitive restructuring and stress management strategies. She participated in "progressive exposure" back to her work environment. She was released to full duty as of 7/8/09 as a bus driver, her medications had been discontinued, and Petitioner verbalized a desire to discontinue treatment. (Px1).

There is only one report of Dr. Beck, dated 3/23/09, which states: "Chart reviewed. Daily anxiety. Vigilance. Sleep latency. Unchanged from _____ (illegible). Seroquel was prescribed and Petitioner was to follow up in one week. (Px2).

Petitioner returned to her regular duty work on 7/10/09 and she had discontinued her related medications by then. She testified that she did not feel ready to go back at that time, but she had to. While she testified that the therapy was helpful, she just felt she still wasn't really up to dealing with the day-to-day issues on the bus that impacted her, such as arguments.

When the Petitioner returned to work she testified that she went back at a west side garage at Kedzie that was about 30 miles further away from her prior garage. She testified this involved being in a new environment that she had to get used to with new bus routes. Petitioner testified she chose to return to the 77th street garage because it was her "home garage" and she lives much closer to it than the Kedzie garage.

Petitioner has not sought any further treatment since July 2009. She testified that prior to the accident she used to feel like the job was fun, but that it now feels like more of a regular job. She felt she has become a better driver.

On cross, Petitioner agreed that she gets to choose which garage she wants to work out of every two years and gets to choose a route every three months. As such, the garages and routes she's had were chosen by her, including her current garage and route. She agreed the shooters on the street had no connection to the bus and had not been passengers. She agreed no shots had been fired at the bus, no one on the bus was hurt and she did not see any blood. There were other cars and pedestrians on the street in the area of the incident. She continued on with her route after the incident and didn't stop and call the police. Petitioner agreed she sustained no physical injuries and did not seek emergency treatment. She completed an accident report on 3/16/09. Petitioner testified she had initially been released to return to work initially with restrictions, but when she actually went back to work she was under no restrictions.

The Arbitrator reviewed multiple views of the what occurred on 3/14/09 via cameras that were installed on the bus. The bus was driving westbound and approaching an intersection. One view shows two guys moving towards the sidewalk on the southeast corner of the intersection to the left in the Petitioner's view while shooting across the street in front of the bus and across the intersection towards guys running towards the sidewalk to the right in the Petitioner's view further west of the northwest corner of the intersection. The shooter on the left appeared to be less than a quarter of a block to the west of the front of the bus and the others were to the right on the other side of the intersection in front of the bus per the arbitrator's view. There was no sound, and while the individual towards the left had his arm raised in a shooting stance, there is no way to tell if actual shooting was occurring or how often just by viewing the video. However, there did appear to be shooting going across the street, and Petitioner's testimony was that shooting was occurring.

Petitioner submitted medical expenses she alleges are causally related to her alleged 3/14/09 accident from Dr. Kelley ($4,236.00) and Dr. Beck ($245.00).

CONCLUSIONS OF LAW

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

The Arbitrator finds that the Petitioner has proven a compensable accident occurred which arose out of and in the course of her employment on 3/14/09.

Petitioner claims a "mental-mental" injury, which is compensable when the employee experiences a severe emotional shock traceable to a definitive event, without any physical trauma aspect to the claim.

The seminal "mental-mental" case in Illinois is *Pathfinder Company v. Industrial Commission*, 62 Ill.2d 556 (1976). There, the claimant, while at work, heard cries for help and turned around to witness a coworker's hand caught in a machine press that ultimately was severed. The claimant pulled the severed hand from the machine and then fainted, after which she developed anxiety and a mental reaction to the situation. In *Pathfinder* the Court reasoned that the direct observation of the shocking physical situation directly caused the Petitioner's mental stress and was of such a magnitude as to be an accident under the Act, specifically stating that an employee who suffers a sudden, severe emotional shock traceable to a definite, time, place and cause which causes psychological injury or harm has suffered an accident within the meaning of the Act though no physical trauma or injury was sustained.

In the case at bar, the Petitioner was driving her bus down a street when just in front of her someone was shooting across the street at someone else. The Arbitrator believes this constitutes a sudden and severe emotional shock that meets the standard outlined in *Pathfinder*. The video of the incident presented into evidence shows that the Petitioner was not far at all from the intersection where this shooting was occurring. It is understandable that the Petitioner would have felt that her life could have been in danger.

Petitioner testified that her close proximity to the gunfire left her "scared and nervous," and the records of Dr. Kelley support this testimony. Petitioner's trauma continued into the following three days when she was taken out of service by Respondent and initially presented to Dr. Kelley.

The risk of such an exposure, in the Arbitrator's view, was increased based on the Petitioner having to drive a specific route through the streets, which is not something required of the general public.

WITH RESPECT TO ISSUE (F), IS THE PETITIONER'S PRESENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that the accident resulted in the Petitioner's treatment with Dr. Kelley and Dr. Beck. There is no evidence which would indicate any other basis for this treatment. That being said, the Arbitrator finds that the Petitioner's causally related condition of ill-being ended as of 7/10/09. There has been no evidence of treatment for almost nine years since that time. Dr. Kelley indicates the Petitioner's emotional distress after the accident was related to the accident, and no evidence has been presented to rebut this.

WITH RESPECT TO ISSUE (J), WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY AND HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that the Respondent is liable for the medical expenses of Dr. Kelley ($4,236) and Dr. Beck ($245.00). The Arbitrator questions the extent and efficacy of this treatment given the paucity of information contained in the records of Dr. Kelley between 3/22/09 and 7/9/09. However, the reports from 3/21/09 and 7/10/09 indicate a basis for finding that there was evidence of a level of emotional distress that was related to the accident, and that the Petitioner had significantly recovered.

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

The Arbitrator finds that the Petitioner is entitled to TTD from 3/15/09 through 7/8/09 based on her being taken off work during this period of time by Dr. Kelley.

Respondent is entitled to credit for $3,200 in paid non-occupational disability benefits, and Respondent shall hold the Petitioner harmless with regard to same, pursuant to Section 8(j) of the Act.

WITH RESPECT TO ISSUE (L), WHAT IS THE NATURE AND EXTENT OF THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

Pursuant to §8.1b of the Act, the following criteria and factors must be weighed in determining the level of permanent partial disability for accidental injuries occurring on or after September 1, 2011:

(a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall report the level of impairment in writing. The report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment. The most current edition of the American Medical Association's (AMA) "Guides to the Evaluation of Permanent Impairment" shall be used by the physician in determining the level of impairment.

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

(i) the reported level of impairment pursuant to subsection (a);

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

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that neither party has submitted an AMA permanent partial impairment rating or report into evidence. This factor carries no weight in the permanency determination.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as a bus driver at the time of the accident and that she has since returned to her regular job. The Arbitrator finds that this factor carries some weight which tends to show a lesser degree of permanency.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 30 years old at the time of the accident. Neither party has presented evidence which would reflect how the Petitioner's age could impact any permanent disability resulting from this accident. This factor carries no weight in the permanency determination.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that no evidence was presented which indicates that the Petitioner's future earning capacity has been negatively impacted by the 3/14/09 accident. This factor carries some weight which does not tend to show a greater degree of permanency.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that the records of Dr. Kelley, outside of his initial report, are extremely minimal. They state virtually nothing with regard to what treatment was being provided outside of a plan of care. They state nothing with regard to any discussions with Petitioner or any potential other life stressors she may have been experiencing.

While the Arbitrator has determined that the shooting taking place was close enough to the Petitioner to constitute a compensable mental-mental claim, the Arbitrator also believes that the description of the incident she provided to Dr. Kelley was somewhat exaggerated. She was not "caught under gunfire." The Petitioner also attempted at one point to testify that the bus was more or less being used by one of the gunmen as a shield, while the video shows the incident occurred way too far in front of the bus for it to have been used in such a manner. The level of distress noted by Dr. Kelley in two narrative reports seem excessive to the Arbitrator given the circumstance the Petitioner was in. The Petitioner reported a history of anxiety to Dr. Kelley. While the claim has been found compensable, it is also accurate that the Petitioner continued on her bus route after the incident, some of which was depicted in the video, with no apparent problems, and she then did not immediately report the incident to the Respondent. There has been no further treatment indicated since July of 2009.

Based on the above factors, the record taken as a whole and a review of prior Commission awards with similar injuries similar outcomes, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of the loss of use of 1% of the person as a whole pursuant to §8(d)2 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF SANGAMON)

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

Mack Raikes,
Petitioner,

vs.

NO: 18 WC 23266

City of Springfield,
Respondent.

20IWCC0314

DECISION AND OPINION ON REVIEW

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

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

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: JUN 10 2020
o5/7/20
DLS/rm
046

Deborah L. Simpson
Deborah L. Simpson

Barbara N. Flores

Marc Parker
Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

20IWCC0314

RAIKES, MACK
Employee/Petitioner

Case# **18WC023266**

CITY OF SPRINGFIELD - CWLP
Employer/Respondent

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:

1189 WOLTER BEEMAN LYNCH ET AL
FRANCIS J LYNCH
1001 S 6TH ST
SPRINGFIELD, IL 62703

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

20IWCC0314

20 IWCC0314

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

MACK RAIKES
Employee/Petitioner

v.

CITY OF SPRINGFIELD - CWLP
Employer/Respondent

Case # **18** WC **23266**

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 **11/13/18**. 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 **5/27/18**, 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 **$90,840.97**; the average weekly wage was **$1,746.94**.

On the date of accident, Petitioner was **37** years of age, ***married*** with **2** dependent children.

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

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

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

ORDER

Respondent shall pay reasonable and necessary medical services of $95,362.80, as set forth in PX 4, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall also reimburse Petitioner for co-pays and deductables in the amount of $215.79.

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 $1,164.63/week for 13 weeks, commencing 5/29/18 through 8/27/18, as provided in Section 8(b) of the Act.

Respondent shall be given a credit for temporary total disability benefits that have been paid.

Based on the factors enumerated in §8.1b of the Act, which the Arbitrator addressed in the attached findings of fact and conclusions of law, and the record taken as a whole, the Respondent shall pay Petitioner permanent partial disability benefits of $790.64/week for 100 weeks, because the injuries sustained caused the 20% 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

7/25/19
Date

ICArbDec p. 2

JUL 25 2019

FINDINGS OF FACT

The Petitioner was a lineman for the City of Springfield. According to the Petitioner's testimony, as well as the testimony of Don Ott, Department Head, and Matt Huff, Petitioner's immediate supervisor, linemen were reconstructing underground power service at Westchester Subdivision in Springfield, Illinois. That work started sometime in late winter or early spring when the ground thawed. The job consisted of pulling out old cable, directional boring for placement of underground conduit, and pushing and pulling new power cable into place. The linemen were responsible for lifting, pulling, pushing, reconstructing, and reconnecting transformers and service facilities.

It was agreed by the witnesses that Mr. Raikes' job required substantial heavy duty physical activity, specifically including lifting up to 100 pounds and pushing and pulling rigid heavy cable.

In late March, the Petitioner experienced mild pain which was described by his chiropractor (PX. 1) as occasional dull and shooting discomfort in the upper back. On a scale of 1 to 10, with 10 being the most severe, he described the intensity as a 1.

He saw the chiropractor 2 more times in late April with similar complaints and again on May 10. The chiropractic records show the Petitioner's complaints gradually increasing during April and May. On May 16, he had notable neck and shoulder spasm, hypomobility, and endpoint tenderness. His complaints continued through visits on May 21 and 24.

According to the Petitioner, during the last week in May the physical activities required from his job increased and he performed an increasing number of tasks which related to lifting, pushing and pulling. During this period the Petitioner had to pull heavy cable through a number of transformers, which required heavy pulling. Both the Petitioner and Respondent's representatives testified that in May the physical demands of the work intensified.

Mr. Raikes testified that he had no specific single injury on Saturday, May 26 and went to bed at about 10:00 p.m. He woke up in the middle of the night on May 27 with severe radiating pain and numbness. These symptoms were worse than those he had experienced previously.

He sought emergency room treatment for his radicular symptoms and was released home.

He returned to the emergency room the next day and was instructed to see his family physician, Dr. Sandercock.

The Petitioner went to Dr. Sandercock's office following his second visit to the emergency room and Dr. Sandercock took a conservative approach to his condition.

At a subsequent visit with Dr. Sandercock on 6/4/18, the Petitioner continued to have symptoms consistent with radiculopathy. An MRI was ordered, and when completed the Petitioner was referred to Dr. William Payne, an orthopedic surgeon in Springfield.

Dr. Payne saw the Petitioner on June 19 and obtained a history from him. Dr. Payne diagnosed C6-7 radiculopathy caused by a large disc herniation. The history that Dr. Payne took was consistent with the

Petitioner's description of the onset of his symptoms along with the increased work and work activity required during the last weeks in May.

Dr. Payne testified that in his opinion the Petitioner's condition was directly causally related to his work as a lineman. He described the onset of symptoms as being consistent with a relatively small disc injury resulting from repetitive trauma and then a more significant disc herniation and nerve entrapment resulting from increased activity close to the time of onset of symptoms. According to Dr. Payne, the Petitioner described a classic C7 radiculopathy from a disc herniation at C6-7 (PX 5, pg. 9).

Dr. Payne's description of the Petitioner's job and the nature of his work was consistent with the testimony presented to the Arbitrator (PX 5, pg. 7) and demonstrated his familiarity with the work of a lineman. Dr. Payne testified that the Petitioner's condition was causally related to Petitioner's work and work activities as described by the Petitioner. According to Dr. Payne: "My opinion is that whenever he was doing all of this pulling of wire through the conduit, he damaged a disc in his neck and that's why I think he was getting all of his pain in the neck that radiated down into the scapula and then at some point he herniated more disc out so basically I think he probably had a small herniation, some sort of injury to that disc and then at some point he got this big herniation and that's what woke him up in bed." (*Id.* at 13-14).

Dr. Payne performed an anterior cervical diskectomy on 8/1/18. He removed the disc and then did a fusion between C6 and C7. He put a plastic spacer in place at that level with bone graft. He then put a plate over the front of the spine with screws to hold the spacer in position (*Id.* at 15).

Petitioner followed up with Dr. Payne's nurse practitioner, Rebecca Harris, on 8/16/18. Petitioner reported at that time that his radiculopathy was completely gone. He had no more pain and the numbness and tingling were gone. His weakness had greatly improved since the surgery. Petitioner was complaining of some pain between his shoulder blades. Petitioner indicated that he was ready to go back to work. He was given a release to return to work without restrictions as of 8/23/18 (PX2). He actually did not return to work until 8/28/18.

CONSLUSIONS

The Arbitrator notes the reasonableness and necessity of the medical treatment Petitioner received nor did they dispute the period of Petitioner's temporary and total disability. They disputed only their liability to pay those benefits based on the issues of accident and causal connection.

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

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

An injury is accidental within the meaning of the Act if "a workman's existing physical structure, whatever it may be, gives way under the stress of his usual labor." *Laclede Steel. Co. v. Industrial Commission*, 128 N.E.2d 718, 720 (Ill. 1955); *General Electric Co. v. Industrial Commission*, 433 N.E.2d 671, 672 (Ill. 1982). In a repetitive trauma case, issues of accident and causation are intertwined. *Elizabeth Boettcher v. Spectrum Property Group and First Merit Venture,* 99 I.I.C. 0961 (1999). Accidental injury need not be the sole causative factor, nor even the primary causative factor, as long as it is a causative factor in the resulting condition

of ill-being. *Sisbro, Inc. v. Indus. Comm'n*, 797 N.E.2d 665, 672-73 (Ill. 2003) (emphasis added). As in establishing accident, to show causal connection Petitioner need only show that some act or phase of the employment was a causative factor of the resulting injury. *Fierke v. Industrial Commission*, 723 N.E.2d 846 (3rd Dist. 2000).

In *Edward Hines Precision Components v. Indus. Comm'n,* 825 N.E.2d 773, (2nd Dist. 2005). the Court expressly stated, "There is no legal requirement that a certain percentage of the workday be spent on a task in order to support a finding of repetitive trauma." *Id.* at N.E.2d 780. Similarly, the Commission noted in *Dorhesca Randell v. St. Alexius Medical Center*, 13 I.W.C.C. 0135 (2013), a repetitive trauma claim, a claimant must show that work activities are a cause of his or her condition; the claimant does not have to establish that the work activities are the sole or primary cause, and there is no requirement that a claimant must spend a certain amount of time each day on a specific task before a finding of repetitive trauma can be made. *Randell* citing *All Steel, Inc. v. Indus. Comm'n*, 582 N.E.2d 240 (2nd Dist. 1991) and *Edward Hines supra.*

In this case, the evidence shows that Petitioner used his hands and arms extensively during the late winter through the spring of 2018. He was required to push and pull large electric cables through underground conduit which required great force. Respondent's other two employees who testified corroborated Petitioner's testimony regarding the extreme force required to push and pull the cable.

The Arbitrator finds that the opinions of Dr. Payne are well reasoned and credible. The history given by the Petitioner to the doctor is consistent with the accident report presented by the Petitioner to his employer and with the Petitioner's testimony before the Arbitrator. The Petitioner's job description is also consistent with the testimony of his immediate and departmental supervisors.

The Arbitrator notes that Dr. Payne was clear in opining that the Petitioner's condition was work-related. The Respondent offered no contrary opinions, and Dr. Payne's opinions were unrebutted.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner has met his burden of establishing that he sustained accidental injuries which arose out of and in the course of his employment with Respondent and that his current condition(s) of ill-being are causally related to the employment.

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

Petitioner incurred medical expenses totaling $95,362.80. (PX4) This figure includes $215.79 which Petitioner paid out of Pocket. Having found in favor of Petitioner regarding issues C & F above, the Arbitrator finds Respondent is responsible for these charges.

Respondent shall pay reasonable and necessary medical services of $95,362.80, as set forth in PX 4, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall also reimburse Petitioner for co-pays and deductables in the amount of $215.79. 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 parties agreed that Petitioner was temporarily and totally incapacitated from 5/29/18 through 8/27/15. Having found in favor of Petitioner regarding issues C & F above, the Arbitrator finds Respondent is responsible for TTD benefits during this period.

Respondent shall pay Petitioner temporary total disability benefits of $1,164.63/week for 13 weeks, commencing 5/29/18 through 8/27/18, as provided in Section 8(b) of the Act. Respondent shall be given a credit for temporary total disability benefits that have been paid.

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 is trained as a lineman and is expected to continue that work until his retirement. Dr. Payne testified about the effects this injury will have on the Petitioner and on his future work capacity. The Petitioner is released to full duty. However, according to Dr. Payne, the Petitioner is more likely than not to require future operative intervention at the vertebral segment immediately above the area where he had the fusion (PX 5, pg. 26). Adjacent segment disease describes the phenomenon associated with ongoing degeneration and disability associated with the vertebral segments immediately adjacent to a level of fusion. It is more than 80% likely that at some time in the future the Petitioner will require treatment for adjacent segment disease above and below the operative site directly related to limitations of motion resulting from fusion at the C6-7 level (*Id.* at 16-17).

According to the testimony of his surgeon, his fusion and adjacent segment disease will limit the Petitioner's future work and work activities and will likely affect his work life, including any possible future sedentary or supervisory work assignment (*Id.* at 28) The Arbitrator therefore gives *greater* weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 37 years old at the time of his injuries. Petitioner has long work life expectancy and will have to live with the residuals of his injury 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 there is no direct evidence of reduced earning capacity contained in the record. The Arbitrator therefore gives *no* weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes the Petitioner was a credible witness. As a result of his intensive, heavy physical employment, Petitioner sustained a large disc herniation an C6-7 which was causing Radiculopathy.

The Petitioner went to Dr. Sandercock's office following his second visit to the emergency room and Dr. Sandercock took a conservative approach to his condition.

At a subsequent visit with Dr. Sandercock on 6/4/18, the Petitioner continued to have symptoms consistent with radiculopathy. An MRI was ordered, and when completed the Petitioner was referred to Dr. William Payne, an orthopedic surgeon in Springfield.

Dr. Payne saw the Petitioner on June 19 and obtained a history from him. Dr. Payne diagnosed C6-7 radiculopathy caused by a large disc herniation. The history that Dr. Payne took was consistent with the Petitioner's description of the onset of his symptoms along with the increased work and work activity required during the last weeks in May.

Dr. Payne testified that in his opinion the Petitioner's condition was directly causally related to his work as a lineman. He described the onset of symptoms as being consistent with a relatively small disc injury resulting from repetitive trauma and then a more significant disc herniation and nerve entrapment resulting from increased activity close to the time of onset of symptoms. According to Dr. Payne, the Petitioner described a classic C7 radiculopathy from a disc herniation at C6-7 (PX 5, pg. 9).

Dr. Payne performed an anterior cervical diskectomy on 8/1/18. He removed the disc and then did a fusion between C6 and C7. He put a plastic spacer in place at that level with bone graft. He then put a plate over the front of the spine with screws to hold the spacer in position (*Id.* at 15). Petitioner did well post surgery and was released to return to work and did return on 8/28/18.

Because the medical records, and the evidence taken as a whole, corroborate the Petitioner's injury and treatment, including the likely hood of further treatment in the future, the Arbitrator therefore gives *greater* weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 20% loss of use of the person as a whole pursuant to §8(d)2 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF SANGAMON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Chrissie Washington,
Petitioner,

20IWCC0315

vs.

NO: 09 WC 24200

SOI/Department of Aging,
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, notice, permanent disability and temporary disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 21, 2019, is hereby affirmed and adopted.

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

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

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: JUN 10 2020
o5/7/20
DLS/rm
046

Deborah L. Simpson

Deborah L. Simpson

Barbara N. Flores

Barbara N. Flores

Marc Parker

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

20IWCC0315

WASHINGTON, CHRISSIE
Employee/Petitioner

Case# **09WC024200**

STATE OF ILLINOIS
Employer/Respondent

On 5/21/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.34% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0352 LaMARCA LAW OFFICE PC
WILLIAM LaMARCA
1118 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

MAY 21 2019

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

20IWCC0315

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Chrissie Washington
Employee/Petitioner

Case # **09** WC **24200**

v.

Consolidated cases: _____

State of Illinois
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Springfield**, on **February 28, 2019. The parties have agreed to the rendering of a decision based on the record as submitted by Thomas L. Ciecko, Arbitrator of the Commision.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **July 31, 2008**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

In the year preceding the injury, Petitioner earned $**45,585.00**; the average weekly wage was $**876.00**.

On the date of the claimed accident, Petitioner was **48** years of age, ***single*** with **0** dependent children.

Respondent is not responsible for medical services for Petitioner.

Respondent is not responsible for payment of charges for such services.

ORDER

Denial of Benefits

Because Petitioner did not sustain an accident that arose out of and in the course of her employment and her current condition of ill-being is not causally related to any incident that arose out of and in the course of 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

5·21·19
Date

MAY 21 2019

Chrissie Washington v. State of Illinois, No. 09 WC 24200

Preface

The parties proceeded to hearing February 28, 2019, before Arbitrator Douglas McCarthy nearly 10 years after Petitioner filed an Application for Adjustment of Claim in this matter, on a Request for Hearing indicating the following disputed issues: whether Petitioner sustained accidental injuries that arose out of and in the course of employment; whether Respondent was given notice of the accident within the time limits stated in the Act; whether Petitioner's current condition of ill-being is causally connected to this injury; whether Respondent is responsible for unpaid medical bills; whether Petitioner is entitled to a period of temporary total disability; and what is the nature and extent of the injury. Chrissie Washington v. State of Illinois, No. 09 WC 24200 Transcript of Proceedings on Arbitration at 4; Arbitrator's Exhibit 1; Arbitrator's Exhibit 2. Those stipulations bind the parties. Walker v. Industrial Commission, 345 Ill. App. 3d 1084 (2004).

Subsequent to the hearing but prior to the rendering of a decision, Arbitrator McCarthy was appointed as a member of the Workers' Compensation Commission. The parties agreed to my rendering a decision based on the record as submitted. Bill@lamarcalawoffice.com "[External] re: Washington v. State of Illinois, Department of Aging, No. 09 WC 24200" received by Ciecko, Thomas. Date of message Wednesday, May 1, 2019, 2:57 p.m.; Grubb, Chelsea "[External] fw: Washington v. Department on Aging, 09 WC 24200" received by Ciecko, Thomas. Date of message Wednesday, May 1, 2019, 3:39 p.m.

Three witnesses testified, Petitioner and via evidence deposition, Dr. Nada Berry and Dr. Anthony Sudekum.

Findings of Fact

Chrissie Washington (Petitioner), a 48 year old female, filed an Application for Adjustment of Claim June 8, 2009, stating an accident occurred July 31, 2008, by repetitive work injuries affecting her left arm, left hand, right arm, and right hand. She stated the nature of the injury as recurrent carpal tunnel and cubital tunnel syndrome. She had previously filed two claims, 04 WC 018035 and 04 WC 18036, alleging accidents March 10, 2003, and November 12, 2003, by repetitive work activities affecting both hands with the nature of the injury being bilateral carpal tunnel syndrome. Those claims settled June 28, 2006, for $39,245.72. Arbitrator's Exhibit 1; Arbitrator's Exhibit 2; Respondent's Exhibit 3.

Petitioner testified she started working for the State of Illinois in 1984 going from the Department of Revenue into the Department on Aging, and finally in 2011 to DHS. She

described her job duties involving copying, writing, keyboarding, phone work, and handling papers. While Petitioner merely testified to an overview of her duties, they are clearly the everyday garden variety office clerical positions commonplace in Illinois. She offered no testimony as to what constituted the repetitive nature of her work or any real detail about the work. Washington at 10-11, 16, 11-12, 17, 35-36, 38, 41.

Petitioner testified her claim involves an accident that happened on or about July 3, 2008, pointing to nothing specific, saying merely she was having issues with her hand. She testified she saw Dr. Hasen July 31, 2008. Without objection, she said he seemed to think there was a relationship between her work condition and her hand. Washington at 10, 18, 19. A review of Dr. Hasen's records suggests this is fiction. Petitioner's Exhibit 1 (unpaginated).

The records of Dr. Thomas Hasen, presumably from some adjunct of SIU, indicated Petitioner first saw Hasen July 31, 2008, complaining of left hand and shoulder pain, and numbness. He noted a carpal tunnel release on the left by Dr. Freitag. He thought it was possibly recurrent carpal tunnel syndrome versus cervical radiculopathy. He saw Petitioner four more times until July 25, 2009. At that time, Petitioner complained only of left shoulder pain. Hasen noted Petitioner had probably cubital tunnel syndrome, which was minimally symptomatic. Petitioner had participated in physical therapy for left shoulder impingement and was clinically improved. She was told to return as needed. Almost a year later, June 1, 2010, Petitioner returned to Hasen, who noted she complained of increased pain in the neck, radiating into the left hand. Hasen assessed Petitioner with bilateral cubital tunnel syndrome, possible right carpal tunnel syndrome in a setting of double crush. She was told to follow up with Dr. Freitag. Petitioner's Exhibit 1 (unpaginated). Despite Petitioner's sworn testimony to the contrary, in none of the records of Hasen was a particular event or occurrence referenced as causing any condition of Petitioner. In none of Hasen's records was there a reference or opinion expressed that any condition was related to or caused by Petitioner's employment.

Petitioner testified she continued working and worked, except for an eight week period of time in 2017 after surgery, from 2008 through the date of hearing. Washington at 21, 25, 29-30.

Petitioner testified she saw Dr. El-Amin in 2010. Washington at 23.

The records of SIU, of Dr. Saadiq El-Amin, indicate that Petitioner did not, as recommended by Dr. Hasen, follow up with Dr. Freitag. Many months later, she saw El-Amin. There are vast gaps in medical treatment from El-Amin of three months, almost three years, and a year, then four months, which Petitioner never explained. Petitioner saw El-Amin in March 2011, December 2013, December 2014, and April 2015. All that can be gleaned from these disparate records is that Petitioner had no interest in any surgery. She admitted she had not followed through with physical therapy, specifically for her hands and carpal tunnel syndrome. Petitioner's Exhibit 4 (unpaginated). As with Dr. Hasen, no events or occurrence referenced a cause for any condition of Petitioner. El-Amin neither referenced nor expressed any opinion that any condition was caused by Petitioner's employment.

During the period of time Petitioner was treating with El-Amin, as well as two other instances, December 10, 2013, May 29, 2015, and February 28, 2017, Petitioner apparently

underwent nerve conduction studies and an EMG by Dr. Edward Trudeau of something called the Center for Neuromuscular Sciences. I say apparently because of the stark contract to a report of Dr. Zend Wang at SIU Healthcare of January 12, 2011, and a report of Dr. Devlesc Howard at SIU Healthcare November 25, 2014. See Petitioner's Exhibit 5; Petitioner's Exhibit 9. Trudeau's documents cross the bounds of medical treatment and evaluation into exaggerated testimonial advocacy. They are at best mere puffery, and at worst outlandish nonsense. Instead of referring to Petitioner as the patient or Ms. Washington, he refers to her 27 times as "a very pleasant lady" or some variation. He gushes over Petitioner's doing a fine job on her questionnaire, her courteous and professional interaction with health care professionals, and who "...despite physical difficulties that many other individuals would have found to be essentially disabling, she continues to keep going...." He stated unwarranted commentary on Petitioner's medical providers, "the excellent Dr. Miller"; "some of the very best doctors, Dr. El-Amin, Dr. Freitag, Dr. Saunders, Dr. Miller....". Trudeau stated Petitioner was fortunate to be working with some of the very best physicians and healthcare professionals anywhere. He continued to refer to "the excellent Dr. El-Amin"; "the eminent Dr. Freitag"; and "the excellent Dr. Berry, one of the very best hand specialists." Trudeau offered rampant speculation throughout, about 20 treatment options, nine speculative diagnoses, and gushed "we do hope she will continue to improve and will be able to continue with her work activities for the State of Illinois." Petitioner's Exhibit 8 (unpaginated); Petitioner's Exhibit 13 (unpaginated); Petitioner's Exhibit 15 (unpaginated). I give no weight to Trudeau whatsoever. His surreal submissions are long on tripe and short on evidence of medical matters. They offer nothing on the relationship between any condition of Petitioner and her employment.

Petitioner testified she ended up seeing Dr. Freitag, who saw her for a fender bender, and she was having neck issues. Washington at 24.

Petitioner finally found her way to Dr. Freitag about five years after Dr. Hasen told her to follow up with him. She saw Dr. Freitag May 13, 2015, who noted he had seen her for left carpal tunnel release in the past. He noted she was doing well until a motor vehicle accident in July 2014. Freitag diagnosed her with bilateral median nerve neuropathy and cervical neck pain and continued physical therapy. By her last visit wit Freitag, six years after filing her Application for Adjustment of Claim, Freitag noted in a Complete Problems list for Petitioner, 28 medical conditions. Among them were: neck, shoulder, leg, abdominal, knee, low back, and elbow pain. Also, hypertension, obesity, osteoarthritis, and carpal tunnel syndrome. Petitioner's Exhibit 10 (unpaginated). As with the previous medical providers, nothing referenced a cause for Petitioner's medical condition or relationship with Petitioner's employment.

During her treatment with Dr. Freitag, Petitioner took part in physical therapy at St. John's Hospital. In the records of St. John's, the Physical Therapy Initial Evaluation done May 8, 2015, seven years after Petitioner claims was the date of her accident, the therapist notes "patient states she cannot specifically think of any activity that aggravates her neck or brings on her symptoms." The therapist also noted "patient states she has been having paid in her neck, midback and shoulder for years now...." The therapist also noted Petitioner's "...skeptical

attitude towards physical therapy," and "...poor sitting posture." Petitioner's Exhibit 12 (unpaginated).

Petitioner testified Freitag recommended injections, but she did not like needles and did not like surgery. Petitioner said she wanted hands on therapy. This despite failing to follow through with physical therapy and recorded comments of her skeptical attitude towards physical therapy. Washington at 25; Petitioner's Exhibit 4 (unpaginated).

Petitioner testified she saw Dr. Berry in 2017. She did not explain how she came to do so. She said her symptoms were getting worse. She did not expand on those symptoms. Washington at 25, 26.

Two years after her last visit with Dr. Freitag and nine years after Petitioner indicated she had a work accident, she sought treatment from Dr. Nada Berry at SIU Institute for Plastic Surgery. She was seen for the first time February 13, 2017, for evaluation of bilateral upper extremity compression neuropathy symptoms. The records noted now 61 active problems including: abdominal, chronic back, chest, elbow, knee, arm, leg, low back, neck, shoulder, rib, flank, and sternal pain. Also noted were carpal tunnel syndrome, osteoarthritis, and morbid obesity. Petitioner was taking five medications, even tough there had been no documentation up to now of such prescriptions and was assessed with peripheral neuropathy. An EMG was recommended. In a follow up visit April 10, 2017, Petitioner's active problems had risen to 69. Berry recommended surgery. On April 3, 2017, Berry performed a right open carpal tunnel release; right open cubital tunnel release; and right long trigger finger release. Post operatively, Berry noted Petitioner was healing well and appropriately and expected a full recovery. Petitioner was returned to work September 28, 2017, with no restrictions. Petitioner's Exhibit 14 (unpaginated); Petitioner's Exhibit 17 (unpaginated).

Petitioner testified she discussed her job duties with Berry, who asked what she did and asked a lot of questions. Washington at 42. In light of Dr. Berry's testimony, this seems a complete fabrication and compromises Petitioner's credibility.

Dr. Berry testified she is board certified in plastic surgery and hand surgery. Her curriculum vitae admitted as Exhibit 1 to her evidence deposition shows her to be an Assistant Professor at SIU Healthcare, School of Medicine, who has practiced for eight years. Berry testified she started treatment of Petitioner in February 2017. She said she had access to the records of Dr. El-Amin and Dr. Freitag, but mostly focused on her own history and physical. Berry said she diagnosed Petitioner with carpal and cubital tunnel, and testified Petitioner provided no background on how long she had been having symptoms and did not share any details about her work activities. Berry testified she performed three procedures on Petitioner and referred her for hand therapy. Berry said she allowed Petitioner to return to full duty without restrictions September 13, 2017, the last time she saw Petitioner. Berry testified she and Petitioner did not talk about her work. She admitted Petitioner's sleeping position could cause or aggravate symptoms in carpal and cubital tunnel. Berry also admitted she never saw a picture of Petitioner's work station or read a formal job description for Petitioner. She testified Petitioner had carpal tunnel for a long time and so it was hard to really pinpoint if her work duties

aggravated or caused carpal tunnel. Petitioner's Exhibit 20 at 7, 8, 9, 10, 12, 14, 16, 18, 27, 29, 30.

Petitioner introduced into evidence and Berry testified about a letter she was sent by Petitioner's attorney June 26, 2017. That letter was a backdoor attempt to introduce Petitioner's work activities, as framed by her attorney, into her medical records where they had heretofore been absent. It contained a brief synopsis of selected medical treatment and without any context simply told Berry that Petitioner "...continued to work for the State of Illinois performing repetitive work activities." This was purely for use in this litigation. Berry responded October 20, 2017, indicating what she had done for Petitioner. Berry wrote, "SIU documentation shows that her work had at least aggravated her symptoms. That was a fabrication by Berry. A close reading of the medical records introduced in this case shows a complete absence of any event or occurrence causing Petitioner's condition, or any notation of any relationship between her work activities and her complaints. Moreover, Berry inasmuch as said she did not look at Petitioner's records, relying on her own history and physical. Berry testified the description of Petitioner's work activities was the first time she was familiarized with those work activities. Berry admitted she did not evaluate Petitioner's positioning of her wrists, and it was hard to pinpoint exactly what work activity could aggravate Petitioner's condition. She finally backed off her letter by equivocating that work activities could still be a contributing factor. Petitioner's Exhibit 9; Petitioner's Exhibit 20 at 8, 19, 21, 22, 26.

Petitioner submitted to an independent medical examination on April 24, 2018, by Dr. Anthony Sudekum, a board certified surgeon of the upper extremities. He performs almost 300 hand surgeries a year and performs surgeries from the elbow to fingertips. Sudekum testified he collected and reviewed records of Petitioner, evaluated her, took her history, conducted a physical examination, asked "...a lot of questions about work, what they do at work, how long they've been doing it...." He testified this was a very complex case with a lot of notes, many prior surgeries, and six to seven nerve conduction studies. He said as far as Petitioner's work history, all her jobs were clerical in nature. Sudekum testified one of the most significant aspects of Petitioner's medical history was that she developed relatively severe generalized osteoarthritic conditions throughout her body at a very young age, in her 30's. There was a strong genetic component present, and consideration given for total knee replacement. Petitioner had significant cervical problems that grew worse and worse over time. Petitioner, said Sudekum, had significant arthritis in her neck, lower back, shoulders, and hands. The arthritis was primarily due to genetic factors. Also, Petitioner was morbidly obese, which can have an effect on her extremities, neck, and back. Respondent's Exhibit 2 at 6-8, 9-11, 13, 14.

Dr. Sudekum testified, essentially, that Petitioner's pathology was in the neck, and sees workers' compensation cases that say carpal tunnel when the appropriate treatment should be the neck. Sudekum said he did a physical examination of Petitioner, finding her morbidly obese with arthritis in the base of the thumb. His diagnosis was resolved bilateral carpal tunnel syndrome and right cubital tunnel syndrome and right middle trigger finger. Her symptoms were consistent with some triggering of the right ring and left middle trigger fingers. She had arthritis of the bilateral thumb CMC joints, right elbow joint, neck, and shoulders, along with significant

bilateral knee arthropathy; significant chronic disc disease of the shoulder, cervical spine and lumbar spine, as well as bilateral knee. Dr. Sudekum testified, in his opinion, Petitioner developed bilateral carpal tunnel syndrome or symptoms, and right carpal tunnel syndrome or symptoms and the trigger digits in both hands due to multiple significant non-work related wrist factors she also suffered from as well as the comorbid conditions she had and/or symptoms regardless of employment. Sudekum testified on cross examination that the medical literature suggests that even typing up to seven hours a day is not going to cause or contribute to the development of carpal tunnel syndrome. He said his source of information on job duties was from Petitioner. Respondent's Exhibit 2 at 17, 18, 21, 22, 25, 29.

Conclusions of Fact

The decision in this case begins and ends with disputed issue **C**, did an accident occur that arose out of and in the course of Petitioner's employment, along with disputed issue **F**, is Petitioner's current condition of ill-being causally related to the injury. A claimant bears the burden of proving by a preponderance of the evidence that her injury arose out of and in the course of the employment. Both elements must be present in order to justify compensation. First Cash Financial Services v. Industrial Commission (Rios), 367 Ill. App. 3d 102, 105 (2006). In the course of employment refers to the time, place, and circumstances of the injury. If the injury occurs within the time period of employment, at a place 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 injury is deemed to have occurred in the course of employment. Eagle Discount Supermarket v. Industrial Commission, 82 Ill. 2d 331, 338 (1980). Arising out of employment pertains to the origin or cause of the claimant's injury. First Cash, supra at 105. A claimant must prove that some act or phase of employment was a causative factor in the injury. Vogel v. Illinois Worker's Compensation Commission, 345 Ill. App. 3d 780, 786 (2005). A repetitive trauma injury is one which has been shown to be caused by the performance of the claimant's job and has developed gradually over a period of time. Peoria County Belwood Nursing Home v. Industrial Commission, 115 Ill. 2d 524, 529 (1987). An employee alleging injury based on repetitive trauma must meet the same standard of proof as a claimant alleging a single definable accident. The difficulty in proving that injury resulting from repeated trauma arose out of and in the course of employment will pose a serious burden for a claimant. Peoria County Belwood Nursing Home v. Industrial Commission, 138 Ill. App. 3d 880, 885 (1985).

I find as a conclusion of law, Petitioner failed to prove an accident occurred that arose out of and in the course of Petitioner's employment by Respondent; and that Petitioner's current condition of ill-being is not related to any workplace accident or in any way connected to her employment. I rely on the following.

There is nothing in the records or reports kept by any of the treating physicians or healthcare providers of Petitioner concerning any relationship between Petitioner's work activities and her complaints or myriad conditions, nor is there any indication Petitioner ever discussed her job duties with any of them. Certainly not Dr. Berry, who testified she never

talked to Petitioner about her work. Petitioner's Exhibit 20 at 10, 18, 19, 29. Berry had no credible basis to say anything on this issue.

Except for a short period of time, Petitioner has worked full duty since 2008. This stands in stark contrast to Dr. Sudekum, who testified comprehensively on Petitioner's medical conditions, her history, work, and outside activities. I find his opinion that Petitioner's condition was due to non-work factors and comorbidity conditions credible and essentially unrebutted by any medical evidence that would establish Petitioner's medical conditions were work related.

In a workers' compensation claim, liability cannot rest upon imagination, speculation, or conjecture, but must arise from facts established by a preponderance of the evidence. Palos Electric Co. v. Industrial Commission, 314 Ill. App. 3d 920, 926 (2000). Petitioner fails to establish such evidence.

In view of the foregoing, the disputed issues of timely notice and payment of medical bills are moot. Because of the foregoing, no temporary total disability or permanent partial disability benefits can be or are awarded.

Arbitrator

5.21.19

Date

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jacqueline Robinson,
Petitioner,

vs.

Walmart,
Respondent.

20IWCC0316

NO: 15 WC 27066

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, bills, temporary disability and permanent disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 22, 2018, is hereby affirmed and adopted.

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

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

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

DATED: JUN 10 2020
o4/16/20
DLS/rm
046

Deborah L. Simpson

Deborah L. Simpson

Barbara N. Flores

Marc Parker

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

20IWCC0316

ROBINSON, JACQUELINE
Employee/Petitioner

Case# **15WC027066**

16WC019976
16WC022314

WALMART
Employer/Respondent

On 10/22/2018, 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 2.41% 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:

0612 DWYER AND COOGAN
CAROLEANN GALLAGHER
140 S DEARBORN ST SUITE 1603
CHICAGO, IL 60603

5074 QUINTAIROS PRIETO WOOD & BOYER
MICHAEL J SCULLY
233 S WACKER DR 70TH FL
CHICAGO, IL 60606

20IWCC0316

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

Jacqueline Robinson
Employee/Petitioner

v.

WALMART
Employer/Respondent

Case # **15** WC **027066**

Consolidated cases: **16 WC 019976**
16 WC 022314

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jeffrey Huebsch**, Arbitrator of the Commission, in the city of **Chicago**, on **2/8/2018, 3/2/2018 and 4/6/2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

20 IWCC0316

FINDINGS

On **June 8, 2015**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did 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 **$19,760.00**; the average weekly wage was **$380.00**.

On the date of accident, Petitioner was **50** years of age, ***single*** with **1** dependent children.

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

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

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

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

ORDER

Claim for compensation denied. Petitioner failed to prove that she sustained accidental injuries which arose out of and in the course of her employment by Respondent on June 8, 2015.

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 22, 2018
Date

ICArbDec p. 2

OCT 22 2018

INTRODUCTION

This matter was tried with two consolidated cases, Nos. 16 WC 019976 and 16 WC 022314.

This case and Case No. 16 WC 022314 involved an alleged accident date of June 12, 2015. The mechanism of injury was: "lifting heavy object" in Case No. 15 WC 027026 and "lifting heavt (sic) bag" in Case No. 16 WC 022314. The injury was said to be a strain of cervical, shoulder and upper arm in Case No. 15 WC 027026 and cervical disc and rotator cuff injuries to the neck and right shoulder in Case No. 18 WC 022314. The Application in Case No. 15 WC 027026 was filed on August 21, 2015. The Application in Case No. 16 WC 022314 was filed on July 21, 2016. (RX 18, 19) At the conclusion of testimony, Petitioner made a motion to amend the Applications in Case Nos. 15 WC 027066 and 16 WC 022314 to state a date of accident of June 8, 2015. The motion was granted over Respondent's objection and the Amended Applications were admitted as Arbitrator's Exhibits 5 and 6.

The Findings of Fact and Conclusions of Law herein shall be the same for Case No. 16 WC 022314.

Case No. 16 WC 019976 involves an alleged injury to Petitioner's head, neck and left eye, as a result of a blunt trauma that occurred on May 30, 2016.

The question of the admissibility of PX 20 (9/20/2017 Respondent's attorney's cover letter to Dr. Neal regarding his record review) was reserved, pending the Arbitrator's review of the evidence deposition transcript and the letter. PX 20 is Admitted.

FINDINGS OF FACT

Petitioner began working for Respondent on May 6, 2014. She first worked as a "remodel" and then worked as a cashier, beginning in about July of 2014. In June of 2015, Petitioner was 50 years old, and single with one dependent child under the age of 18. Petitioner is right handed.

Prior to June of 2015, Petitioner had been diagnosed with fibromyalgia, Sjogren's Syndrome, diabetes, high blood pressure, asthma, and NASH (non-alcoholic fatty liver disease). Petitioner testified that Sjogren's Syndrome causes aching of joints and muscles. She was under the care of Dr. Aruna Kandula, her primary care physician, and Dr. Carmelita Colbert, a rheumatologist. Petitioner said that she did not have any particular problem with her right shoulder before June of 2015 and had not been prescribed injections for her right shoulder. Petitioner said that she had no treatment for either shoulder before June of 2015.

Petitioner's medical records show that she was seen by Dr. Colbert on January 26, 2015 for bilateral shoulder pain and other complaints. The problem list included muscle spasms of the left shoulder. Dr. Colbert diagnosed Petitioner with shoulder pain due to tendonitis and discussed cortisone injections with her. (RX 7)

On the first day of trial, Petitioner called LaTasha Muse, Assistant Store Manager for Respondent, as a witness. Muse was Petitioner's supervisor in June of 2015. Muse testified that Petitioner did not work for Respondent on June 12, 2015. RX1, an Electronic Time Adjustment form, documents that Petitioner did not work on June 12, 2015. This information was available to Petitioner, prior to trial, as she could look it up on-line. Respondent's employees are not given any formal training regarding reporting accidents or injuries at work.

Supervisors at Respondent fill out computer forms to document reported accidents. Respondent's process includes an accident report (known as an incident report until the associate seeks medical attention), witness statements, photographs if appropriate, viewing CCTV video (if appropriate and available), and having management accompany the injured associate to the doctor.

On direct examination by Petitioner's counsel, Muse testified that Petitioner came into work on June 20, 2015 and told her that she had been sent home on June 18, 2015 because she had reported to work with lifting restrictions from a doctor. Petitioner did not report any specific incident or accident precipitating her right shoulder pain. Petitioner said that her doctor told her that it must have happened at work. Petitioner told Muse that she did not remember any injury. Petitioner did not know what happened, or when it happened. Petitioner did not mention an injury due to lifting soil at work. Muse told Petitioner to call her if she remembered any injury and Petitioner was sent home. Muse testified that she heard nothing thereafter from Petitioner until July 14, 2015. Muse was unsure whether she called Petitioner, or Petitioner called her on July 14, 2015. On examination by Respondent's counsel, Muse said that on June 20, 2015 she became aware that Petitioner was claiming that she had injured her right shoulder at work. On further examination by Petitioner's counsel, Muse said that she talked to Petitioner about being injured (not her shoulder and not at work) on June 20, 2015. Muse said that her testimony regarding Petitioner reporting a shoulder injury at work on June 20, 2015 was not correct. On June 20, there were no specifics regarding what body part was injured and what happened. Muse asked Petitioner if it happened at work and Petitioner said that she didn't remember.

Muse specifically denied that on June 20, 2015 Petitioner told her that she had been hurt at work. Muse denied that Petitioner requested that an accident report be filled out and denied that she told Petitioner that she was too busy to fill out a report and closed a door in Petitioner's face on that occasion.

Muse testified that Petitioner worked on June 8, 2015 and June 9, 2015. Petitioner did not work on June 10, June 11 or June 12, 2015. RX 2 was a transaction report (Associate Register Receipt), showing all of the transactions that Petitioner rang in as a cashier from June 8, 2015 to June 22, 2015. RX 2 does not show that Petitioner rang up any bags of soil on June 8 or June 9, 2015. It does show that Petitioner rang up potting mix on June 8, 2015 at 12:47 pm. (RX 2, PX 30) RX 2 was given to Petitioner's counsel on the first trial date.

On July 16, 2015, Petitioner filled out an Associate Incident Report, which detailed an injury occurring on June 12, 2015 at 10:00 am, while Petitioner was working as a cashier on Register 15. She hurt her right arm, shoulder and neck when she pulled a big bag of soil from under a cart, not knowing that it was soaked with water. (PX 24) Petitioner also completed an Associate Statement on July 16, 2015. Petitioner wrote: " I was servicing my customers and an older customer had big bags of soil under the bottom of the cart. I didn't know the soil was soak and wet which made it harder to lift so I pulled it out from the bottom of the cart and the cart moved + I felt sharp pain and pull in my right shoulder and neck. I scanned the merchandise and put it back but I continued to fill(sic) the pain so when I went home I called the doctor and I went there and received medical treatment + I informed personnel who gave me information who to call." (PX 25)

On the second day of trial, Petitioner submitted the testimony of Rashia Williams, a Personnel Coordinator at Respondent. On June 18, 2015, Williams saw a doctor's note, regarding work restrictions for Petitioner, on her desk. Respondent does not honor medical restrictions for non-work injuries. She asked Petitioner about the note and what happened. Petitioner said she didn't know. Williams asked Petitioner if anything happened to her at work and she said she didn't know. Williams testified that Petitioner said that the doctor said that it had to have happened at work. Williams wrote up a Witness Statement on July 14, 2015. The statement does not say that Petitioner said that the doctor said that the injury must be work related. The statement does say that Petitioner said that she didn't know what happened, didn't know if anything happened at work and that she didn't know

where it happened. The statement also says that Petitioner said that she was taking shots for an illness and maybe that had something to do with her body aching. Petitioner was told that she couldn't stay at work because it wasn't a work related injury. Petitioner said that she was going to see her doctor and Williams asked Petitioner to call after she had seen her doctor. Williams was asked by Muse in July if Petitioner had reported a work injury to her. (PX 31) Williams was asked by Muse in July if Petitioner reported to her that she had hurt her arm lifting soil and Williams said that wasn't what Petitioner told her, that Petitioner said she didn't know how her incident happened.

Petitioner next submitted the testimony of Jennifer Bell, Respondent's Store Manager. Bell received a subpoena to bring documents to the hearing. She did not bring documents to trial. Bell spoke to Rashia Williams, who was to transmit the subpoena to HR and Legal. Bell did not bring any wage records for Petitioner or any other documents requested in the subpoena to the hearing. (PX 37)

Petitioner testified after Muse, Williams and Bell had testified.

Petitioner began her employment with Respondent in May of 2014. Her date of birth is March 25, 1965. She has 4 children, including a son who was 16 at the time of trial. Petitioner testified that her wages at Respondent were consistently around $380.00 per week. Petitioner did not receive any training from Respondent regarding reporting accidents or injuries sustained at work.

After reviewing RX1, Petitioner agreed that she was not working for Respondent on June 12, 2015. Petitioner did recall injuring her right shoulder at work. She might not remember the date of injury. After the last hearing, Petitioner reviewed RX2, the transaction report. Petitioner identified PX 30 as a receipt showing that she sold potting mix to a customer on June 8, 2015 at 12:47pm. According to Petitioner, this could possibly be the transaction that she was doing when she hurt her shoulder.

Petitioner testified that she identified her injury date as June 12, 2015 because she felt pressured to fill out documents so that she could go to the doctor with LaTasha Muse in July of 2015. Petitioner was in pain and wanted to see what was wrong. Petitioner was told that she had to put a specific date on the report documents so that they could be processed. She could change the date later. According to Petitioner, it was possible that she thereafter used June 12, 2015 as the accident date that she told her doctors about.

Petitioner was asked to describe what happened to her at Wal-Mart on the day that she was checking out the potting mix. Petitioner testified that it was busy. She was checking out an elderly woman, who was with a child. Petitioner attempted to scan a large bag of dirt. It was a big bag and it wouldn't scan. She grabbed the bag and the cart went backwards; Petitioner went with the cart and she immediately felt something go up her right arm. She then lifted the bag off the cart onto the conveyor belt, keyed the numbers into the register and put the bag back on the cart. She felt stinging and pressure in her arm. A sharp pain, like if you bumped it really hard. She rubbed her arm and continued working. Petitioner said that she told a supervisor, Tyiasha, and another supervisor, Billie Brown, about the incident. Brown mentioned doing paperwork, but Petitioner didn't do it because she didn't want to get Brown in trouble. Her arm hurt, but she finished her shift and went home.

Petitioner worked the next day, from 7:00 to 3:09. She took Tylenol, Motrin and used Ben Gay for arm pain. According to Petitioner, she told her manager about the incident on this day and the manager assigned Petitioner to the small order register. The manager was Barbara or Chiteka. The Arbitrator notes that Notice was in dispute in this case and Petitioner did not identify Tyiasha, Billie Brown, Barbara or Chiteka as people that she gave notice to in Paragraph 3 of the RFH. (ArbX 1) Neither Party called Tyiasha, Billie Brown, Barbara or Chteka as a witness.

Petitioner sought no medical care for her injured shoulder on June 8, June 9 or June 10, 2015.

Petitioner already had an appointment on June 11, 2015 scheduled with Dr. Kandula, her PCP. She did not make the appointment because of her injured shoulder. Petitioner said that she told Dr. Kandula about what happened at Wal-Mart. Dr. Kandula's PCP Chronic Care Note from June 11, 2015 notes the reason for Petitioner's visit was elevated blood sugar. Petitioner's complaints on this date included a discussion of her diabetes, diffuse joint pain and swelling, decreased range of motion, and ongoing issue with numbness in both lower legs. Petitioner's low back pain, hypertension, and pelvic pain were also a focus of the appointment. Bilateral shoulder pain is listed as an ongoing issue, but there is no other reference to shoulder pain. There were no specific complaints regarding Petitioner's right shoulder. Physical examination showed stable, symmetric and opposite side strength a 5/5, full range of motion, no swelling, no point tenderness, no crepitations, no contractures, and no atrophy. There is no mention of a shoulder injury as a result of lifting potting mix in the record of this visit. (RX 5) Petitioner testified that Dr. Kandula instructed Petitioner to tell Dr. Colbert, her rheumatologist, about the shoulder injury at work. Petitioner had a previously scheduled visit with Dr. Colbert set for June 15, 2015.

Petitioner testified that she told Dr. Colbert about the specific incident at work with the bag of dirt or potting mix. Dr. Colbert charted that Petitioner's job involves her scanning heavy cases of water and pop. There is no mention of a shoulder injury sustained lifting a bag of potting mix. Dr. Colbert's Clinical Summary from June 15, 2015 notes the health issues that were reviewed were cervical paraspinal muscle spasm, degenerative arthritis of the lumbar spine, degenerative spinal arthritis, and right shoulder tendonitis. In terms of shoulder issues, Petitioner was noted to have muscle spasm of the left shoulder, right shoulder tendonitis, and bilateral shoulder pain on this date. The record indicates a cortisone injection was given to the right shoulder and a physical therapy referral was given. There is no documentation of the cause of Petitioner's right shoulder pain "tendonitis". (RX 7)

Dr. Colbert gave Petitioner the work restrictions which Petitioner gave to Rashia on June 18, 2015. Petitioner said that Rashia spoke with her at the self check out station and advised her to clock out, because she had a work restriction. Petitioner said that she inquired: "even if I got hurt here?" and Rashia said yes and referred Petitioner to Sedgwick. Sedgwick handles Respondent's non-occupational disability claims. Petitioner said that she was working the self check out because management was aware of her injury. Petitioner contacted Sedgwick and was advised that they would contact CMI, Respondent's workers' compensation provider.

Petitioner did not agree with the testimony of Rashia that Petitioner told her that she didn't know what happened to her arm.

Petitioner said that she tried to call LaTasha and was unable to reach her. She met with LaTasha on June 20, 2015 at Respondent's store. Petitioner said she asked LaTasha about filling out accident documentation. LaTasha said that she was busy and closed the door in Petitioner's face. Petitioner denied telling LaTasha or anyone that a doctor told her that based upon her injury, it had to have happened at work. Petitioner went home and waited for someone from Respondent to call her.

Petitioner testified that LaTasha called her on July 14, 2015. Petitioner filled out paperwork on July 16, 2015 and LaTasha took Petitioner to Concentra in Bridgeview on July 15, 2015. Petitioner testified that she talked to LaTasha about what happened during the accident. Petitioner denied telling LaTasha that she wasn't sure if it happened at work. She did not tell anyone at Respondent that she was not sure.

Petitioner presented to Concentra for right shoulder and neck pain on July 15, 2015. The history was that she was helping a customer with a check out, lifted a heavy bag at the bottom of a cart and hurt her right shoulder. She saw her PMD (Rheumatologist), who diagnosed a shoulder sprain and gave her an injection that lasted a few days. The date of injury was said to be June 12, 2015. Treatment at Concentra was from July 15, 2015 to August 7, 2015, involving check-ups and PT. Concentra recommended an MRI and more PT, which was apparently not authorized by Respondent. (PX 2)

Petitioner next worked at Respondent on July 16, 2015. She returned to work at the self check out area, which is considered limited duty.

Concentra referred Petitioner to an orthopedist. Petitioner saw Dr. Garelick on August 17, 2015. The history given was that the patient lifted a heavy bag of dirt that had been sitting outside and filled with water on June 12, 2015 and ever since had pain in her anterior shoulder and up into the neck. He recommended continued PT and did not agree that an MRI was needed. The diagnosis was myofascial sprain. The physical exam revealed 5/5 RTC strength. There was a negative Hawkins and Neer test. (PX 2)

Petitioner did not like the way that she was treated at Concentra, so she stopped treating with Concentra and talked with a lawyer. She then began treatment with Dr. Hooton, DC, at ACMI-South Holland Medical Center on August 24, 2015. The Application herein was filed on August 21, 2015. Petitioner had complaints of neck and right shoulder pain. Petitioner stated she was at work on June 12, 2015 when she picked up a bag of soil weighing approximately 25 pounds and felt a pop in her neck and right shoulder, followed by pain. She worked the following day with increasing pain and then went to her primary care doctor. Later the same day she saw her rheumatologist for her Sjorgens Syndrome, at which time she had a steroid injection. The diagnosis was cervical sprain, shoulder/upper arm sprain, and cervical radiculitis vs. shoulder brachial neuritis. (PX 3)

Petitioner presented to the ER at Advocate Christ Medical Center on September 8, 2015, following a car accident on September 5, 2015. Petitioner was a restrained driver in a funeral procession when another vehicle struck her driver's side mirror. The following day she felt lateral neck pain from her chin to her left hand with finger numbness and "felt like I got hit with a bat." She complained of symptoms to her right arm and tightness between her shoulder blades. No over-the-counter medications had been attempted. She reported that the chest pain that she was experiencing following the accident had abated, but she was still experiencing upper back tightness and pain bilaterally. She complained of tenderness over the paraspinal and trapezius muscles. She was diagnosed with chest pain and shoulder and neck pain. (RX 6)

On September 10, 2015, Petitioner presented to AMCI – South Holland Medical Center for physical therapy and reported that she had been in a car accident on September 5, 2015. "Mrs. Robinson was the restrained driver of a vehicle that was sideswiped by another vehicle. She was thrown side to side in her seat." She went to Christ Hospital ER, where X-rays were taken. She was prescribed Norco and valium and discharged. When she presented to AMCI, she reported neck pain rated 9/10, shoulder pain at 6/10, and radicular symptoms including pain and numbness in both arms, down to her fingertips. "Prior to the 09/05/2015 accident her radicular symptoms radiated to just her right elbow". (PX 3)

An MRI of Petitioner's right shoulder was performed on September 28, 2015 at Molecular Imaging Advantage MRI, which revealed a full thickness tear of the supraspinatus and the subscapularis tendon, a small subchondral cyst/erosion in the head of the humorous, and acromioclavicular joint arthropathy. The biceps tendon and labrum were normal and the articular surfaces were normal and intact. The acromioclavicular joint showed irregularity and capsular hypertrophy with spur formation. On September 30, 2015, an MRI was performed on Petitioner's cervical spine, which revealed disc dehydration throughout, and a 1-millimeter diffuse disc protrusion with effacement at the C4-5 to C6-7 levels. (PX 3, PX4)

On October 15, 2015, Petitioner presented to orthopedist Dr. Thomas Bilko at AMCI for an evaluation. Dr. Bilko did not document any history given by the patient ("prior notes reviewed"). Dr. Bilko's diagnoses were cervical disc herniation, rotator cuff tear, and cervical radiculitis vs. brachical radiculitis. He recommended surgery to address the full thickness RTC tear, prescribed a corticosteroid injection to the right shoulder, and continued therapy pending surgery. He referred Petitioner to Dr. Agrawal for PMR/interventional pain and spine evaluation and further treatment. Dr. Bilko charted "MRI findings causally related and/or exacerbated by the work incident noted in the initial visit." (PX 3)

Petitioner was seen by Dr. Divya Agrawal, physiatrist at AMCI, on October 27, 2015 for a pain consultation. Petitioner's date of accident is listed as June 12, 2015. Petitioner complained of persistent neck pain up to 8/10 radiation to the right forearm and first and second digits with numbness, tingling, and weakness. Nerve testing was ordered to verify radiculopathy. (PX 3)

An upper extremity EMG study was performed on November 10, 2015 to verify radiculopathy. Petitioner's complaints were right upper extremity pain and paresthesias status post work-related accident on June 12, 2015. The clinical diagnosis was carpal tunnel syndrome. The NCV & EMG findings showed no evidence of instability in any examined muscle, and the impression was mild neuropathies at the wrists consistent with CTS. There was no electrodiagnostic evidence of a cervical radiculopathy or plexopathy. (PX 3)

On December 8, 2015, Dr. Agrawal noted that Petitioner's neck pain had subsided and she was placed at MMI regarding her cervical spine. (PX 3)

Petitioner was seen by Dr. Kandula on April 22, 2016, following an admission to Christ Hospital for dizziness and chest pain. Petitioner's blood sugar was 207 that morning. Petitioner reported worsening lower back pain and discomfort, but right shoulder pain was not noted. (RX 5)

On July 14, 2016, Petitioner presented to Dr. Kandula with complaints of discomfort and decreased right shoulder ROM. Petitioner was requesting paper work to be off work, as she was unable to handle basic ADL's due to pain. She reported that she was injured in June of 2015, when she lifted about 20-30 pounds from the floor to put in on the conveyer belt about 3-4 feet high but had to put the weight back down due to acute pain in the shoulder. An MRI was done in September of 2015, which revealed a full thickness tear of the supraspinatus. Petitioner reported another work related injury that happened on May 30, 2016, in which she was hit in the face, eye, and left ear by a shepherd's hook. Dr. Kandula's treatment plan included review of the right shoulder pain

with a hand surgeon for further management, sparing use of pain meds, PT advised; and ophthalmology review and audiogram for the "Different work injury". (RX 5)

Dr. Sonnenberg at Midland Orthopedic saw Petitioner on July 27, 2016 for complaints of neck and right shoulder pain. Petitioner reported that she injured herself at work on June 12, 2015, when she lifted a package from the bottom of a cart onto the counter while she was a checker at Wal-Mart. She reported feeling a tearing sensation in her right shoulder. She was seen by an orthopedic specialist who eventually diagnosed her with a rotator cuff tear. Petitioner reported that she was still working and that she was referred by Dr. Kandula. On examination, she displayed full ROM of her cervical spine, although she displayed tenderness on the right side of her neck. She also displayed full ROM in her right shoulder, although there was a positive impingement sign and empty can test. An x-ray of Petitioner's cervical spine revealed straightening of the cervical spine, but no degenerative disc disease. An MRI of the right shoulder revealed a small full thickness rotator cuff tear of the anterior portion of the supraspinatus. An MRI of the cervical spine revealed some disc protrusion at multiple levels, but no dramatic narrowing. She was assessed with a right rotator cuff tear and cervical radiculitis with minimal MRI findings. Dr. Sonnenberg recommended a subacrominal steroid injection into her right shoulder and therapy for the cervical spine. (PX 5)

Petitioner was seen again by Dr. Sonnenberg on August 1, 2016. She had received an injection in her right shoulder, which had provided a bit of relief. On examination, she was tender over the right shoulder rotator cuff with a positive impingement sign and a very positive empty can test for pain and weakness. She was assessed with having a right rotator cuff tear with some superimposed cervical radiculitis. At Petitioner's request, surgery was tentatively planned for August 30, 2016. (PX 5)

On September 9, 2016, Petitioner underwent surgery performed by Dr. Sonnenberg. The pre- and post-operative diagnoses were right shoulder rotator cuff tear. The procedure performed was a right shoulder arthroscopy with synovectomy, repair of rotator cuff, subacromial decompression to remove a significant bone spur, and debridement of the greater tuberosity and edges of the rotator cuff. (PX. 5)

Petitioner's first physical therapy evaluation after surgery was on November 9, 2016 at ATI. Petitioner reported she initially injured her shoulder at work on June 12, 2015. Her intake diagnosis was right shoulder pain and status-post right rotator cuff repair. She presented with decreased ROM, strength, flexibility, joint mobility, soft tissue mobility, and increased edema and pain. Petitioner complained of pain, swelling, and numbness at the right shoulder that went down to her hand and thumb. Her recommendedcourse consisted of therapy three times per week for six weeks. (PX 9)

On December 21, 2016, Petitioner presented to Jessica Pezzo at Midland Orthopedic Associates for re-evaluation of her right shoulder. She was status post rotator cuff repair surgery from September 6, 2016. It was noted that Petitioner had not followed up since her first post-op check in on September 12, 2016. She had also delayed her physical therapy until November 9, 2016. Petitioner reported that once she started therapy, her shoulder began to swell and become painful, though she was improving with ROM. She denied any numbness, tingling, or radiating symptoms. On examination, she had significantly decreased ROM and displayed

significant shoulder weakness. It was reiterated to Petitioner that she was well behind in her physical therapy. She received an updated prescription for therapy and was instructed to take Tylenol to deal with the swelling. She was taken off of work. (PX 5)

Petitioner attended 13 physical therapy appointments at ATI between January 2 and January 31, 2017. The therapist noted Petitioner's objective improvements in ROM and strength through the month. (PX 9)

Petitioner had a follow-up evaluation with Dr. Maday at Midland Orthopedic Associates on January 17, 2017. Petitioner was approximately four months following a rotator cuff repair. She reported pain and stiffness in her shoulder and claimed that she was having difficulty obtaining mobility. The doctor recommended that she continue with her course of therapy over the next month. If there was no improvement a manipulation or arthropscopic debridement with capsular release should be considered. Dr. Maday noted that since Petitioner was diabetic, a capsular release would be the more beneficial of the two options. (PX 5)

Petitioner attended 9 physical therapy appointments at ATI between February 3 and February 27, 2017. Objectively, Petitioner's range of motion and strength had increased since January. On March 7, 2017, Petitioner was discharged from ATI physical therapy, having made objective improvements in range of motion, joint mobility, strength, soft tissue mobility, flexibility, posture, body mechanics, and lifting mechanisms. (PX 9)

On March 31, 2017, Petitioner presented to Dr. Maday for further follow-up. Petitioner had not been seen for approximately 10 weeks and she was supposed to have been seen approximately 6 weeks prior. She was assessed with decreased range of motion of the shoulder and given a prescription for an MRI to assess scar tissue. Petitioner requested additional narcotic pain medication that she said was for therapy. However, since she had been released from physical therapy on March 7, 2017, Dr. Maday "did not feel that this was in her best interest." No medications were prescribed. (PX 5)

An MRI of Petitioner's right shoulder was performed at Preferred Open MRI on April 21, 2017. The Impression was "S/P supraspinatus tendon repair with residual patch of signal abnormality from post-surgery changes or residual/recurrent tendinopathy". (PX 5)

Petitioner was last seen by Dr. Maday on May 16, 2017. He reviewed the MRI results and opined that it did not reveal any significant abnormalities of the rotator cuff and that the repair appeared to be intact. Dr. Maday's assessment was status post rotator cuff repair with decreased motion and decreased strength. He recommended either manipulation with a possibly arthroscopic capsular release followed by work conditioning or just a work conditioning program. Petitioner was to start a work conditioning program and return for reevaluation in three weeks. (PX 5)

Petitioner was given a form by Midland Orthopedic Associates at her appointment on May 16, 2017 that includes a diagnosis of "adhesive capsulitis right shoulder". (Dr. Neal DepX 5)

Petitioner testified that her shoulder remains painful. She has decreased strength. She can't pick up stuff. She does not sleep well. She can't reach up high. She can't open jars. She doesn't carry much. She has problems bathing and washing her hair.

Dr. M. Bryan Neal authored a Medical Record Review Summary report on October 13, 2017 and was deposed on January 19, 2018. (RX 10) Dr. Neal is a board certified orthopedic surgeon, fellowship trained in hand and upper extremity surgery. Dr. Neal's diagnosis was chronic right shoulder pain and stiffness secondary to adhesive capsulitis, status post shoulder arthroscopy, synovectomy, and repair of a rotator cuff tear. Dr. Neal opined that Petitioner's right shoulder condition was not caused by any work activity on or around June 12, 2015. Dr. Neal further opined that the medical treatment Petitioner received for her right shoulder condition was not causally related to any of her work activities on or around June 12, 2015, and that Petitioner was capable of returning to her regular job duties on a full-time basis. (RX 10)

On cross examination, Dr. Neal stated that the basis for his opinion that Petitioner did not injure herself on June 12, 2015 was Petitioner's medical records from January 26, 2015, in which bilateral shoulder pain was noted, as well as the June 11, 2015 medical record, in which bilateral shoulder pain is also noted. "And then if you look at that first note of June 15, okay, where they talk about bilateral shoulder pain, it's significant. Why would you have significant contralateral left shoulder pain if you only injured the right?" (RX 10)

Additionally, Dr. Neal noted that Dr. Sonnenberg did not make a definitive statement regarding causation in his records; that Dr. Bilko did not make a definitive statement regarding causation in his records; and that Dr. Maday informally diagnosed Petitioner with adhesive capsulitis, the same as Dr. Neal's diagnosis. Dr. Neal testified that while Petitioner consistently related that her date of injury was June 12, 2015, her description of the mechanism of injury was not consistent. In Dr. Neal's opinion, to a reasonable degree of medical and surgical certainty, Petitioner's injury was not as she described. In Dr. Neal's opinion, Petitioner had pre-existing adhesive capsulitis in her right shoulder and did not suffer a work-related injury on or around June 12, 2015. The RTC tear was an incidental finding and the surgery was not causally connected to any injury. Dr. Colbert diagnosed shoulder tendonitis on June 15, 2015. This diagnosis is consistent with adhesive capsulitis. Petitioner did not have RTC weakness on June 15, 2015. Thus, it is not likely that she had experienced a full thickness RTC tear three days prior. The RTC tear is likely chronic. The adhesive capsulitis is likely due to Petitioner's diabetes, age and lung condition (steroid use). (RX 10)

Petitioner has not returned to work since her shoulder surgery. Dr. Maday recommends further surgery. Petitioner cannot afford to pay for the surgery. Her last visit with Dr. Maday was in May of 2017. He recommends surgery and that Petitioner remain off work.

Petitioner had an injury at work on May 30, 2016. She went to get supplies for the self check out area and was struck by a pole in the face. That accident is the subject of Case No. 16 WC 019976. Petitioner's employment with respondent was terminated in February of 2017.

LaTasha Muse and Rashia Williams testified in rebuttal. Muse testified that potting mix with fertilizer is sold in-store only for environmental reasons. Muse thought that the price indicated that the product was a smaller bag of potting mix. Muse offered to check the UPC scan number for the potting mix on PX 30 to describe the

item, but that was declined. Petitioner testified in surrebuttal the potting mix was at least a 25 pound bag, based on its price.

The Parties agreed that the PPD and TTD rates for the case would be $253.00 when their exhibits were being tendered into evidence.

CONCLUSIONS OF LAW

The Arbitrator adopts the above Statement of Facts in support of the Conclusions of Law set forth below.

To obtain compensation under the Act, petitioner has the burden of proving, by a preponderance of the evidence, all of the elements of her claim (O'Dette v. Industrial Commission, 79 Ill.2d 249, 253 (1980)), including that there is some causal relationship between her employment and her injury. Caterpillar Tractor Company v. Industrial Commission, 129 Ill.2d 52, 63 (1989)

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

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

Petitioner failed to prove that she sustained accidental injuries which arose out of and in the course of her employment by Respondent on June 8, 2015.

First, Petitioner claimed that the accident date was June 12, 2015, as is shown in PX 24, PX 25, the histories given to all of the treating physicians and in the Applications in Case Nos. 15 WC 027066 and 16 WC 022314. Petitioner's explanation for this is that she was pressured to name an accident date so that Muse could process paperwork and get Petitioner to treatment at Concentra in July of 2015, so Petitioner chose June 12.

Petitioner testified that she was told that she could change the accident date later. Petitioner did not change the accident date until the second day of trial, after testimony established that Petitioner was not working on June 12, 2015. Petitioner's attendance records were available for her review, but she apparently did not check them.

Petitioner claimed the accident occurred on June 8, 2015, after reviewing transaction receipts and discovering that she checked out a customer with "potting mix" at 12:47pm on that date. Muse thought that this was a smaller package. Petitioner thought that this was a 25# bag. Petitioner declined to have Muse check the UPC code to verify the product. The Associate Statement that Petitioner wrote up places the time of accident at 10:00am and says that the customer had bags of soil on the bottom of her cart. (PX 25) PX 30 shows that only one "potting mix" was rung up. Thus, it is not likely that the transaction on PX 30 was the one that precipitated Petitioner's right shoulder complaints, if indeed any such event occurred. Petitioner's testimony does not persuade the Arbitrator that she was certain that the accident occurred on June 8, 2015 (could possibly be the transaction where she got hurt?). Petitioner has not established a definite time, place and circumstance for the alleged injury to her right shoulder.

Importantly, while Petitioner testified that she told both Dr. Kandula and Dr. Colbert about the accident at work, their chart notes of June 11, 2015 and June 15, 2015 contain no mention of a shoulder injury from lifting potting mix at work, occurring days before these doctor's visits. If there was a history of an injury at work, the physicians would have charted it. "It is presumed that a declaration to a treating physician as to one's physical condition and the cause thereof is true because the patient will not falsify such statements to the one from whom he expects to get medical aid." Shell Oil Co. v. Industrial Commission, 2 Ill.2d 590, 602 (1954) The absence of a history of an injury at work to these physicians who were seen shortly after the alleged accident occurred persuades the Arbitrator that no such accident occurred on June 8, 2015.

Additionally, it is noted that while Petitioner consistently gave the wrong accident date of June 12 to the doctors after she reported the injury to Respondent in July of 2015, the mechanisms of injury are all slightly different and not consistent with her trial testimony, although they do involve lifting heavy soil.

The Arbitrator believes the testimony of Muse and Williams that Petitioner was unsure of how her shoulder came to hurt and was unable to identify a specific injury at work.

After observing Petitioner's testimony, the Arbitrator concludes that she was not sure that the event occurred on June 8, 2015.

If Petitioner had suffered a full thickness RTC tear as a result of the event that she described at trial, she would not have been able to lift the bag of soil up onto the counter and put it back on the lower part of the cart. She would not have been able to complete her work on June 8, 2015 and work a full day on June 9, 2015. She would have sought medical treatment before the scheduled visit with Dr. Kandula and she would have given an accurate and complete history of injury to Drs. Kandula and Colbert. As Dr. Neal said, if she had suffered such an injury on June 8, 5/5 RTC strength would not have been noted by Dr. Colbert on June 15, 2015. The initial medical records do not provide evidence of a full thickness tear occurring days before the visits.

Additionally, the histories to the physicians of the event are all slightly different. While this would generally not be fatal to Petitioner's claim, it is here where there is no corroborating evidence that the claimed event of June 8, 2015 occurred.

"Liability under the Act cannot rest upon imagination, speculation or conjecture. It must be based upon facts affirmatively connecting the employee's duties as a cause of the resulting injury." Arbuckle v. Industrial Commission, 32 Ill.2d 581, 585 (1965) The evidence adduced fails to do so.

Given the above, the Arbitrator declines to find that Petitioner sustained accidental injuries which arose out of and in the course of her employment by respondent on June 8, 2015. The claim for compensation is, therefore, denied.

WITH RESPECT TO ISSUE (E), WAS TIMELY NOTICE OF THE ACCIDENT GIVEN TO THE RESPONDENT, THE ARBITRATOR FINDS:

Notice, in accordance with Section 6(b) of the Act was established by the testimony of Petitioner, Muse and Williams.

WITH RESPECT TO ISSUE (F), IS THE PETITIONER'S PRESENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS:

As the Arbitrator has found that Petitioner failed to prove that she sustained accidental injuries which arose out of and in the course of her employment by Respondent on June 8, 2015, the Arbitrator needs not decide this issue.

Additionally, the Arbitrator finds the opinions of Dr. Neal to be credible and persuasive and consistent with the evidence. Even if the alleged accident of June 8, 2015 occurred, the Arbitrator would deny the claim on the basis of causation.

WITH RESPECT TO ISSUE (G), WHAT WERE THE PETITIONER'S EARNINGS, THE ARBITRATOR FINDS:

No finding on this issue is required, given the Arbitrator's finding above on the issue of accident.

The Arbitrator notes that at the time of submission of exhibits on March 2, 2018, the Parties agreed that the TTD rate and PPD rate was $253.00. Therefore, the Arbitrator found Petitioner's claimed AWW of $380.00 to be valid, as is set forth above in this Decision.

WITH RESPECT TO ISSUE (I), DID PETITIONER HAVE A DEPENDENT CHILD AT THE TIME OF THE ACCIDENT, THE ARBITRATOR FINDS:

Petitioner's unrebutted testimony establishes that she had a 16 year old son at the time of the accident.

WITH RESPECT TO ISSUE (J), WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY AND HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, ISSUE (K), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY, TEMPORARY PARTIAL DISABILITY AND/OR MAINTENANCE, ISSUE (L), WHAT IS THE NATURE AND EXTENT OF THE INJURY, THE ARBITRATOR FINDS:

As the Arbitrator has found that Petitioner failed to prove that she sustained accidental injuries, arising out of and in the course of her employment by Respondent on June 8, 2015, the Arbitrator needs not decide these issues.

WITH RESPECT TO ISSUE (N) IS RESPONDENT DUE ANY CREDIT?, THE ARBITRATOR FINDS:

Respondent raised this issue on the RFH for Case Nos. 15 WC 027066 and 16 WC 022314, but it should have been raised regarding Case No. 16 WC 19976. Accordingly, no finding is made on this issue in this case.

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: Up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JACQUELINE ROBINSON,

Petitioner,

20IWCC0317

vs.

NO: 16 WC 19976

WALMART,

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 average weekly wage, benefit rate, temporary total disability ("TTD"), and 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.

Petitioner testified that while she was off work due to her work-related injury, she received income of $10.50 an hour for 15 hours a week from Help-at-Home working as a caregiver for her mother. Petitioner's testimony was not rebutted. The Arbitrator awarded Petitioner 25&6/7 weeks from September 7, 2016 through March 7, 2017, the date of Petitioner's termination. The Arbitrator found that normally Petitioner would be entitled to TTD from June 16, 2016 to March 7, 2017 for 39&5/7 weeks. "However, Petitioner testified that she received wages from Help-at-Home during this period." Therefore, she was not temporarily totally disabled for that period. He also noted that she did not claim temporary partial disability benefits. Therefore, the Arbitrator awarded TTD for only 25&6/7 weeks.

The Commission finds that the Arbitrator erred in denying all temporary disability benefits for the period of time Petitioner received some income from Help-at-Home. While she did receive some income for that work, that did not suggest that she was able to return to work at her prior job

20IWCC0317

with Respondent. We conclude that Petitioner is entitled to temporary partial disability benefits for that period representing 80% of the difference in her average weekly wage and the income she received from her work for Help-at-Home. The Commission has the authority to award such benefits when the record indicates that they are warranted even though the Petitioner did not formally request temporary partial disability benefits. We do not believe it is appropriate to punish a claimant because of a failure to formally request a certain benefit when the record indicates that such benefit is due. Based on the evidence in the record, the Commission awards an additional award of $178.00 for a period of 13&6/7 weeks, representing 80% of the difference between her average weekly income of $380.00 and the actual income she received from Help-at-Home of $157.50 for that period.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $253.00 per week for a period of 25&6/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the additional sum of $178.00 for a period of 13&6/7 weeks, that being the period of temporary partial incapacity for work under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner permanent partial disability benefits of $253.00 per week for a period of 40 weeks, because the injuries sustained caused the loss of the use of 8% 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 $20,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUN 10 2020

Deborah L. Simpson

Deborah L. Simpson

Barbara N. Flores

Marc Parker

DLS/dw
O-4/16/20
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ROBINSON, JACQUELINE
Employee/Petitioner

Case# **16WC019976**

15WC027066
16WC022314

WAL-MART STORE 3601
Employer/Respondent

20IWCC0317

On 10/22/2018, 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 2.41% 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:

0612 DWYER AND COOGAN
CAROLEANN GALLAGHER
140 S DEARBORN ST SUITE 1603
CHICAGO, IL 60603

5074 QUINTAIROS PRIETO WOOD & BOYER
MICHAEL J SCULLY
233 S WACKER DR 70TH FL
CHICAGO, IL 60606

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20 IWCC0317

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

Jacqueline Robinson
Employee/Petitioner

v.

Wal-Mart Store 3601,
Employer/Respondent

Case # **16** WC **019976**

Consolidated cases: **15 WC 027066**
16 WC 022314

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jeffrey Huebsch**, Arbitrator of the Commission, in the city of **Chicago**, on **2/8/2018, 3/2/2018 and 4/6/2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

20IWCC0317

FINDINGS

On **May 30, 2016**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$19,760.00**; the average weekly wage was **$380.00**.

On the date of accident, Petitioner was **51** years of age, ***single*** with **1** dependent children.

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

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

Respondent shall be given a credit of **$10,868.00** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$10,868.00**.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $253.00 per week for 25-67 weeks, commencing 9/7/2016 through 3/7/2017, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $253.00 per week 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 the compensation benefits that have accrued from 5/30/2016 through 4/6/2018, 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

October 22, 2018
Date

OCT 22 2018

INTRODUCTION

This matter was tried with two companion cases, Case Nos. 15 WC 027066 and 16 WC 022314, which involved the claimed accident date of June 8, 2015 (after amendments of the Applications for Adjustment of Claim at the end of Petitioner's testimony).

FINDINGS OF FACT

Petitioner was employed by Respondent as a cashier. She began working for Respondent in May of 2014.

On May 30, 2016, Petitioner was working the self check registers. Petitioner was struck by a pole on the left side of her face as she tried to get supplies for the registers. Petitioner testified that she was struck on the left side of her head, left side of her face, her left eye, left ear, jaw and forehead. There wasn't any blood, but there was swelling. She was dazed and grabbed a cart to steady herself. A co-worker summoned help. Petitioner sat down and was attended to by the night manager. He brought a first aid kit and ice for her face. The night manager said he was getting paperwork for an incident report. He did not come back, apparently going home. Petitioner then found her supervisor, LaTasha Muse and told her that she was hit in the face. Petitioner said that she wanted to go home. Muse said that she would be assessed attendance points if she went home. Another supervisor, Clinique, had Petitioner fill out paperwork and had her sit in the self checkout area until her shift was over.

The next day, Petitioner contacted Muse and inquired about seeing a doctor, as she was dizzy, could not hear, had a black eye, her face was swollen and her head was pounding. Muse said that she would get back to Petitioner, but she did not. Petitioner called Muse the next day and was instructed to come into the store. Muse took Petitioner to Concentra on June 2, 2016. This is where Petitioner first received medical care for her injuries.

Petitioner had treatment at Concentra from June 2, 2016 to June 7, 2016. On June 2, 2016, She was seen with a history of being struck in the face with a shepherd's hook on May 30, 2016. Her complaints were of left ear pain and pressure, headache, nausea, blurred vision, swelling in the eye and neck pain. There was no loss of consciousness or fall. The physical exam showed very mild swelling of the left lower eyelid. The rest of the PE was benign. The diagnosis was: cervical strain; facial contusion and eye contusion. The recommendations were: Ibuprofen; CT of the head and orbital CT. She was taken off work for June 2 and could work modified duty thereafter. (PX 10)

Petitioner was seen for re-check on June 3, 2016. She had complaints of dizziness, blurred vision and headaches. The CT was negative for intracranial hemorrhage. She had been working her regular duties. An ophthalmology referral was made. Petitioner could return to work, sitting work only. Petitioner was seen on June 7, 2016 and was referred to a neurologist. It was recommended that she be seen that week. She was taken off work, effective June 7, 2016 and instructed to limit activities ("No activity, no work"). (PX 10, PX 11)

Petitioner was sent by Respondent to Dr. Andriani Siavelis, OD at Westchester Eye Surgeons. She was seen on June 7, 2016. The diagnosis was: 1. Cortical senile cataract; 2. Macular edema absent; 3. Type II DM; and 4. Moderate head injury (without injury to the eyeball). A neurologic exam was recommended and the patient was to be off work until the exam by a neurologist.

Apparently, there was a delay in setting up the neurologic consult. Petitioner's attorney and Respondent were able to agree that Petitioner be examined by Dr. Richard Lazar on February 21, 2017. Dr. Lazar's assessment was that Petitioner sustained a concussion at work, that she was experiencing headaches with some features due to post-concussion and some due to stress and emotional components, but that her headaches were getting better. Petitioner told Dr. Lazar that she wanted to return to work but that she also wanted some symptomatic headache treatment. Dr. Lazar recommended her primary care physician "administer something like Limbitrol or Fiorinal" on an as needed basis, that Petitioner have two more weeks off of work to get the medications and make any necessary adjustments, at which point she could return to work without restriction. (RX 9)

Petitioner's employment with respondent was terminated February 8, 2017. This was apparently due to alleged deficiencies in her FMLA paperwork. It appears that Petitioner could re-apply for a job at Respondent, but she has not done so. Petitioner has applied for perhaps 300 jobs since February of 2017, but has not been hired, apparently because of limitations regarding her shoulder.

Petitioner testified that she does not hear as well as she did before the accident. She cannot see as well as before the accident. She has headaches and ear pain. She complains of vertigo. She has problems sleeping. She copes with the headaches as best she can.

Petitioner testified that she received TTD benefits from Walmart from June 2, 2016 through March 14, 2017. Petitioner claims that she is owed TTD benefits from Respondent from March 8, 2017 through March 2, 2018.

Petitioner testified that she was employed by Help at Home, LLC as a home health care aid from September 11, 2014 through September 6, 2016 and earned $10.05 per hour. She agreed that she worked about 15 hours per week for Help at Home, LLC. Petitioner denied filing an unemployment claim against Help at Home, LLC but testified that she had filed a claim for unemployment against Respondent. No documentation of an unemployment claim against Respondent was offered at trial.

Evidence of Petitioner's unemployment claim against Help at Home, LLC was admitted. These records show that Petitioner filed a claim for unemployment benefits against Help at Home, LLC, as well as two appeals of administrative determinations regarding her claim. The claims adjudicator determined that Petitioner was not eligible for benefits. Following the claims adjudicator's determination, the claim was appealed to a Referee, then to the Board of Review, and finally to the Circuit Court of Cook County. (RX 15)

On April 23, 2017, Petitioner filed a claim for unemployment insurance against Help at Home, LLC. The employer protested Petitioner's right to benefits, and submitted allegations that Petitioner voluntarily quit and provided no reason or notice despite the availability of continuing work. On May 17, 2017, the claims adjudicator denied Petitioner benefits because the evidence showed that Petitioner was not available for work and that Petitioner conditionally narrowed her opportunities and had no reasonable prospects for securing work. Petitioner appealed the denial. (RX. 15)

A telephonic hearing was held regarding Petitioner's appeal of the claims adjudicator's determination that she was not eligible for benefits on June 8, 2017. During the telephonic hearing testimony was taken under oath by the Referee. Petitioner testified that she was released to return to work without restrictions sometime at the end of February of 2017. Petitioner also provided "pages 4 and 5 of a purported medical note releasing her to return to work" and a discharge summary from Petitioner's physical therapy provider. Petitioner further testified that she had made five job contacts each of the two weeks under review, or ten job contacts total. Petitioner also admitted that she had not contacted Help at Home, LLC following her release to return to work. The representative for Help at Home, LLC testified that Petitioner would be returned to work if she attended a three-day training session. (RX. 15)

On June 9, 2017, the Referee issued an Administrative Law Judge's Decision, which affirmed the determination of the claims adjudicator. The Referee found that "Her testimony and work search was not credible," and that Petitioner failed to meet her burden to establish her eligibility for benefits. (RX. 15)

Petitioner appealed the Administrative Law Judge's Decision to the Board of Review on July 7, 2017. The Board of Review issued a decision on August 30, 2017 finding that Petitioner did not did not meet her burden to show that she was entitled to receive unemployment benefits in light of testimony from Petitioner that was inconsistent with the medical records she provided as evidence. (RX. 15)

On October 2017, Petitioner filed a Pro Se Complaint for Administrative Review in the Circuit Court of Cook County, Law Division. On February 14, 2018, Judge Daniel Kubasiak entered an Opinion and Order in the case which includes a Procedural History, Facts, Discussion, and Order. Judge Kubasiak found that Petitioner told her employer that she was not coming back to work during a phone conversation on October 31, 2016 and that her testimony was inconsistent with the medical records she provided as evidence. The judge also found that "The manifest weight of the evidence supports the finding that Plaintiff merely made a perfunctory effort in her work search to qualify for unemployment benefits." Judge Kubasiak confirmed the decision of the Board of Review. (RX. 15)

Petitioner's testimony establishes that she worked for and collected wages from Help at Home LLC while she was collecting TTD from Respondent. She stopped working for Help at Home, LLC when she had the shoulder surgery by Dr. Sonnenberg.

Petitioner's claimed bills regarding this case were admitted as PX 19. Respondent's Medical Payment Ledger was admitted as RX 14. Respondent's TTD Ledger was admitted as RX 13.

CONCLUSIONS OF LAW

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

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

including that there is some causal relationship between her employment and his injury. Caterpillar Tractor Company v. Industrial Commission, 129 Ill.2d 52, 63 (1989) To be compensable under the Act, an injury need only be a cause of an employee's condition of ill-being, not the sole or primary causative factor. Sisbro, Inc. v. Industrial Comm'n, 207 Ill.2d 193, 205 (2003)

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

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

Petitioner sustained accidental injuries which arose out of and in the course of her employment by Respondent on May 30, 2016. This finding is based upon petitioner's testimony and the medical records.

WITH RESPECT TO ISSUE (E), WAS TIMELY NOTICE OF THE ACCIDENT GIVEN TO RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

Respondent disputed Notice, but the testimony establishes that Petitioner's supervisor took her to the company clinic for medical treatment on June 2, 2016, three days after the accident. Notice was proved.

WITH RESPECT TO ISSUE (F), IS PETITIONER'S PRESENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner's current condition of ill-being, as diagnosed by Dr. Lazar (status post concussion 5/30/2016 at work, with mixed headaches, post concussion and stress related) is causally related to the injury. This finding is based upon Petitioner's testimony, the medical records and Dr. Lazar's report.

WITH RESPECT TO ISSUE (G), WHAT WERE PETITIONER'S EARNINGS, THE ARBITRATOR FINDS AS FOLLOWS:

At the time of submission of exhibits on March 2, 2018, the Parties agreed that the TTD rate and the TTD rate would be $253.00. Therefore, the Arbitrator found Petitioner's claimed AWW of $380.00 to be correct, as is set forth above in this Decision.

WITH RESPECT TO ISSUE (I), DID PETITIONER HAVE A DEPEDENT CHILD AT THE TIME OF THE ACCIDENT, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner's unrebutted testimony establishes that she had a 16 year-old son at the time of the accident.

WITH RESPECT TO ISSUE (J), WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY AND HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner claimed medical expenses from Concentra, Skan-Bedford Park and Westchester Eye Surgeons, SC as a result of the injury. (PX 19). RX 14 and PX 19 show that the bills were paid by Respondent and there are no outstanding balances. Accordingly, no bills are awarded.

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

Given Petitioner's claimed TTD on ArbX 2, her testimony and the medical records, along with RX 13 (the TTD summary), Petitioner would be entitled to TTD from 6/2/2016 to 3/7/2017, a period of 39-5/7 weeks. However, Petitioner testified that she received wages from Help at Home during this time period, through September 6, 2016. Therefore, as she was not temporarily and totally disabled from June 2, 2016 through September 6, 2016, she is not entitled to TTD for that time period.

No wage or attendance records from Help at Home were submitted. There was no claim for TPD. Therefore, the wages from Help at Home do not impact the AWW and the Arbitrator relies on Petitioner's testimony in awarding TTD only from 9/7/2016 to 3/7/2017, a period of 25-67 weeks.

WITH RESPECT TO ISSUE (L), WHAT IS THE NATURE AND EXTENT OF THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

Pursuant to §8.1b of the Act, the following criteria and factors must be weighed in determining the level of permanent partial disability for accidental injuries occurring on or after September 1, 2011:

(a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall report the level of impairment in writing. The report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment. The most current edition of the American Medical Association's "Guides to the Evaluation of Permanent Impairment" shall be used by the physician in determining the level of impairment.

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

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

No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no permanent partial disability impairment report and/or opinion was submitted into evidence. Accordingly, this factor is given no weight in determining PPD.

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 cashier 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, per Dr. Lazar. This factor is given substantial weight in determining PPD.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 51 years old at the time of the accident. This factor is given some weight in determining PPD.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that Petitioner testified that her employment opportunities are limited due to her shoulder condition, which is not the subject of this case. This factor is given some weight in determining PPD.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that it took some time for an examination by a neurologist to be done, even though Respondent's clinic documented the urgency of an examination (as was documented by the eye doctor, Dr. Siavelis). The Arbitrator does give weight to Dr. Lazar's opinions that the post-concussion headaches are at least in part related to the injury. Thus, some of Petitioner's subjective complaints are corraberated by medical records and the opinion of a specialist. Moderate weight is given to this factor in determining PPD.

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 8% loss of use of the person as a whole, pursuant to §8(d)2 of the Act.

WITH RESPECT TO ISSUE (N), IS RESPONDENT DUE ANY CREDIT, THE ARBITRATOR FINDS AS FOLLOWS:

Respondent paid Petitioner $10,868.00 in TTD benefits. The TTD rate is $253.00 per week. Petitioner is awarded 25-6/7 weeks of TTD, or $6,541.82. There has been an overpayment of TTD benefits in the amount of $4,326.18, for which Respondent is entitled to a credit against the PPD award.

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

Jacqueline Robinson,
Petitioner,

vs.

Walmart,
Respondent.

20IWCC0318

NO: 16 WC 22314

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, bills, temporary disability and permanent disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 22, 2018, is hereby affirmed and adopted.

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

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

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

DATED: JUN 10 2020
o4/16/20
DLS/rm
046

Deborah L. Simpson

Barbara N. Flores

Marc Parker

Bibliography

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

20IWCC0318

ROBINSON, JACQUELINE
Employee/Petitioner

Case# **16WC022314**

15WC027066
16WC019976

WALMART
Employer/Respondent

On 10/22/2018, 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 2.41% 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:

0612 DWYER AND COOGAN
CAROLEANN GALLAGHER
140 S DEARBORN ST SUITE 1603
CHICAGO, IL 60603

5074 QUINTAIROS PRIETO WOOD & BOYER
MICHAEL J SCULLY
233 S WACKER DR 70TH FL
CHICAGO, IL 60606

20IWCC0318

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

Jacqueline Robinson
Employee/Petitioner

v.

Walmart
Employer/Respondent

Case # **16** WC **022314**

Consolidated cases: **15 WC 027066**
16 WC 019976

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jeffrey Huebsch**, Arbitrator of the Commission, in the city of **Chicago**, on **2/8/2018, 3/2/2018 and 4/6/2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☒ What was the date of the accident?
E. ☒ Was timely notice of the accident given to Respondent?
F. ☒ 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. ☒ Did Petitioner have a dependent child 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 **June 8, 2015**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did 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 **$19,760.00**; the average weekly wage was **$380.00**.

On the date of accident, Petitioner was **50** years of age, ***single*** with **1** dependent children.

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

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

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

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

ORDER

Claim for compensation denied. Petitioner failed to prove that she sustained accidental injuries which arose out of and in the course of her employment by Respondent on June 8, 2015.

In support of this Decision, the Arbitrator incorporates the Findings of Fact and Conclusions of Law set forth in the decision in Case No. 15 WC 02766 filed contemporaneously herewith.

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 22, 2018
Date

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

GALE MATHUS, as grandfather and next best friend of
AUSTIN MICHAEL INZERMA, a minor,

Petitioner,

vs. NO: 12 WC 13080

CONTINENTAL TIRES/ THE AMERICAS,LLC,

20IWCC0319

Respondent.

DECISION AND OPINION ON REVIEW

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

Procedural History

This action was brought on behalf of Austin Michael Inzerma, the minor son of David Mathus, deceased by Gale Mathus as Grandfather and Next Friend of the minor. Gale Mathus was the father of David Mathus, the original Petitioner in this action. David Mathus sustained a work accident on December 23, 2010 that resulted in grievous injuries. David Mathus underwent a prolonged course of medical treatment and rehabilitation. David Mathus died of causes unrelated to the work injury on December 20, 2014. Decedent was unmarried and his sole heir is his minor son Austin. On October 12, 2011, an Order for Support was entered which established paternity. Evelyn Mushero was and remains the custodial parent of Austin Michael Inzerma.

The matter proceeded to hearing before Arbitrator Hemenway on June 8, 2017 with Gale

Mathus acting as Grandfather and Next Friend of minor Austin Inzerma. There was no evidence presented establishing Gale Mathus' authority to act in a representative capacity for the minor. A Decision was filed on March 13, 2018. Respondent filed a Petition for Review on March 26, 2018. Respondent did not raise the issue of Gale Mathus' capacity to act on behalf of Austin Inzerma at the time of hearing or on review.

Oral argument before the Commission was conducted on November 6, 2019. Petitioner's counsel, Brian T. Morrow appeared and advised the Commission that Gale Mathus died during the pendency of the review. At the commencement of the proceedings before the Commission on November 6, 2019 an oral motion was presented by Petitioner's counsel seeking to substitute Austin's grandmother, Elizabeth Mathus as Representative Petitioner for the minor. No evidence was presented in support of the Motion to Substitute to establish that Elizabeth Mathus was the duly appointed representative of the minor. The Commission entered and continued the matter pending presentation of evidence of proper appointment of a legal representative to represent the interests of Austin Michael Inzerma. (See order attached as Exhibit 1).

On February 26, 2020 an order was entered in the Circuit Court of the Second Judicial Circuit, Jefferson County, Illinois appointing Evelyn Mushero as Special Representative of Austin Michael Inzerma for purposes of "accepting or rejecting an award" in the instant case. The order ratified the representation of Mr. Morrow to represent the estate. (See order attached as Exhibit 2). The Commission thereafter deliberated on April 28, 2020 on the Petition for Review previously filed by Respondent.

Discussion

The parties stipulated to accident, notice, causation, and temporary total disability benefits paid from December 24, 2010 through November 22, 2011. Respondent asserted that Petitioner was permanently and totally disabled pursuant to Section 8(f) of the Act commencing November 23, 2011 when Dr. Jacob declared him to be at maximum medical improvement and stated that he was "permanently disabled secondary to visual deficits." Respondent asserts that the benefits for such disability terminated when Petitioner died on December 20, 2014.

Petitioner argued that Petitioner's decedent reached maximum medical improvement on August 27, 2013 and that 1) he was not permanently and totally disabled pursuant to Section 8(f) of the Act; 2) that his resulting permanent partial disability under Section 8(d)2 of the Act survived his death pursuant to Section 8(h); and 3) that the resulting permanent partial disability under Sections 8(e) 6, 8(e)11, and 8(e) 12 survived his death pursuant to Section 8(e)19 of the Act.

The Arbitrator found that Plaintiff's decedent became permanently and totally disabled effective November 23, 2011 based upon Dr. Jacobs' documentation that Petitioner was permanently and totally disabled secondary to his visual deficits. The arbitrator made awards pursuant to Section 8 (d) 2 and Section 8(e) of the Act. The Commission *must vacate* the 8(d)2 award pursuant to the Illinois Supreme Courts ruling in *Beelman Trucking v. Illinois Workers' Compensation Comm'n,* 233 Ill.2d 364,380 (2009). The award of benefits pursuant to Section 8(d) 2 of the Act is hereby vacated. All else is affirmed.

20IWCC0319

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $575.91 per week for a period of 47 5/7 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 to Petitioner permanent total disability benefits of $575.91 per week for 160 4/7 weeks for the period commencing November 23, 2011 through December 20, 2014. Respondent shall pay total disability benefits for 208 2/7 weeks, for a total of $119,953.83.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of benefits pursuant to Section 8(d)2 of the Act is hereby vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner sustained the following losses:

1) 30% loss of use of the left foot (50.1 weeks) pursuant to Section 8(e) of the Act.
2) 15% loss of the use of the right foot (25.05 weeks) pursuant to Section 8(e) of the Act.
3) 5% loss of the use of the right leg (10.75 weeks) pursuant to Section 8(e) of the Act.
4) 30% loss of use of the right great toe (11.4 weeks) pursuant to Section 8(e) of the Act.

Respondent shall pay a total of 97.3 weeks totaling, $50,432.53.

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 in the amount of $120,858.83 for all amounts paid 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 10 2020
SJM/msb
O: 11/6/19
44

Stephen J. Mathis

Douglas McCarthy

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MATHUS, GALE AS GRANDFATHER AND NEXT BEST FRIEND OF MICHAEL INZERMA, AUSTIN A MINOR
Employee/Petitioner

Case# **12WC013080**

20IWCC0319

CONTINENTAL TIRE THE AMERICAS LLC
Employer/Respondent

On 3/14/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.85% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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0299 KEEFE & DePAUL PC
JAMES K KEEFE JR
22 EXECUTIVE DR
FAIRVIEW HTS, IL 62208

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

GALE MATHUS, AS GRANDFATHER AND NEXT BEST FRIEND OF AUSTIN MICHAEL INZERMA, A MINOR
Employee/Petitioner

v.

CONTINENTAL TIRES THE AMERICAS LLC
Employer/Respondent

Case # **12** WC **13080**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christina Hemenway**, Arbitrator of the Commission, in the city of **Mt. Vernon**, on **June 8, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **December 23, 2010**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**44,921.24**; the average weekly wage was $**863.87**.

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

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

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

Respondent shall be given a credit of $**120,858.83** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**120,858.83**.

Respondent is entitled to a credit of $**239,634.41** under Section 8(j) of the Act.

ORDER

As explained in the Arbitration Decision, Respondent shall pay Petitioner temporary total disability benefits of **$575.91** per week for **47 5/7 weeks**, for the period of December 24, 2010, through November 22, 2011. Respondent shall pay Petitioner permanent total disability benefits of **$575.91** per week for **160 4/7** weeks, for the period of November 23, 2011, through December 20, 2014. Respondent shall pay total disability of **208 2/7 weeks**, for a total of **$119,953.83**. Respondent shall receive credit for prior payments totaling **$120,858.83**.

Respondent shall pay Petitioner the sum of **$518.32 per week** for a further period of **150 weeks**, as provided in **Section 8(d)2** of the Act, because the injuries sustained caused a **30% loss of use of the body as a whole**; and a further period of **97.3 weeks**, as provided in Section **8(e) of the Act**, because the injuries sustained caused a **30% loss of use of the left foot** (50.1 weeks), **15% loss of use of the right foot** (25.05 weeks), **5% loss of use of the right leg** (10.75 weeks), and **30% loss of use of the right great toe** (11.4 weeks). Respondent shall pay a total of **247.30 weeks**, totaling **$128,180.54.**

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

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

Signature of Arbitrator

March 13, 2018
Date

STATE OF ILLINOIS)
) SS
COUNTY OF JEFFERSON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

GALE MATHUS, AS GRANDFATHER AND NEXT BEST FRIEND OF AUSTIN MICHAEL INZERMA, A MINOR
Employee/Petitioner

v.

Case #: **12 WC 13080**

CONTINENTAL TIRES THE AMERICAS LLC
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

The parties stipulated that on December 23, 2010, David Mathus ("David") sustained an accident which arose out of and in the course of his employment with Respondent. On that date, he was driving a forklift when several pallets of large tires fell on him, resulting in serious injuries to multiple body parts including his brain, skull, face, legs, feet, and right toe. He filed an Application for Adjustment of Claim on April 13, 2012, alleging he had suffered multiple fractures; multiple injuries to muscles, tissues, ligaments, and organs; and multiple functional impairments. On December 20, 2014, David died of causes unrelated to the injuries he suffered at work.

On February 17, 2015, Gale Mathus, ("Gale"/Petitioner) as grandfather and next best friend of Austin Michael Inzerma, filed an Amended Application for Adjustment of Claim. On the date of David's accident, on the date of his death, and on the date of arbitration, he was survived by his minor son Austin Inzerma as well as two adult non-dependent children. On the date of his death, David was obligated to pay child support for his minor son Austin.

Respondent stipulated to accident, notice, causation, and temporary total disability benefits from December 24, 2010, through November 22, 2011. Respondent asserts that Petitioner was permanently and totally disabled from November 23, 2011, through the date of his death on December 20, 2014. Petitioner asserts that David reached maximum medical improvement on August 27, 2013, and that he was entitled to maintenance benefits from August 28, 2013, through his death on December 20, 2014. Petitioner further asserts that David's claim survives through his minor son, Austin Inzerma, and that permanent partial disability benefits are thereby owed. He did not return to any employment before his death on December 20, 2014. Respondent paid weekly benefits from the day after the accident until the date of his death at the rate of 66 2/3% of his average weekly wage.

Following David's accident on December 23, 2010, he was transferred to Barnes Hospital in St. Louis, Missouri. He sustained multiple injuries to multiple body parts, including skull, brain, face, feet, legs, and right great toe. He underwent multiple surgeries and a prolonged period of treatment.

Neurosurgeons Dr. John Kirby and Dr. Albert Riew diagnosed a **left zygoma fracture** and **left orbital roof fracture** extending into a **left skull fracture**. They performed surgery consisting of open reduction and internal fixation of the zygomaticomaxillary fracture, open reduction and internal fixation of the left orbital roof fracture and reconstruction of the left orbital blowout fracture with Medpor implant. Subsequently, neurosurgeons Dr. Kirby and Dr. Joshua Dowling performed bi-frontal craniotomy to repair the skull fractures, exenteration of the frontal sinuses, and evacuation of a left frontal epidural hematoma. RX1.

David suffered **bilateral malleolus fractures** and **right metatarsal fractures involving all five toes**. On December 27, 2010, Dr. Christopher McAndrew performed open reduction and internal fixation of the left lateral malleolus fracture, closed treatment of the right medial malleolus fracture and closed treatment of the right metatarsal fractures. David was discharged from Barnes Hospital on December 30, 2010. RX1. His care was transferred to The Rehabilitation Institute of St. Louis, where he remained inpatient under the care of Dr. Sindhu Jacob until February 16, 2011. RX1. Upon discharge from The Rehab Institute, he was prescribed multiple medications and instructed to follow up with the neurosurgeon, Dr. Dowling, and his primary care physician for medication management. RX3.

On January 18, 2011, David was evaluated by Dr. Nicole Werner for a neuropsychological evaluation. Dr. Werner diagnosed (1) a traumatic brain injury with less than one month of post-traumatic amnesia; (2) a moderate to severe deficit in verbal memory and milder deficits in sustained attention and processing speed; and (3) probable bi-temporal hemianopsia. It was noted that language functions, visual spacial processing, visual and memory and executive functioning were relatively spared. She opined that the cognitive deficits were likely as a result of the traumatic brain injury and hemorrhages. Additional cognitive recovery was expected for the next several months. Dr. Werner recommended supervision and assistance secondary to the cognitive deficits, continued outpatient cognitive rehab and follow up with a neuro-ophthalmologist secondary to the visual problems (bi-temporal hemianopsia). She recommended against driving and indicated that David remained disabled from work. RX4.

David returned to Dr. Werner June 14, 2011. He had a mild deficit in sustained auditory attention with otherwise generally intact cognition. The bi-temporal hemianopsia improved, but was still present. He had improved verbal memory and processing speed, consistent with cognitive recovery after the traumatic brain injury. Dr. Werner felt his cognition was stable. She recommended follow up with a neuro-ophthalmologist given the visual defects. She opined if clinically indicated he could participate in vocational rehabilitation, but that his visual field defect may be a limiting factor in terms of returning to work as a forklift driver. RX3.

For the lower extremity fractures, David followed up with Dr. McAndrew on January 21, February 11, and April 22, 2011. At the final visit, Dr. McAndrew felt that the x-rays showed

good healing of all fractures. David was released to weight bearing as tolerated and was able to return to work from the standpoint of the lower extremities. RX6.

David followed up with the neurosurgeons, including Dr. Couch and Dr. Dowling, on February 16, February 28, March 28, and May 9, 2011. On May 9, 2011, it was noted, "Since his last visit, his vision has not really changed. He feels that he is physical doing fairly well. He also feels that he is doing well cognitively. He is still being followed by Dr. Jacobs in brain injury rehab." On examination, cranial nerve function was reactive to light, facial sensation was diminished over his forehead, his tongue was midline, and strength was 5/5 throughout. Dr. Dowling released him from a neurosurgical standpoint and recommended continued brain rehab with Dr. Jacob. RX5.

David began treating with Washington University Ophthalmology on January 24, 2011. He was diagnosed with bi-temporal hemianopsia with fixation loss in the left eye. He returned on February 28, 2011, and continued to report "tunnel vision" in both eyes. Examination and diagnosis remained unchanged. On May 9, 2011, he returned. Assessment at that time was "complete bi-temporal hemianopsia" and it was noted that the condition was very unlikely to improve over time. The last record from the ophthalmologist was January 9, 2012. His examination and vision were unchanged and it was again noted that there would likely be no further improvement. A repeat MRI was ordered and he was to follow up as needed. RX7.

David was seen by Dr. Jacob on April 12, 2011, and reported he had continued daily headaches. He further reported that his peripheral vision in both eyes was still compromised. It was noted that his cognitive defects seemed to have improved to baseline. He returned on May 3, 2011, and it was noted that his brother accompanied him to the appointment. His brother advised he had difficulty multitasking and got frustrated at times because of his visual defects. It was noted that he continued to have tunnel vision and could only see objects directly in front of him, which Dr. Jacob assessed as "tubular vision". David was instructed not to drive since his vision was "severely compromised". RX3.

On July 12, 2011, David returned to Dr. Jacob and advised he had been told that there was no further recovery expected for his eyesight. Dr. Jacob noted the following: (1) continued headaches, managed with current medications; (2) severe visual field deficits due to bi-temporal hemianopsia; and (3) cognitive deficits near normal on limited testing, neuropsych eval showed improvement to near baseline, depression due to inability to drive or work. Dr. Jacob opined that David was at maximum medical improvement with regard to deficits from his work-related injury. He noted, "His visual deficit doesn't allow him to go back to his job as forklift driver. For the same reason, he won't be a candidate to return to any work which would involve heavy machinery operation. However, he would be able to train in some other clerical type of job with some accommodation which would not require him to have significant peripheral visual input." RX3.

David followed up with Dr. Jacob on November 22, 2011. It was noted, "His visual deficit is his biggest limitation. Dr. Sheppard on his evaluation reported that no significant improvement is expected at this state and that he would be endangering himself and others if he is to return to driving." Cognitive testing appeared normal and it was again noted that the neuropsych eval showed improvement to near baseline. Dr. Jacob again opined that Petitioner was at MMI. He

prepared a separate note which stated, "This is to certify that Mr. David Mathus has reached MMI with regard to the TBI suffered on 12/23/10 and remains **permanently disabled secondary to visual deficits**. He is released to the care of his PCP." RX3.

David returned to Dr. Jacob on August 27, 2013. The note states his last visit was November 2012, but the record supports that the last prior visit was November 2011. He reported worsening headaches, along with nightmares and sleep disturbances. His father, who accompanied him, reported he had a shorter temper. Dr. Jacob recommended a new medication for the headaches and PTSD symptoms. David was still not driving secondary to the visual deficits. RX3.

David received treatment at the Marion Eye Center from January 27, 2010, through June 11, 2013. The visits were primarily for getting corrective eyewear. The doctors' impressions remained bi-temporal hemianopsia with chiasmal lesion. PX4.

David saw his primary care physician on September 4, 2013. He was prescribed medications in accordance with Dr. Jacobs' recommendation for the worsening headaches. PX5.

David underwent physical therapy at Good Samaritan Hospital on February 23, 2011. He gave a history at the initial evaluation that he would like to be able to work again, but did not believe that would happen unless his vision cleared up. PX6.

Respondent's Exhibit 8 consisted of letters from Respondent's counsel to Petitioner's counsel between December 10, 2012, and October 13, 2014, 17 letters in total. In each letter, Respondent stipulated that David (Petitioner at the time) was permanently and totally disabled and that they would be willing to have an award entered so that he would be eligible for the Rate Adjustment Fund. RX8.

Petitioner's Exhibit 8 consisted of emails and letters exchanged between Petitioner's counsel and Respondent's counsel between November 10, 2014, and December 5, 2014. The correspondence indicates that settlement negotiations took place and that a tentative agreement had been reached between the parties. Petitioner's counsel requested contracts be presented to the arbitrator for approval on December 8 or 9, 2014. Respondent's counsel advised he was waiting for further confirmation from Respondent. PX8. The Arbitrator notes that David Mathus passed away on December 20, 2014, prior to settlement contracts being approved.

Petitioner's Exhibit 1 is the Certificate of Live Birth for Austin Michael Inzerma. The father's name is left blank. Petitioner's Exhibit 2 is a Uniform Order for Support entered on October 12, 2011. The Order indicates that DNA results showed David Mathus was the father of Austin Inzerma. Petitioner's Exhibit 3 is the Certificate of Death for David Mathus. Date of death was December 20, 2014, and cause of death was lung cancer. PX1, PX2, PX3.

Gale Mathus/Petitioner testified at trial. He testified that prior to the work accident his son David was extremely active, both at work and outside of work, including using his carpentry skills. He testified that after the accident David was significantly limited in his ability to not only engage in activities he performed before the accident, but also in his ability to walk and see.

On cross-examination, Mr. Mathus testified that David had expressed to him that he did not think he could ever hold a job. He acknowledged that David was on social security disability at the time of his death. He further acknowledged that from the time of the accident through the date of his death, David never looked for work. He testified that David could no longer drive because of his visual defects.

Melody Cravens testified on behalf of Respondent. She testified that David Mathus had been terminated one year post-accident, pursuant to company policy for not having worked in that year. Respondent did not tender vocational rehabilitation to Mr. Mathus because Respondent considered him to be permanently and totally disabled. On cross-examination, Ms. Cravens testified that light duty has been given to other employees at Continental Tire. However, because Mr. Mathus had been terminated one year post-accident, there was never any discussion about allowing him to return to work.

CONCLUSIONS OF LAW

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

In support of the Arbitrator's decision relating to issue (K), Petitioner's entitlement to temporary partial disability and/or maintenance benefits, and issue (L), the nature and extent of Petitioner's injury, the Arbitrator finds the following:

Petitioner first asserts that prior to the death of David Mathus, the parties had a meeting of the minds and an agreement as to settlement of his case. Petitioner further asserts that such agreement to settle should be honored and treated as if such settlement had been finalized. The Arbitrator is not persuaded and finds that any tentative settlement prior to the death of Mr. Mathus was just that—tentative. Settlement contracts were not approved by an arbitrator and thus a settlement of all issues was not effected.

Respondent asserts that (1) Mr. Mathus was permanently and totally disabled from returning to substantial gainful employment pursuant to Section 8(f) of the Act; (2) that he became so disabled as of November 23, 2011, when Dr. Jacob declared him to be at maximum medical improvement and stated that he was "permanently disabled secondary to visual deficits"; and (3) that benefits for such disability terminated when Mr. Mathus died on December 20, 2014.

Petitioner asserts that (1) Mr. Mathus was not permanently and totally disabled pursuant to Section 8(f); (2) that his resulting permanent partial disability under Section 8(d)2 survived his death pursuant to Section 8(h); and (3) that his resulting permanent partial disability under Sections 8(e)6, 8(e)11, and 8(e)12 survived his death pursuant to Section 8(e)19.

Petitioner sustained the following injuries under the purview of Section 8(d)2:

1. Left zygoma fracture, with open reduction and internal fixation
2. Left orbital roof fracture and left skull fracture, with open reduction and internal fixation and reconstruction with implant

3. Bifrontal skull base fractures, with craniotomy for repair of multiple frontal skull fractures
4. Depressed left frontal bone fracture, with exenteration of the frontal sinuses
5. Left frontal epidural hematoma, with evacuation of hematoma and dural repair

Petitioner sustained the following injuries under the purview of Section 8(e):

1. Left lateral malleolus fracture, with open reduction and internal fixation (¶11)
2. Right medial malleolus fracture, with closed treatment (¶11)
3. Right metatarsal fractures of each toe, including comminuted fracture of the proximal phalanx of the great toe with extension into the interphalangeal joint and fractures of the medial and lateral distal phalanx of the great toe with intra-articular extension, with closed treatment of all fractures (¶6 and 7)
4. Right proximal fibula minimally displaced fracture, with closed treatment (¶12)
5. Bilateral loss of vision (¶13)

The Arbitrator finds that Mr. Mathus became permanently and totally disabled effective December 23, 2011, pursuant to Dr. Jacob's determination that he had reached maximum medical improvement but "remains permanently disabled secondary to visual deficits". The Arbitrator further finds this to be a specific case of permanent and complete loss of use of both eyes, pursuant to Section 8(e)18, rather than a nonspecific case pursuant to Section 8(f). In so concluding, the Arbitrator finds significant that all of the treating physicians released Mr. Mathus for his other injuries, but noted that he remained disabled from working due to his bilateral vision deficits. Dr. McAndrew released him for his lower extremity fractures on April 22, 2011. Dr. Dowling released him for his skull and facial fractures on May 9, 2011. Dr. Werner released him for his neuropsychological issues on June 14, 2011. Dr. Jacob released him for his traumatic brain injury on November 22, 2011. It is uncontroverted that Mr. Mathus sustained loss of vision in both of his eyes, that only tunnel or tubular vision remained, and that such loss of vision precluded him from driving or returning to work.

The Arbitrator further finds that Mr. Mathus reached maximum medical improvement for his remaining injuries prior to his death and that permanent partial disability for those injuries survived his death, pursuant to Section 8(h) and Section 8(e)19.

The Act permits a worker to recover for the loss of two members under Section 8(e)18 as well as for any additional scheduled losses beyond the two losses compensated under that section. *Beelman Trucking v. Illinois Workers' Compensation Comm'n*, 233 Ill.2d 364, 380 (2009).

The Arbitrator finds that Mr. Mathus sustained the following:

1. 30% loss of use of the person as a whole (150 weeks), pursuant to Section 8(d)2 of the Act.
2. 30% loss of use of the left foot (50.1 weeks), pursuant to Section 8(e) of the Act.
3. 15% loss of use of the right foot (25.05 weeks), pursuant to Section 8(e) of the Act.
4. 5% loss of use of the right leg (10.75 weeks), pursuant to Section 8(e) of the Act.
5. 30% loss of use of the right great toe (11.4 weeks), pursuant to Section 8(e) of the Act.

The Arbitrator finds that Mr. Mathus was temporarily and totally disabled from December 24, 2010, through November 22, 2011, a period of 47 5/7 weeks. The Arbitrator further finds that Mr. Mathus was permanently and totally disabled from November 23, 2011, through the date of his death on December 20, 2014, a period of 160 4/7 weeks. The total disability is 208 2/7 weeks.

The parties stipulated that the average weekly wage was $863.87. The Arbitrator finds the temporary total disability rate and the permanent total disability rate is $575.91. Respondent is liable for benefits of $119,953.83. The parties stipulated and the Arbitrator finds that Respondent is entitled to a credit of $120,858.83 for benefits previously paid.

The Arbitrator finds that Mr. Mathus sustained a total of 247.30 weeks of permanent partial disability, which survived under Sections 8(e)19 and 8(h), and that Respondent is liable to Petitioner for this. The Arbitrator further finds the permanent partial disability rate is $518.32.

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

Megan Miller,

20IWCC0320

Petitioner,

vs. No. 10 WC 44485

LaSalle Veteran's Home/State of Illinois,

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, temporary disability, maintenance, permanent disability and benefit rates, 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 finds the Arbitrator's award of temporary total disability benefits actually encompasses periods of temporary total disability and maintenance. The Commission awards temporary total disability benefits from November 6, 2010 through April 1, 2014, the date Dr. An found Petitioner at maximum medical improvement and imposed permanent restrictions. The Commission awards maintenance benefits from April 2, 2014 through April 25, 2015, the day before Petitioner started a part-time job at Arby's.

The Commission corrects the summary of Findings to reflect, consistently with the Statement of Facts, that the parties stipulated to an average weekly wage of $648.04.

The Commission affirms and adopts the Arbitrator's award of accrued and prospective section 8(d)1 benefits. With respect to accrued 8(d)1 benefits, the Commission affirms and adopts the Arbitrator's calculations of: the sum of $19,146.92 for the period from April 26, 2015 to April 26, 2016; the sum of $33,286.68 for the period from April 26, 2016 to December 31, 2017; and the sum of $37,022.48 for the period from January 1, 2018 to August 26, 2019. The accrued 8(d)1 benefits total

$89,456.08. The Commission also agrees with the Arbitrator's calculations of prospective 8(d)1 benefits of $420.71 per week.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 3, 2019 is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $432.03 per week for a period of 177 4/7 weeks, from November 6, 2010 through April 1, 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 to Petitioner maintenance benefits of $ 432.03 per week for a further period of 55 4/7 weeks, from April 2, 2014 through April 25, 2015.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay reasonable and necessary medical expenses of $107,340.42, pursuant to §§8(a) and 8.2 of the Act. To the extent Respondent claims §8(j) credit, Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner benefits under Section 8 (d) 1 of the Act from April 26, 2015 to the date of the arbitration hearing in the amounts referenced above.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $420.71 per week commencing August 26, 2019 (the date of the arbitration hearing) for the duration of Petitioner's disability as provided in §8(d)1 of the Act, for the reason that the injuries sustained caused Petitioner to become partially incapacitated from pursuing her usual and customary line of employment.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner accrued §8(d)1 benefits in the sum of $89,456.08.

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

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

20 IWCC0320

Pursuant to §19(f)(1) of the Act, there shall be no right of appeal as the State of Illinois is Respondent in this matter.

DATED: JUN 10 2020

d-05/06/2020
SM/sk
44

Stephen Mathis

Douglas McCarthy

SPECIAL CONCURRENCE/DISSENT

I concur with the decision reached by the Majority save its award of benefits pursuant to Section 8(d)1 of the Act. As to this award, I respectfully dissent.

At arbitration, Petitioner sought wage differential benefits. Pursuant to Section 8(d)1, an impaired worker is entitled to a wage differential award when she is (1) "partially incapacitated from pursuing [her] usual and customary line of employment" and (2) there is a "difference between the average amount which [she] would be able to earn in the full performance of [her] duties in the occupation in which [she] was engaged at the time of the accident and the average amount which [she] is earning or is able to earn in some suitable employment or business after the accident." *820 ILCS 305/8(d)1* (West 2012). The Majority in affirming and adopting the Arbitrator's decision concluded that Petitioner proved both elements and, in calculating the benefits owed, relied on the opinions of both vocational experts (Mr. Matthew Sprong and Ms. Tracey Peterlin), thereby determining that Petitioner is capable of earning between $9.25 and $10.00 per hour for a varying work week. While I agree Petitioner established entitlement to wage differential benefits, I view the evidence as to earning capacity differently. Instead, I find the evidence establishes three distinct Section 8(d)1 amounts for five separate durations based upon a 40-hour work week.

Calculating the wage differential rate requires the Commission to make two earnings determinations: (1) "the average amount which [she] would be able to earn in the full performance of [her] duties in the occupation in which…[she] was engaged at the time of the accident," and (2) "the average amount which [she]…is able to earn in some suitable employment or business after the accident." *820 ILCS 305/8(d)1*. It is certainly clear the rate for future wage differential benefits must be determined as of the hearing date. *See, e.g., United Airlines, Inc. v. Illinois Workers' Compensation Commission*, 2013 IL App (1st) 121136WC, ¶22, 991 N.E.2d 458 ("The statute, under its plain and ordinary language, does not contemplate multiple figures to be computed and awarded at future dates."). However, as the Supreme Court of Illinois made clear in *Cassens Transportation Co. v. Industrial Commission*, the Commission must consider evidence of changing circumstances and the effect of new information as it developed prior to arbitration:

> By its plain language, [Section 8(d)1] allows arbitrators and the Commission the option of determining that a claimant's disability is likely to end, abate, or increase after a certain duration, and awarding compensation accordingly. *See, e.g., Phillips v. Consolidated Personnel Corp.*, Ill. Workers' Compensation Comm'n, No. 01WC 59242 (May 25, 2005) (awarding worker three separate section 8(d)(1) wage differential awards for three separate durations)...the Act establishes that employees and employers alike must use the opportunity of their initial hearing to present evidence showing the likely duration of an injury and its effect on the claimant's earning capacity." *Cassens Transportation Co.*, 218 Ill.2d 519, 529-30, 844 N.E.2d 414 (2006).

On April 1, 2014, Dr. An found Petitioner's condition of ill-being plateaued. Dr. An released her to return to work within the parameters of the FCE of no lifting greater than 20 pounds and to avoid frequent bending and twisting. PXB; PXF. No restriction was provided regarding work hours.

On April 2, 2014, Petitioner embarked on vocational retraining during which time she was paid maintenance benefits. On April 24, 2015, Petitioner accepted a part-time job paying $9 per hour with the "opportunity for bonuses, commission, and additional hours..." RX6. Petitioner testified she decided not to pursue this employment position as she did not understand the computers. T. 39. Instead, Petitioner obtained employment at Arby's initially earning $9.25 then $9.50 an hour; then at the beginning of 2016, Petitioner earned $10.00 an hour all while working a 30-hour work week. T. 39-40. Petitioner remained at Arby's through March 20, 2018 when she accepted a job at Farmers Insurance making the same rate of pay and working the same hours; the job she continues to work. T. 41-42.

On May 17, 2010, Petitioner commenced her employment with Respondent as a CNA on a salaried basis. T. 25-26. Ms. Monica Weeks, a human resources specialist for Respondent testified on behalf of Petitioner. Ms. Weeks identified a general pay plan which was offered into evidence as PXI which evidences Step and salary increases. PXI. Unfortunately, there is no testimony as to specific meaning of the numbers identified on this document. In reviewing PXI in conjunction with Ms. Meeks testimony that Petitioner earned a monthly salary of $2801.00, this would qualify her as a VETERAN'S NURSING ASSISTANT-CERTIFIED (RC-009-12) at Step 1a. PXI, T. 25.

Assuming annual increases as testified to by Ms. Meeks, as of April of 2015 (the commencement of her new employment), Petitioner would be a VETERAN'S NURSING ASSISTANT-CERTIFIED (RC-009-12-B) at Step 5 earing an annual salary of $44,112.00 with a weekly wage of $848.31. PXI. At Arby's Petitioner earned $9.50 per hour which at a 40-hour work week equals $380.00 per week. As such, the wage differential is $312.21 per week. This differential is payable through December 31, 2015. On January 1, 2016, Petitioner's hourly rate increased to $10.00 (T. 40) resulting in a weekly wage of $400.00, thereby decreasing the differential to equal $298.87 per week payable through March 31, 2016.

As of April 1, 2016, Petitioner would qualify as a VETERAN'S NURSING ASSISTANT-CERTIFIED (RC-009-12-B) at Step 6 earning an annual salary of $45,576.00 with a weekly wage of $876.46. PXI. With her current earnings of $400.00 per week, this results in a differential equal to $317.64 payable through April 30, 2017.

As of May 1, 2017, Petitioner would qualify as a VETERAN'S NURSING ASSISTANT-CERTIFIED (RC-009-12-B) at Step 7 earning an annual salary of $45,580.00 with a weekly wage of $915.00. PXI. With her current earnings of $400.00 per week, this results in a differential equal to $343.33 payable through April 30, 2018.

As of May 1, 2018, Petitioner would qualify as a VETERAN'S NURSING ASSISTANT-CERTIFIED (RC-009-12-B) at Step 8 (the maximum salary) earning an annual salary of $49,488.00 with a weekly wage of $951.69. PXI. With her current earnings of $400.00 per week, this results in a differential equal to $367.79 payable through the duration of her disability.

For the above stated reasons, I dissent as to the calculation of the award of benefits pursuant to Section 8(d) 1 of the Act.

L. Elizabeth Coppoletti

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MILLER, MEGAN
Employee/Petitioner

Case# **10WC044485**

20IWCC0320

LASALLE VETERAN'S HOME
Employer/Respondent

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:

5475 BERTRAND LAW OFFICE
LOUIS L BERTRAND
613 1ST ST SUITE 100
LA SALLE, IL 61301

5001 ASSISTANT ATTORNEY GENERAL
JOSEPH BLEWITT
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

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

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

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

OCT 3 - 2019

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

STATE OF ILLINOIS)
)SS.
COUNTY OF LaSalle)

20 IWCC0320

☐ 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

Megan Miller
Employee/Petitioner

v.

LaSalle Veteran's Home
Employer/Respondent

Case # **10** WC **44485**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Seal**, Arbitrator of the Commission, in the city of **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 **Is the Petitioner entitled to a wage differential due to her injury?**

FINDINGS

On **11-5-2010**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**35,360.00**; the average weekly wage was $**680.00**.

On the date of accident, Petitioner was **27** years of age, ***single*** with **1** 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 $**97,860.54** for TTD, $**2,715.74** for maintenance for a total credit of $**100,576.28**.

ORDER

Respondent shall be given a credit of $**97,860.54**, and $**2,715.74** for maintenance benefits, for a total credit of $**100,576.28**.

Respondent shall be given a credit for any 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

Respondent shall pay reasonable and necessary medical services of $107,340.42, as provided in Section 8(a) of the Act.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $432.03/week for 228 weeks, commencing 11-5-10 through 4-26-15, as provided in Section 8(b) of the Act.

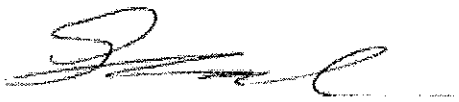
Respondent shall be given a credit of $97,860.54 for temporary total disability benefits that have been paid.

Permanent Partial Disability: Wage differential

Respondent shall pay Petitioner permanent partial disability benefits, commencing 4-26-15 through 8-28-19, totaling $89,456.08 to the date of the hearing, because the injuries sustained caused a loss of earnings, as provided in Section 8(d)1 of the Act.
Respondent shall pay Petitioner the sum of $420.71per week from the date of the hearing for the lifetime of the Petitioner for wage differential under section 8(d)1 of the Act.

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

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



Signature of Arbitrator

October 2, 2019
Date

OCT 3 - 2019

STATEMENT OF FACTS

Petitioner first saw Dr. An at the request of the Respondent. Dr. An found the Petitioner's condition of ill being causally related the industrial injury sustained on November 5, 2011. He found that she was temporarily totally disabled from working from the injury date until she reached maximum medical improvement, which was March 24, 2014. Dr. An performed surgery on the Petitioner on November 8, 2012. The Petitioner underwent a partial laminectomy of L5, foraminotomy at L5-S1. Insertion of an interbody device at L5-S1 disk space, posterior instrumentation at L5-S1 and a posterolateral fusion at L5-S1 with allograft.

The Petitioner was released to work on March 24, 2014, with the following restrictions: no lifting greater than 20 pounds, avoid frequent bending or twisting, and frequent lifting of 10 pounds or less. At that time, Dr. An indicated that the physical restrictions were permanent.

The Petitioner cannot return to her previous employment as a CNA in any capacity. Functional Capacity Evaluations confirm Dr. An's restrictions as of the date the Petitioner had reached MMI. The Respondent then hired a vocational rehabilitation expert to provide job placement assistance. The Petitioner was able to secure employment on April 26, 2015, at Arby's and was earning $9.25 per hour working 32 hours a week with the employer being able to accommodate her work restrictions. In April of 2016, her wages were increased to $10.00 per hour still working 32 hours per week. The employer was then purchased by a different company and at that time the employer was less able to work with the Petitioner to

provide work accommodations. She left the employ of Arby's and started working at Farmer's Insurance on March 20, 2018, and they were better able to accommodate her work restrictions. She was then earned $10.00 per hour and continues to do so. She works an average of 30 hours a week.

The Petitioner had an AWW of $648.04 by agreement of the Petitioner and the Respondent. The Petitioner submitted as Exhibit "I" the HR director for the Respondent provided evidence of what the Petitioner would have been making had she stayed in the employ of the Respondent. The totals for the relevant periods of time are as follows:

January 1, 2011 to July 1, 2011-AWW=$652.85
July 1, 2011 to December 31, 2011-AWW=$682.62
January 1, 2012 to February 1, 2012-AWW=$705.00
February 1, 2012 to July 1, 2012-AWW=$730.62
July 1, 2012 to July 1, 2013-AWW=$753.92
July 1, 2013 to March 1, 2014-AWW=$780.92
March 1, 2014 to July 1, 2014-AWW=$805.85
July 1, 2014 to December 31, 2014-AWW=$822.00
January 1, 2015 to April 1, 2016-AWW=$848.31
April 1, 2016 to December 31, 2017-AWW=$915.00
January 1, 2018 to August 26, 2019-AWW=$951.69

Wage differential calculation:

April 26, 2015 to April 26, 2016-Earnings-$9.25 x 32 hours=$296.00
AWW=$848.31
66% of Differential is $368.21 x 52 weeks=$19,146.92
April 26, 2016 to December 31, 2017-Earnings-$10.00 x 32 hours=$320.00
AWW=$915.00
66% of Differential is $396.27 x 84 weeks=$33,286.68
January 1, 2018 to August 26, 2019 Earnings-$10.00 per hour x 32 hours=$320.00
AWW=$951.69
66% of Differential is $420.71 x 88 weeks=$37,022.48
Total differential from 4-26-2015 to present is:
$89,456.08.

CONCLUSIONS OF LAW

The Arbitrator finds that pursuant to Section 8(d)1 of the Act the Petitioner is owed $89,456.08 in accrued wage differential from April 26, 2015, to the date of arbitration, August 26, 2019.

The Arbitrator further finds that the Respondent is ordered to pay the Petitioner the sum of $420.71 per week for the lifetime of the Petitioner.

Both vocational rehabilitation experts who have submitted reports in this case agree that the current earnings of the Petitioner are within the expected earnings for the Petitioner given her permanent physical restrictions, education, training and transferrable job skills. The expectation is that her earnings would fall between $8.25 and $12.89 per hour. The current earnings are within that range. The medical records in this case establish from every competent source that the restrictions set forth above established as of March 24, 2014, when the Petitioner reached MMI, are permanent and prevent the Petitioner from performing her normal job duties.

The Petitioner has sustained a loss of earnings capacity as set forth above and is entitled to wage differential payments as set forth herein above.

The Arbitrator further finds that all of the medical bills contained in Petitioner's exhibit "G" are causally related to the work-related injury that occurred on November 5, 2010, and are reasonable and necessary. The Respondent is ordered to pay the sum of $107, 340.42 to the Petitioner.

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

Melba Johnson,
Petitioner,

vs. No. 18 WC 14356

Unity Point Methodist,
Respondent.

20IWCC0321

DECISION AND OPINION ON REVIEW

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

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

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

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

20IWCC0321

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: JUN 10 2020

Marc Parker

mp/wj
06/04/20
68

Deborah L. Simpson

Barbara N. Flores

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

JOHNSON, MELBA
Employee/Petitioner

Case# **18WC014356**

UNITY POINT METHODIST
Employer/Respondent

20IWCC0321

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:

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

5354 STEPHEN P KELLY ATTY AT LAW
MATTHEW BREWER
2710 N KNOXVILLE AVE
PEORIA, IL 61604

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
19(b)

MELBA JOHNSON
Employee/Petitioner

v.

UNITY POINT METHODIST
Employer/Respondent

Case # **18** WC **14356**

Consolidated cases: **N/A**

20 IWCC0321

An *Application for Adjustment 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 **Rock Island**, on **October 9, 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, **04/28/18**, 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 $**28,190.76**; the average weekly wage was $**542.13**.

On the date of accident, Petitioner was **69** years of age, ***single*** with **0** dependent children.

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

Respondent shall be given a credit of $**4,543.57** for TTD, $**0** for TPD, $**0** for maintenance, and $**20,325.66** for other benefits, for a total credit of $**24,869.23**.

ORDER

Respondent shall pay reasonable and necessary medical services of $84,091.51, as provided in Sections 8(a) and 8.2 of the Act and subject to the medical fee schedule. The payment shall be sent directly to Petitioner's attorney in accordance with Section 9080.20 of the Rules Before the Illinois Workers' Compensation Commission. Respondent shall receive a credit for any medical expenses it has already paid.

Respondent shall pay Petitioner temporary total disability benefits of $361.42/week for 74 weeks, commencing 5/10/18 through 10/9/19, as provided in Section 8(b) of the Act.

Respondent shall authorize and provide payment for the medical treatment, recommended by Petitioner's treating physician Dr. Rhode, including his recommendation for surgery to Petitioner's left knee. The authorization shall be in writing and forwarded to Petitioner's attorney.

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

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

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

Signature of Arbitrator Gerald Granada

11/7/19
Date

NOV 8 - 2019

20IWCC0321

FINDINGS OF FACT

This case involves Petitioner, Melba Johnson, who alleges injuries sustained while working for Respondent Unity Point Methodist on April 28, 2018. Respondent disputes Petitioner's claims, with the issues being: 1) causation; 2) medical expenses; 3) prospective medical care; and 4) TTD.

Petitioner worked for Respondent as a certified nurse's assistant for approximately 6-1/2 years. Her employment with Respondent was terminated in August 2018. Petitioner is currently unemployed and resides in Tennessee. Her duties as a nursing aide for Respondent required her to engage in some heavy lifting. Prior to her undisputed work accident on April 28, 2018, Petitioner would work approximately 60 hours a week. She did not have any prior problems with her neck, low back, left shoulder or left hand and other than a baker cyst in her left knee she did not have any problems with her left knee.

On April 28, 2018, Petitioner was injured while working for Respondent when she tripped and fell on an IV cord. Petitioner testified that her left foot caught on the IV cord laying on the floor and as she was falling she tried to break her fall with her left hand. She struck her left knee on the floor and fell on her hip and low back. She later started experiencing head pain. Petitioner testified that she twisted her left knee and her whole left side of the body during the fall. After the accident, she notified her immediate supervisor, and was later instructed to be checked at Unity Point Methodist Emergency Room.

The Unity Point Health medical records reflect that on April 28, 2018 Petitioner presented with a history of a fall consistent with Petitioner's testimony. The medical records indicate that Petitioner struck her left knee on the floor and she has pain to that area. She also reported soreness to her left hip and lower back, which she twisted in the fall. A physical examination of patient's left knee revealed medial joint line tenderness, medial and patella tenderness. (PX 5, p.8) Petitioner was diagnosed with acute pain of left knee. Imaging of her knee was ordered, she was given ibuprofen, and was instructed to follow up with Illinois Work Injury Resource Center (IWIRC).

Petitioner followed up with IWIRC on May 1, 2018, where she complained of left shoulder, left knee and neck pain. Physical examination revealed edema to the left knee. She was diagnosed with cervical sprain/strain, sprain/strain of left shoulder/upper arm tendon and contusion of left knee. She was given thermal soft gel cold/hot pack, self-adhering wraps, and was instructed to perform home exercises for her back and shoulder and was referred for physical therapy. She was also given cyclobenzaprine with a recommendation to return to work with light duty restrictions.

After visiting IWIRC Petitioner spoke to Kerry Owens, who testified via evidence deposition. (RX 6) Ms. Owens testified that she discussed the facts of the accident with Petitioner and completed the Form 45. She testified that Petitioner did not notify her about twisting her left leg but only notified her of twisting her body. She did note that as a result of the accident Petitioner sustained left thigh swelling pain, left shoulder pain, neck pain and did acknowledge during the fall Petitioner had hit her left thigh, left knee and left wrist.

Petitioner testified that she was not happy with the medical treatment that was being provided to her from IWIRC. She wanted to undergo more diagnostics for her left knee due to the pain, so she made an appointment to see Midwest Orthopaedic Center. Petitioner testified that contrary to what is contained within the medical records of Midwest Orthopaedic Center she did not refuse physical therapy after

seeing IWIRC. The records from Midwest Orthopaedic Center note that Petitioner presented to them for an evaluation of knee pain following a fall at work on April 28, 2018. The records also show that Petitioner reported that her visit was part of a workers' compensation case, however they did not receive any prior workers' compensation authorization. The records indicate Petitioner complained of diffuse pain in her knee that is worse when she is climbing stairs or walking. She also complained of neck and shoulder pain. The records from Midwest further reflect that Petitioner was instructed to perform work on a light duty basis by IWIRC. She did go back to work and was only able to last for about 5 hours and had to leave work because her pain became too severe.

Petitioner's exam at Midwest Orthopaedic Center revealed mild tenderness to palpation over the medial joint line and lateral joint line, and noted mild to trace effusion. After performing a physical examination, a cortisone injection was administered to Petitioner's left knee. The medical records show that Petitioner wanted to undergo an MRI on her left leg, but it was not recommended by Midwest Orthopaedic Center, who noted that Petitioner's visit was technically not a workers' compensation case because they did not have prior authorization and they would therefore bill Petitioner's private insurance. It was also noted that the physician's assistant seeing Petitioner for knee pain could not treat her left shoulder and neck and she was to see Dr. Cohen for evaluation of neck and shoulder pain. Petitioner testified that she did not want the medical treatment to be billed to her private insurance, so she saw Dr. Blair Rhode - a doctor that she was told by her attorney would see her without pre-authorization from the workers' compensation insurance company. Petitioner testified that it was her understanding that the workers' compensation insurance was not approving any further medical treatment other than IWIRC.

On May 10, 2018, the Petitioner saw Dr. Blair Rhode. Dr. Rhode's records note that Petitioner presents due to a work related cervical spine, left shoulder, left hand and left knee injury secondary to a fall while at work on April 28, 2018. She fell on an outstretched left hand and twisted her left knee as she fell. Subsequent x-rays of the knee and shoulder were negative for any fracture. Petitioner complained of lateral shoulder pain with numbness and tingling radiating to the hand and left sided medial knee pain. Petitioner denied a prior cervical, left shoulder or left knee injury. Dr. Rhode noted from his physical examination of Petitioner medial joint line tenderness, lateral joint line tenderness, a positive McMurray along with medial joint with a negative McMurray along the lateral joint line for Petitioner's left knee. The physical examination of her left shoulder revealed a positive impingement sign especially with internal rotation representing posterior rotator cuff. Physical examination of Petitioner's neck revealed a positive left sterling maneuver. Petitioner was assessed with an initial diagnosis of knee pain, shoulder pain, hand pain, rotator cuff strain, cervical radiculopathy and a medial meniscus tear. Dr. Rhode recommended Petitioner undergo an MRI of her cervical spine, left shoulder, and left knee and recommended that Petitioner undergo physical therapy. Dr. Rhode also took Petitioner off of work during this visit.

At Dr. Rhode's recommendation Petitioner started physical therapy at Orland Park Orthopedics on May 15, 2018. She also had MRI's of her left shoulder, her left knee and cervical spine completed on June 1, 2018 at Unity Point Health. The left shoulder MRI indicated rotator cuff tendonitis with rotator cuff impingement by advanced acromoclavicalular joint arthritis, a labral tear, and short segment horizontal bicep tendinosis. The cervical spine MRI revealed moderate central disc bulge at C3-4 with associated posterior osteophyte formation and uncinal spurring, moderate central disc bulge at C6-C7, and mild lesion with changes at other levels. The left knee MRI revealed tri-compartmental chondromalacia with

complex medial and lateral meniscus tear, small to moderate supra patellar bursal effusion with synovitis, miltilocular baker's cyst with partial cyst eruption great to MCL sprain, quadriceps, semi membranous and medial gastrocnemius tendonitis.

Petitioner continued to follow up with Dr. Rhode, who administered injections to Petitioner's left knee on June 13, 2018. On June 27, 2018, Dr. Rhode noted that the injection provided Petitioner with temporary relief and that she continues to experience locking and catching with her left knee. Dr. Rhode noted an underlying degenerative condition superimposed on a medial meniscus tear. He indicated that a knee arthroscopy can improve mechanical symptoms such as locking and catching but would not improve symptomatology associated with degenerative tear. Dr. Rhode acknowledged that Petitioner's primary complaints are mechanical in nature and recommended Petitioner undergo an arthroscopic partial medial meniscectomy. Dr. Rhode subsequently referred Petitioner to Dr. Kube for treatment of her cervical spine.

On August 2, 2018, Petitioner underwent an Independent Medical Evaluation with Dr. Michael Lewis at the request of the Respondent. Dr. Lewis diagnosed Petitioner with a cervical strain superimposed on a pre-existing degenerative disc disease that was resolved at the time of his evaluation. He also diagnosed Petitioner with a resolved left shoulder strain superimposed upon rotator cuff impingement secondary to pre-existing advanced AC joint arthritis. Dr. Lewis also diagnosed Petitioner's left knee condition with a medial collateral sprain superimposed on tri-compartmental degenerative arthritis. He recommended four additional weeks of physical therapy for Petitioner's medial collateral ligament strain. He opined that during the physical therapy Petitioner would require restriction of no prolonged standing.

On August 29, 2018 Petitioner saw Dr. Kube, who recommended Petitioner undergo an EMG, which was completed on September 17, 2018 with Dr. Edward Trudeau. After reviewing the EMG and MRI studies, Dr. Kube offered Petitioner a cervical injection, but did not believe she needed surgery for her cervical condition. Petitioner testified that she no longer sees Dr. Kube after only two to three visits.

Dr. Rhode testified via evidence deposition on April 17, 2019. (See PX 12) He testified that his final diagnosis for Petitioner was that of a medial meniscus tear in her left knee, a rotator cuff strain, and cervical radiculopathy. Dr. Rhode testified that he believes that Petitioner's medial meniscus tear is causally related to her fall based on the mechanism of injury - specifically a twisting of left knee when she tripped over the IV tubing, her subsequent complaints of mechanical locking and catching, and her serial physical exams consistent of a positive medial McMurray on sequential visits, and the MRI findings. He also believes that patient's work related fall onto an outstretched left hand was causative for her rotator cuff strain as it is an eccentric load applied across the tendon, which can stretch the tendon and in worse case scenarios tear it. Dr. Rhode is currently recommending a partial medial meniscectomy to treat Petitioner's knee. Dr. Rhode testified that all medical treatment that he is currently recommending and believes is causally related to Petitioner's April 28, 2018 work accident.

Dr. Michael Lewis testified via evidence deposition on June 24, 2019. (RX 5) Dr. Lewis testified consistent with his Independent Medical Evaluation report in which he opined that Petitioner sustained a sprain of her medial collateral ligament superimposed upon pre-existing tri-compartmental degenerative arthritis, and that other than physical therapy, Petitioner required no additional treatment with regards to the MCL sprain/ strain and was in a position to return to work at a full duty capacity. Dr. Lewis confirmed that the incident form filled out by Petitioner as a result of her accident indicated that

20IWCC0321

Petitioner's left knee was twisted during the accident and that subsequent medical reports show that as a result of the accident, Petitioner injured her left thigh, left shoulder and neck. Dr. Lewis agreed that Petitioner did complain of neck pain and left shoulder pain as early as the day after the accident, but Petitioner did not indicate to him any radicular complaints in his evaluation. Dr. Lewis indicated that the Petitioner's impingement signs noted by Dr. Rhode may have resolved by the time Dr. Lewis saw her. He opined that Petitioner had a sprain of the medial collateral ligament, her positive medial meniscus pathology would be suggestive of a medial collateral ligament strain, and that Petitioner's medial joint line tenderness could be arthritis or it could be a strain of the medial collateral ligament. Dr. Lewis confirmed that Petitioner did have a medial and lateral meniscus tear pertaining to her left knee noted in the MRI of June 1, 2018 and that a twisting mechanism is a competent mechanism for a medial meniscus tear.

Petitioner testified that she continues to experience significant left knee pathology, including locking and catching in her knee. Petitioner wants to undergo the surgical intervention recommended by Dr. Rhode. She still has issues with sitting for very long time, climbing stairs, standing. Petitioner testified that during the pendency of her case, she moved to Tennessee to gain some assistance from family as she was unable to remain in her house due to problems that she was experiencing with her left knee.

CONCLUSIONS OF LAW

1. With regard to the issue of causation, the Arbitrator finds that the Petitioner has met her burden of proof. In support of this finding, the Arbitrator relies on the Petitioner's unrebutted testimony and the preponderance of the medical evidence. The dispute on this case is focused on Petitioner's left knee injury and is in part based on a question of the mechanism of Petitioner's injury (i.e. did she twist her knee), and on the different medical opinions (i.e. strain or tear). The majority of the evidence supports Petitioner's claim that she twisted her left knee during her undisputed April 28, 2018 accident when she tripped on an IV cord while working for Respondent. Both the initial injury report (PX 1) and the Form 45 report (PX 2) make reference to Petitioner twisting either her knee (per the injury report) or her body (per the Form 45) – which Petitioner addressed in her testimony when she explained that her leg is part of her body that she twisted when she fell. The subsequent medical evidence shows a consistent history of Petitioner's account of twisting her leg when she fell. Accordingly, the Arbitrator concludes that the Petitioner twisted her knee when she fell during her undisputed accident. As to the question of medical causation, the Arbitrator finds persuasive the medical evidence from Petitioner's treating physicians. Although Respondent's IME, Dr. Lewis notes Petitioner sustained a sprain injury, he does not deny the MRI findings showing a tear in Petitioner's left meniscus. There is no evidence that Petitioner sustained the tear in her meniscus from any intervening incident. Petitioner's continued complaints of pain with locking and catching in her knee comport with Dr. Rhode's assessment of a meniscal tear injury. Based on the preponderance of the medical evidence, the Arbitrator concludes that the Petitioner's current condition of ill-being – specifically her left medial and lateral meniscus tear – are causally connected to her undisputed April 28, 2018 work accident.

2. Regarding the issue of medical expenses, the Arbitrator finds that the Petitioner's medical treatment as set forth in the medical evidence has been reasonable and necessary in addressing her work-related conditions, and as such awards all related expenses. This issue has been in dispute based on the question of causation and the Arbitrator's decision on this issue is based on the above findings regarding

causation. As such, the Respondent shall pay the medical expenses totaling $84,091.51 set forth in Petitioner's Exhibit #16, subject to the Fee Schedule. Respondent shall receive a credit for any medical expenses it has already paid. Payment of said expenses shall be made directly to the Petitioner via her attorney in accordance with Section 9080.20 of the Rules of the Illinois Workers Compensation Commission.

3. Consistent with the Arbitrator's conclusions above, the Arbitrator further finds that the Petitioner's request for prospective medical care is reasonable and necessary in addressing her work related condition. Respondent shall authorize and pay for the Petitioner's prospective medical care recommended by Dr. Rhode to address Petitioner's work-related conditions, including the recommendation for surgery to the Petitioner's left knee.

4. Regarding the issue of TTD and consistent with the conclusions above, the Arbitrator further finds that the Petitioner was temporarily totally disabled from the date she was taken off work by Dr. Rhode on May 10, 2018 through the date of the arbitration hearing. In support of this finding, the Arbitrator relies on the Petitioner's unrebutted testimony and the preponderance of the medical evidence, which show that Petitioner was either taken off work completely or given restrictions, which Respondent did not accommodate. The records show that Petitioner's employment was terminated while she was on work restrictions and said restrictions have not been lifted. Accordingly, Respondent shall pay Petitioner TTD benefits that have accrued from May 10, 2018 through October 9, 2019, a period of 74 weeks. Respondent shall receive a credit for any TTD it may have paid during this time period.

16 WC 29265

20IWCC0298

STATE OF ILLINOIS) BEFORE THE ILLINOIS WORKERS' COMPENSATION

)SS COMMISSION

COUNTY OF MADISON)

SANDRA KENNEDY,

Petitioner,

v. 16 WC 29265

WARREN G. MURRAY CENTER, 20 IWCC 0298

Respondent.

ORDER OF RECALL UNDER SECTION 19(F)

The Commission on its own Motion recalls the Decision and Opinion on Review of the Workers' Compensation Commission dated May 28, 2020, pursuant to Section 19(f) of the Act due to a clerical error.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision and Opinion on Review dated May 28, 2020 is hereby recalled and a Corrected Decision and Opinion on Review is hereby issued simultaneously.

Stephen J. Mathis

STEPHEN J. MATHIS

DATED: JUN 10 2020

SJM/sj

44

16 WC 29265
20IWCC0298

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

Sandra Kennedy,

Petitioner,

vs.

NO: 16 WC 29265
20IWCC0298

Warren G. Murray Center,

Respondent.

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

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

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

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

Pursuant to §19(f)(1) of the Act, this Decision and Opinion on Review of a claim against the State of Illinois is not subject to judicial review.

DATED: JUN 10 2020
SJM/sj
o-5/19/2020
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

KENNEDY, SANDRA K
Employee/Petitioner

Case# **16WC029265**

WARREN G MURRAY CENTER
Employer/Respondent

20IWCC0298

On 7/8/2019, 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 2.04% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

0558 ASSISTANT ATTORNEY GENERAL
NICOLE M WERNER
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

1745 DEPT OF HUMAN SERVICES
BUREAU OF RISK MANAGEMENT
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

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

JUL - 8 2019

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

20 IWCC0298

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)

Sandra K. Kennedy
Employee/Petitioner

v.

Warren G. Murray Center
Employer/Respondent

Case # 16 WC 29265

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 Collinsville, on May 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 _____

20IWCC0298

FINDINGS

On the date of accident, June 13, 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 $39,851.89; the average weekly wage was $813.30.

On the date of accident, Petitioner was 56 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 $19,790.00 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $19,790.00.

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 as identified in Petitioner's Exhibit 7, 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 cervical fusion surgery recommended by Dr. David Robson.

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 2, 2019
Date

JUL 8 - 2019

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged she sustained an accidental injury arising out of and in the course of her employment by Respondent on June 13, 2016. According to the Application, "Petitioner was injured while trying to change and dress an uncooperative individual" and sustained an "Acute cervical injury, MAW & other body parts" (Arbitrator's Exhibit 2). This case was tried in a 19(b) proceeding and Petitioner sought an order for payment of medical bills as well as prospective medical treatment. By agreement, counsel for Petitioner and Respondent reserved issues in regard to Petitioner's entitlement to temporary total disability and temporary partial disability benefits. Respondent stipulated Petitioner sustained a work-related accident, but disputed liability on the basis of causal relationship (Arbitrator's Exhibit 1).

Petitioner worked for Respondent as a mental health technician. On June 13, 2016, Petitioner was attempting to change the clothing of a patient who was uncooperative. Petitioner was next to the patient's bed and, when she attempted to raise him, she felt a "shock" in the base of her neck. The accident was reported to Respondent in a timely manner.

Petitioner initially sought medical treatment at SSM Health Express Clinic on June 13, 2016, where she was seen by Kendra Bowen, a Physician Assistant. Petitioner informed PA Bowen of the accident and complained of pain referable to the upper back. PA Bowen diagnosed Petitioner with a muscle strain and prescribed medication (Petitioner's Exhibit 1).

Petitioner was subsequently evaluated by Dr. Robert Guillemette, a physician with SSM Health Express Clinic, on June 28, 2016. At that time, Petitioner complained of upper back/neck pain. Dr. Guillemette prescribed medication and ordered physical therapy (Petitioner's Exhibit 1).

Dr. Guillemette continued to see Petitioner in July/August, 2016. When he saw Petitioner on August 12, 2016, Petitioner had complaints of neck pain with radiation into the right shoulder. Petitioner had been receiving physical therapy, but advised it was not helping. Dr. Guillemette ordered an MRI scan of Petitioner's cervical spine (Petitioner's Exhibit 1).

The MRI was performed on October 7, 2016. According to the radiologist, the MRI revealed degenerative disc disease at C5-C6 and C6-C7 as well as moderate/severe foraminal narrowing relating to disk osteophyte complex (Petitioner's Exhibit 4).

On October 18, 2016, Petitioner was seen at SSM Health Express Clinic by Michelle Harter, a Physician Assistant. PA Harter's record of that date noted the findings of the MRI scan and referred Petitioner to Dr. Robinson [Robson], a spine specialist (Petitioner's Exhibit 1).

Petitioner was evaluated by Dr. David Robson, an orthopedic surgeon, on January 11, 2017. Petitioner advised Dr. Robson of the accident and that she continued to have lower neck and right shoulder pain and physical therapy had worsened her symptoms. Dr. Robson reviewed the MRI scan and opined Petitioner had a disk osteophyte complex at C5-C6 and C6-C7. He recommended Petitioner undergo an epidural steroid injection and referred Petitioner to Dr. Kaylea Boutwell, a pain management specialist (Petitioner's Exhibit 5).

Dr. Boutwell saw Petitioner on February 13, 2017. At that time, Dr. Boutwell administered an epidural steroid injection on the right at C6-C7 (Petitioner's Exhibit 6).

When Petitioner was seen by Dr. Robson on February 23, 2017, she advised the injection had a complete resolution of her pain symptoms; however, it was temporary. Petitioner was again complaining of neck and right arm pain. Dr. Robson recommended Petitioner undergo another epidural steroid injection (Petitioner's Exhibit 5).

Dr. Boutwell again saw Petitioner on March 13, 2017. At that time, Dr. Boutwell administered an epidural steroid injection on the right at C6-C7 (Petitioner's Exhibit 6).

When Petitioner was seen by Dr. Robson on March 30, 2017, she advised the second injection was not as effective as the first. However, Dr. Robson recommended Petitioner undergo another epidural steroid injection (Petitioner's Exhibit 5).

At the direction of Respondent, Petitioner was examined by Dr. Michael Chabot, an orthopedic surgeon, on June 5, 2017. In connection with his examination of Petitioner, Dr. Chabot reviewed medical records provided to him by Respondent. Included in the medical records reviewed/abstracted by Dr. Chabot were medical records, which predated the accident, dated July 5, July 31, and August 14, 2012. According to Dr. Chabot's medical report, the records appeared to be in regard to a lumbar strain (Respondent's Exhibit 4). The actual records were not tendered into evidence at trial.

Dr. Chabot's findings on examination were benign and he noted only a slight decrease of the range of motion of the cervical spine. He reviewed the MRI and agreed it revealed disc degeneration at C5-C6 and C6-C7. Dr. Chabot opined Petitioner was at MMI, could return to work without restrictions and no further medical treatment was indicated, including epidural steroid injections (Respondent's Exhibit 4).

Petitioner was scheduled to be seen by Dr. Robson on June 12, 2017, but the appointment was canceled. At trial, Petitioner testified she was returning from the canceled appointment and was a passenger in a vehicle driven by her husband. While on the highway, the vehicle Petitioner was in was involved in a serious accident and Petitioner's husband was killed as a result thereof. The vehicle's airbag was deployed and Petitioner sustained a fracture of the sternum and two ribs. However, Petitioner testified she did not experience any new neck symptoms as a result of the accident.

Subsequent to the vehicular accident, Petitioner was treated at St. Louis University Hospital. Respondent tendered into evidence the hospital records which confirmed Petitioner sustained a fracture of the sternum as well as the left fourth and fifth ribs. Petitioner underwent CT scans of the cervical, thoracic and lumbar spine, which revealed no evidence of fractures. Petitioner did not receive any treatment for cervical/neck complaints (Respondent's Exhibit 6).

Petitioner was again seen by Dr. Robson on April 25, 2018, which was over one year since the last time she saw him on March 30, 2017. At trial, Petitioner testified that while her neck symptoms continued, her life was dominated by dealing with the tragic loss of her husband.

When Dr. Robson saw Petitioner on April 25, 2018, Petitioner continued to complain of neck pain as well as bilateral arm pain. Petitioner was willing to consider surgery. Dr. Robson reaffirmed his diagnosis of disk osteophyte complex at C5-C6 and C6-C7 which had failed conservative treatment over a significant period of time. Dr. Robson ordered an MRI scan of the cervical spine (Petitioner's Exhibit 5).

The MRI was performed on April 30, 2018. According to the radiologist, there was disc bulging at multiple levels of the cervical spine, mild central canal stenosis at C6-C7 and C7-T1 and moderate left foraminal stenosis at C5-C6 and C6-C7 (Petitioner's Exhibit 5).

Dr. Chabot was deposed on March 23, 2018, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Chabot's testimony was consistent with his medical report and he reaffirmed the opinions contained therein. Dr. Chabot stated that, based upon his review of the medical records, Petitioner had a history of neck complaints prior to the accident of June 13, 2016. He testified Petitioner sustained a lower cervical and thoracic strain as a result of the accident, Petitioner was not in need of any further medical treatment, was at MMI and could work without restrictions (Respondent's Exhibit 5; pp 9, 14-17).

Respondent's counsel then posed a hypothetical question to Dr. Chabot in which they asked him to assume Petitioner had been involved in an automobile accident in which she had sustained a fracture of the sternum and fractured ribs and whether this could affect her cervical condition. Dr. Chabot responded that such an accident could have caused Petitioner to have sustained a whiplash injury (Respondent's Exhibit 5; pp 17-18).

On cross-examination, Dr. Chabot agreed that the records he reviewed regarding the treatment Petitioner sought in July/August, 2012, made no reference to Petitioner having cervical spine or neck complaints. Dr. Chabot also agreed he had no knowledge of Petitioner's current condition or complaints (Respondent's Exhibit 5; pp 19-24).

Dr. Robson was deposed on December 20, 2018, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Robson's testimony was consistent with his medical records and he reaffirmed the opinions contained therein. In regard to his not having seen Petitioner for over one year, Dr. Robson testified it was his understanding Petitioner's husband had died and her life had been dominated with dealing with that tragedy. Dr. Robson ordered the second MRI scan because of the amount of time that had lapsed since the first MRI scan was performed and Petitioner was contemplating surgery (Petitioner's Exhibit 8; pp 12-14).

Dr. Robson testified the MRI scans were similar and consistent with his findings on examination. He recommended Petitioner undergo an anterior cervical discectomy and fusion from C5 to C7. He testified the accident of June 13, 2016, was the cause of the condition he diagnosed and for which he was recommending surgery (Petitioner's Exhibit 8; pp 14-17).

In regard to the automobile accident, Dr. Robson testified this did not cause him to change his opinion in regard to either causation or Petitioner's need for medical treatment (Petitioner's Exhibit 8; pp 18-19).

On cross-examination, Dr. Robson was interrogated about his opinion in regard to the automobile accident. He agreed it was "possible" that a fractured sternum and fractured ribs could have also affected her neck; however, he noted he had reviewed MRIs taken before and after the accident which were "unchanged" (Petitioner's Exhibit 8; pp 26-28).

At trial, Petitioner testified she still has neck and arm pain. Petitioner no longer works as a mental health technician because she obtained a job in Respondent's kitchen. At trial, Petitioner testified she was concerned about the safety of both herself and the patients because of her neck pain. Petitioner stated she does seek help from other employees on an as needed basis. She wants to proceed with whatever treatment Dr. Robson recommends.

Rebecca Spencer testified for Respondent at trial. Spencer was Petitioner's supervisor in dietary. Spencer testified Petitioner was able to perform all of her job duties. On cross-examination, she agreed Petitioner was an honest person.

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 June 13, 2016.

In support of this conclusion the Arbitrator notes the following:

There was no dispute Petitioner sustained a work-related accident injuring her neck and right arm on June 13, 2016.

There was no evidence Petitioner had any neck or cervical spine symptoms prior to June 13, 2016. The prior medical records from July/August, 2012, referenced in Dr. Chabot's report were apparently in regard to a lumbar strain. As noted herein, the actual records were not tendered into evidence at trial.

Petitioner's primary treating physician, Dr. Robson, has opined Petitioner has a disk osteophyte complex at C5-C6 and C6-C7 which has failed conservative treatment. In that regard, Petitioner has received medication, physical therapy and undergone epidural steroid injections. According to Petitioner, the physical therapy worsened her symptoms and the injections only provided temporary relief.

Respondent's Section 12 examiner, Dr. Chabot, opined Petitioner had prior cervical spine and neck complaints, apparently basing this on the medical records from July/August, 2012. As aforestated, these records apparently referenced a lumbar strain. Further, on cross-examination, Dr. Chabot admitted there was no reference in those prior medical records regarding any neck/cervical complaints by Petitioner.

Dr. Chabot has also opined Petitioner may have sustained a whiplash injury as a result of the vehicular accident in which she sustained a fractured sternum and fractured ribs.

Dr. Robson testified the car accident did not cause him to change his opinion in regard to causality. While he agreed it was "possible," the vehicular accident may have affected Petitioner's neck, he noted that he reviewed MRIs of the cervical spine taken before and after the accident which were "unchanged."

Given the preceding, the Arbitrator finds the opinion of Dr. Robson to be more persuasive than that of Dr. Chabot in regard to causality.

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

Based upon the Arbitrator's conclusion of law in regard to disputed issue (F) the Arbitrator concludes that all of the medical treatment provided to Petitioner was reasonable and necessary and Respondent is liable for payment of the medical bills incurred therewith.

Respondent shall pay reasonable and necessary medical services as identified Petitioner's Exhibit 7, 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:

Based upon the Arbitrator's conclusion of law in disputed issue (F) the Arbitrator concludes Petitioner is entitled to prospective medical treatment, including, but not limited to, the cervical fusion recommended by Dr. Robson.

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS
COUNTY OF JEFFERSON)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Michael Cowger,
Petitioner,

vs.

No: 19 WC 09703,
20 IWCC 0289

CPC Logistics, Inc.,
Respondent.

ORDER

Motion to Recall pursuant to Section 19(f) of the Act was filed by the Respondent on June 2, 2020. The Commission finds that a clerical error does not exists in its Decision and Opinion on Review dated May 20, 2020.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Respondent's motion to correct a decision, pursuant to Section 19(f) dated June 2, 2020, is hereby denied.

DATED: JUN 10 2020

Marc Parker

mp/wj
68

STATE OF ILLINOIS)
) SS
COUNTY OF LASALLE)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Megan Miller,

Petitioner,

vs.

No. 10 WC 44484

LaSalle Veteran's Home/State of Illinois,

Respondent.

ORDER

This matter comes before the Commission on the Commission's own motion to strike the petition for review filed in this case. The Commission having been advised of the facts and law, finds and orders as follows:

On November 1, 2019, Respondent filed a petition for review captioned with two case numbers: 10 WC 44484 and 10 WC 44485. However, only case No. 10 WC 44485 proceeded to an arbitration hearing, following which the arbitrator issued a decision. Case No. 10 WC 44484, alleging a different date of accident, remains pending at arbitration.

IT IS THEREFORE ORDERED BY THE COMMISSION that the petition for review in case No. 10 WC 44484 is stricken. The Commission's decision in case No. 10 WC 44485 is being issued contemporaneously.

DATED: JUN 10 2020
SM/sk
44

Stephen Mathis

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

Terry Crippin,
Petitioner,

vs. No. 13 WC 023548

20IWCC0322

Meineke Car Care Center,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of temporary total disability, maintenance and the nature and extent of Petitioner's 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.

Prior to arbitration, the parties agreed that Petitioner was entitled to temporary total disability for 29 6/7 weeks, that Respondent had paid the amount owed for such period and that Respondent was entitled to credit for $12,872.95 for those payments. In her Decision, the Arbitrator found that Respondent should receive a credit of $12,872.95 for the amount of temporary total disability paid prior to arbitration but did not include an award of those temporary total disability benefits. On appeal, Petitioner contends that the Arbitrator's Decision should have included an award of temporary total disability for 29 6/7 weeks, in accord with the parties' pre-hearing stipulation. The Commission agrees and hereby modifies the Arbitrator's Decision.

Sanitized

20 IWCC0322

The Respondent shall pay Petitioner temporary total disability benefits of $431.11 a week for 29 6/7 weeks commencing January 21, 2013 through August 17, 2013, as provided for in Section 8(b) of the Act. The Respondent, in accordance with the parties' agreement, shall receive a credit of $12,872.95 for temporary total disability benefits paid.

All else is Affirmed and Adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 20, 2019, is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall pay Petitioner temporary total disability benefits of $431.11/week for 29 6/7 weeks commencing January 21, 2013 through August 17, 2013, as provided in Section 8(b) of the Act. The Respondent shall receive a credit of $12,872.95.

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.

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: JUN 10 2020

Marc Parker

Deborah L. Simpson

Barbara N. Flores

mp/dak
o-06/04/20
68

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CRIPPIN, TERRY
Employee/Petitioner

Case# **13WC023548**

MEINOKE CAR CARE CENTER
Employer/Respondent

20IWCC0322

On 11/20/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.54% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0347 MARSZALEK AND MARSZALEK
STEVEN GLOBIS
221 N LASALLE ST SUITE 400
CHICAGO, IL 60602

1454 THOMAS & ASSOCIATES
ROBERT A HOFFMAN
30 S WACKER DR SUITE 2200
CHICAGO, IL 60661

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

☐ 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

TERRY CRIPPIN,
Employee/Petitioner

v.

MEINEKE CAR CARE CENTER,
Employer/Respondent

Case # **13** WC **23548**

Consolidated cases: _____

20IWCC0322

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Maureen Pulia**, Arbitrator of the Commission, in the city of **Urbana**, on **10/16/19**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ 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 **7/24/12**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

Petitioner's current condition of ill-being as it relates to his left shoulder ***is*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**33,625.79**; the average weekly wage was $**646.65**.

On the date of accident, Petitioner was **58** years of age, ***single*** with **no** dependent children.

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

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

Respondent shall be given a credit of $**12,872.95** for TTD, $**00.00** for TPD, $**00.00** for maintenance, and $**00.00** for other benefits, for a total credit of $**12,875.95**.

Respondent is entitled to a credit of $**00.00** under Section 8(j) of the Act.

ORDER

Petitioner has failed to prove by a preponderance of the credible evidence that he is entitled to maintenance benefits pursuant to Section 8(a) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $387.99/week for 200 weeks, because the injuries sustained caused the 40% 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.

Kaureen Hallis

Signature of Arbitrator

11/6/19
Date

NOV 20 2019

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 58 year old store manager/mechanic, sustained an accidental injury to his shoulders that arose out of and in the course of his employment by respondent on 7/24/12 when he tripped and fell while carrying a tire. Petitioner is right hand dominant. He has a high school diploma and completed some Junior College. He did not graduate from college. Petitioner worked in respondent's location in Urbana. Petitioner lived in Indianola, IL when he worked for respondent, and still lives there. He stated that Indianola, IL is about 42 miles from Urbana.

Petitioner began working for respondent in January of 1988. Prior to working for respondent he worked as a mechanic for other businesses since high school. On the date of injury petitioner had been a manager for respondent for more than 10 years. His duties included completing and filing paperwork for his boss, and assigning various tasks to other employees. Petitioner also did the same work as the other employees, particularly as it relates to the more technical stuff. Petitioner testified that his job duties required him to push, pull, and carry over 5 pounds. He worked on mufflers, brakes, rotors, transmissions, clutches, suspensions, and working overhead while under the car, especially with respect to exhaust systems, shocks, and getting stuff loose under the car. Petitioner reported that he spent about 2/3 of his time under the vehicles. Petitioner was ambidextrous with respect to his work duties, but mostly used tools in his right hand.

Following the injury petitioner had pain in both his shoulders, and had no strength in his left arm. On 8/3/12 petitioner presented to the Occupational Medicine Department at Carle. He was seen by Wayne Mathews, PA. Petitioner complained of left shoulder pain, worse with rotary movements of his shoulder and flexion of his left bicep. He reported that he first pulled it on 7/24/12, but did not seek immediate treatment. He reported problems with motion while working. An examination revealed that he could abduct fairly comfortably to 90 degrees; had tenderness along the biceps tendon with flexion extending to the elbow to the insertion of the left shoulder. Petitioner was assessed with left bicipital tendinitis and placed on restrictions of avoiding repetitive left shoulder motions. An x-ray of the left shoulder showed mild degenerative change of the AC joint with slight spurring of the articular margin.

On 8/8/12 petitioner returned to PA Mathews for follow-up of his left shoulder pain. He reported that for most of the time he had been working within his restrictions of avoiding overhead work and repetitive movement of the left shoulder. He reported that his pain was unchanged. Petitioner reported clicking and pain when he internally rotated. Mathews recreated this clicking below the acromion, and was of the opinion it was indicative of impingement. No muscle atrophy of the left upper extremity was noted. His sensation was

normal. Mathews assessed left shoulder impingement syndrome. An MRI was ordered. Petitioner was instructed to avoid repetitive motion of the left shoulder, and any overhead work or lifting.

On 8/24/12 petitioner returned to Mathews. He reported that his condition was unchanged and he was getting pain in his right shoulder due to favoring of the left shoulder. He was able to abduct the left shoulder to 70 degrees. He still had impingement signs on the left. The MRI showed a complete supraspinatus tendon tear consistent with his symptoms. Mathews assessed a left shoulder rotator cuff tear. Petitioner was referred to Dr. Robert Gurtler, an orthopedic surgeon.

On 9/4/12 petitioner presented to Dr. Gurtler. He reported an injury to his left shoulder at work. He reported that he could raise it, but it hurt. He reported prior left shoulder issues, but nothing like what he was currently experiencing. He reported that he was still working, but his left shoulder hurt every day. Petitioner was tender at the anterior lip of the acromion and on the AC joint, and in the bicipital groove. He was able to lift it to 140 degrees, but was weak. Dr. Gurtler read the MRI and was of the opinion petitioner had a rotator cuff tear by the biceps and probably subluxation of the biceps, and a biceps tear. He recommended a left shoulder arthroscopic exam to evaluate the biceps, and an open rotator cuff repair with a probable biceps release or tendinosis. Dr. Gurtler's impression was left shoulder rotator cuff tear.

On 10/8/12 petitioner underwent a Section 12 examination performed by Dr. Lawrence Li, at the request of the respondent. Petitioner gave a consistent history of the accident and treatment to date. Dr. Li also performed a record review that included the records from Carle Occupational Health Clinic, the MRI images, the MRI report of 8/17/12, and the notes of Dr. Gurtler. Dr. Li noted that petitioner had a history of hypertension, as well as ankle, knee, and back problems. He also noted that petitioner had bilateral shoulder pain for three years. Dr. Li performed a physical examination. Based on petitioner's history, his record review, and physical examination, Dr. Li diagnosed a left shoulder full thickness tear of the supraspinatus tendon. Dr. Li was of the opinion that the mechanism of injury would aggravate or cause the left shoulder rotator cuff tear, He was also of the opinion that the treatment to date was reasonable and petitioner would need surgery to repair his rotator cuff tear. Dr. Li saw no evidence of a biceps tendon tear. Dr. Li recommended an arthroscopic rotator cuff repair over an open one because of the decreased rehabilitation time. Dr. Li was of the opinion that petitioner could work full duty. He diagnosed a left shoulder rotator cuff tear, and was of the opinion that it should be repaired.

On 11/2/12 petitioner returned to Dr. Gurtler due to increased left shoulder pain. He reported that he was having a lot of difficulty, particularly at night. Petitioner was taking Vicodin and Ibuprofen. Dr. Gurtler also prescribed Flexeril. Petitioner underwent a pre-operative physical and cardiovascular evaluation.

On 1/21/13 petitioner underwent a left shoulder arthroscopic examination, followed by an open rotator cuff repair and excision, and biceps tendon, performed by Dr. Gurtler. His post-operative diagnosis was left shoulder rotator cuff tear and biceps tendon tear. Petitioner followed-up post-operatively with Dr. Gurtler. He also followed up for his uncontrolled hypertension, obstructive sleep apnea, GERD, and abnormal EKG.

On 2/5/13 petitioner followed up with Dr. Gurtler. The staples were removed, and Dr. Gurtler was of the opinion that the repair was good and petitioner was healing well. Physical therapy was prescribed.

On 2/7/13 petitioner presented to Dr. Robert Born for unrelated foot pain following a motorcycle accident in July of 2012, where he sustained a crush injury to his right foot. He reported problems with ambulation, as well as associated numbness and tingling. He was diagnosed with possible radiculopathy, and was referred for an evaluation of his back and neurologic symptoms to the Pain Center.

On 2/19/13 petitioner returned to Dr. Gurtler. Petitioner reported that he was tolerating physical therapy very well, but did have soreness following his sessions. Dr. Gurtler noted that overall, petitioner was pleased with the process. Petitioner's grip strength was 5/5; he had passive range of motion to 45 degrees abduction and flexion from the glenohumeral joint; and, he had full elbow range of motion. Dr. Gurtler instructed petitioner to continue in physical therapy. Petitioner was continued off work.

On 4/9/13 petitioner followed-up with Dr. Gurtler. He reported that he was still in physical therapy and progressing in all respects. He reported that he was working on active assisted range of motion primarily. He reported that overall his pain was improved, and he had no significant concerns. Dr. Gurtler continued petitioner in physical therapy and off work.

On 5/9/13 petitioner returned to Dr. Gurtler. He reported that his range of motion was advancing in physical therapy. He reported significant difficulty sleeping at night. Dr. Gurtler continued petitioner in physical therapy. He also gave petitioner a script for Ambien. He released petitioner to return to work. On 6/11/13 petitioner reported overall improvement, though slow, to Dr. Gurtler. Dr. Gurtler noted that petitioner's range of motion continued to improve with therapy. He noted weakness with overhead motions. Petitioner reported that his concern with returning to work for respondent was that it required an extensive amount of lifting overhead. Petitioner reported that his narcotic use was decreased considerably. Petitioner reported that he was concerned about his right shoulder. Dr. Gurtler ordered an x-ray of the right shoulder, continued

petitioner in therapy with a transfer to work conditioning when appropriate, and instructed him to rest and ice as needed.

On 7/16/13 petitioner showed Dr. Gurtler that he was getting his left arm overhead. He stated that he was pushing himself in therapy and making nice progress. Dr. Gurtler noted that therapy anticipated four more weeks, which he believed was reasonable, and then he anticipated releasing petitioner to regular duty. He believed petitioner would be at maximal medical improvement in 6 weeks. On 7/23/13 Dr. Gurtler told petitioner that his right shoulder x-ray showed some changes where the collar bone meets the shoulder, but not too bad. Petitioner stated that it was not hurting like the left shoulder and he was satisfied with it at that point.

In therapy, the therapist noted that petitioner reported that he felt comfortable with returning to work doing brake work, when he is working below shoulder level. He did not feel comfortable with overhead work. The therapist noted that petitioner still had weakness in his left shoulder, especially with his arm extended away from his body. The therapist recommended that petitioner avoid heavy work overhead and that he use a hoist, and a dolley or cart for moving heavy objects due to his back, knee, and ankle pain.

On 8/13/13 petitioner returned to Dr. Gurtler. Dr. Gurtler reviewed the final physical therapy report and was of the opinion that petitioner needed some significant restrictions. He instructed petitioner to avoid overhead work, and no overhead lifting over 5 pounds; no pushing or pulling over 5 pounds; and no repetitive work with the left shoulder. Dr. Gurtler placed petitioner at maximum medical improvement and discharged him from his care.

On 10/16/18 Bob Hammond, M.A. AVBE, a Vocational Consultant from Hammond Vocational Consultants performed a Vocational Report for petitioner. Hammond reviewed file information to make a vocational determination. Hammond did not meet with petitioner. He only performed a record review and formulated his opinions. Hammond relied on the work restrictions outlined by Dr. Gurtler. Hammond was of the opinion that petitioner has skills he could transfer to other skilled level occupations. He noted that petitioner supervised others, managed other mechanics, and managed a store. He was of the opinion that petitioner had skills and knowledge that would transfer to service advisor, parts store manager, and mechanic educator. He was also of the opinion that petitioner had the residual functional abilities to work within the essential functions of occupations such as a service advisor and store manager.

Hammond also performed a Labor Market Survey that included a random sampling performed by researching the internet, calling employers, reviewing local newspapers, and networking with other vocational agencies. Where appropriate and available, Hammond contacted employers and those that responded stated that

they would consider a person with petitioner's profile. Hammond noted that only positions within the skills area were identified.

The jobs Hammond identified included a Pre-Owned Vehicle Service Advisor at Heller Ford; Service Advisor at St. Joseph Automotive and Diesel; Assistant Store Manager at Advanced Auto Parts; Automotive Store Manager at Car X Tire and Auto; Service Advisor at Rick Ridings Ford; Auto Body General Manager at Gerber Collision and Glass; Automotive Service Advisor at Sullivan Parkhill Automotive; Service Advisor at Gem City Tire; Automotive Service Manager at JD Byrider; Automotive Department Manager at Farm and Fleet; Automotive Department Manager at Walmart; Service Advisor at Service King Collision Repair of Urbana; Instructor at Parkland Community College; Instructor at Danville Area Community College; Auto Damage Adjustor Trainee for Champaign Geico; Dispatcher for Tuscola Manpower; and Dispatcher Router Outbound for R&L Carrier.

Hammond opined that petitioner could work a number of light duty positions in a skilled, unskilled or semi-skilled position. His expected earnings for petitioner was between $15-$25/hr for service advisor occupations, and store management positions. He was further of the opinion that if petitioner were to work in a semi-skilled and unskilled occupations such as assembler, telephone worker, and other lower level occupations, he could also have access to the general labor market, and positions exist on a regular and consistent basis that he could avail himself to if he were to seek a job where he could utilize his skills and abilities. Hammond was of the opinion that appropriate occupations for petitioner included parts store manager, service advisor, and less skilled entry level occupations.

Hammond was of the opinion that petitioner had limitations regarding his left shoulder, but had no limits regarding his right shoulder. He also noted that petitioner had limits in overhead work, and lifting 5-10 pounds with the left arm. He noted that petitioner could no longer return to installer, mechanic work, but has skills to transfer to service advisor, and store manager. Hammond opined that petitioner has the residual functional capacity to work in the local economy and has skills that could be used to find and maintain employment. He opined that petitioner needed a more systematic approach than using the internet and would need to use other sources that actually have job openings. He further opined that petitioner needed a system of approach for seeking employment with employers that were hiring, and apply for occupations within his skill area. Hammond opined that petitioner could return to work and could earn in excess of $40-50,000 annually.

Petitioner testified that he never returned to work for respondent. He stated that after he was released with restrictions he went to his boss Bob Milburn and Milburn told him he was not sure if he wanted him back. He

testified that a few weeks later Milburn said he did not want him back. Petitioner testified that he was never offered any light duty work by respondent. Petitioner stated that the shop he worked in for respondent was now closed.

Petitioner testified that he looked for work but was not hired by anyone. He testified that he contacted 5-6 employers for 9 weeks. Petitioner testified that he did not look for jobs after the 9 weeks because he had no money. Petitioner never requested vocational rehabilitation, and respondent never offered any vocational rehabilitation services. Petitioner testified that he reviewed Hammond's Labor Market Survey and went to local businesses, but was not offered any work. Petitioner had no job logs and could not identify the places he looked for jobs and the positions he applied for. Petitioner is currently 65 years old.

Currently, petitioner stated that his body is "worn out". He complained of torn up knees and back, and problems with his right shoulder. With respect to his left shoulder he complained of aches, pops, creaks, decreased strength, and trouble reaching behind or above. He reported that his motion is good. Petitioner testified that his right shoulder catches now and then and is painful. He stated that these complaints stated shortly after the injury, but nothing was done about it. Petitioner denied any problems with his left shoulder before the injury.

Petitioner testified that after he was released from care with restrictions by Dr. Gurtler, he worked about 3 ½ weeks for his ex-wife in her florist shop, Cindy's Flower Patch. He stated that his duties included trimming pine branches. Petitioner stated that the florist shop burned down years later.

Bob Hammond, Vocational Consultant, was called as a witness on behalf of respondent. Hammond has been a Vocational Assistant for 30 years. He performs vocational services for respondents 60% of the time and for petitioners 40% of the time. Hammond has also performed services for respondent's attorney, even when he was represented petitioners. Hammond testified that in formulating the Labor Market Survey in 2018 he reviewed pertinent information pertaining to petitioner regarding his medical and past work history, but did not speak or meet with petitioner. Hammond testified that all the jobs he identified in the Market Labor Survey were within 45 minutes of Urbana, which is the amount of time petitioner traveled from his home in Indianola, IL, to respondent's place of business. Hammond testified that the jobs located were in a similar wage range to what petitioner was earning while working for respondent. Hammond testified that the labor market is currently better than when he performed the Market Labor Survey in November of 2018. Hammond was of the opinion that the longer a person is out of work, the more likely that person is to remain out of work. Hammond opined that petitioner is currently gainfully employable.

On cross examination Hammond testified that he is a Certified Vocational Counselor certified by the American Board of Vocational Experts. He testified that he has a Masters Degree and special training in vocational counseling. Hammond testified that he had to take a test and has been certified since 2002. Hammond was of the opinion that petitioner is likely to obtain employment and is capable of performing jobs. Hammond testified that he did not perform any vocational testing on petitioner. He also was unaware of petitioner's educational background, but was aware of the skills he had acquired from his prior work. Hammond was of the opinion that the jobs he believed petitioner was qualified for were listed in the Market Labor Survey. He noted that petitioner has managerial skills based on his employment with respondent. He also believed he could work in a parts store due to the fact that he is familiar with the industry. He admitted that petitioner would likely be competing with younger applicants, but would have an advantage because of his experience. He was further of the opinion that petitioner's physical disabilities would not be a deterrent since the passage of the ADA. Hammond testified that he was unaware of any limitations petitioner has that were not related to his left shoulder.

F. IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?

It is unrebutted that petitioner sustained an accidental injury that arose out of and in the course of his employment by respondent on 7/24/12 after tripping while carrying a tire in his left hand. Petitioner testified that following the injury he had pain in both shoulders, and no strength in his left arm. Petitioner initially sought treatment on 8/3/12 and complained of left shoulder pain. An MRI showed a complete supraspinatus tendon tear. On 8/24/12 petitioner reported pain in his right shoulder compensating for his left shoulder. Petitioner began treatment with Dr. Gurtler on 9/4/12. Surgery was recommended.

Dr. Li examined petitioner on behalf of respondent. He reported bilateral shoulder pain for three years. He also noted that it was worse since the accident. Dr. Li agreed with petitioner's left shoulder diagnosis and that the mechanism of injury would aggravate or cause a left rotator cuff tear. He also recommended surgery to repair the left rotator cuff tear.

Petitioner underwent a left shoulder arthroscopic examination, followed by an open rotator cuff repair and excision, biceps tendon performed by Dr. Gurtler. Petitioner followed up post-operatively with Dr. Gurtler. This treatment included physical therapy. Petitioner was eventually released to work with permanent restrictions for this left arm.

With respect to his right shoulder, on 5/2/13 petitioner reported that he was concerned about it. X-rays showed some changes where the collar bone meets the shoulder, but no too bad. Petitioner reported that it did not hurt like his left shoulder and was satisfied with it.

Petitioner also had complaints with respect to his low back, knee, and left ankle/foot, unrelated to the injury on 7/24/12.

Based on the above, as well as the credible evidence, the arbitrator finds the petitioner's current condition of ill-being as it relates to his left shoulder is causally related to the injury he sustained on 7/14/12. Given the petitioner's prior right shoulder problems, and the fact that no medical provider offered and opinion that petitioner's current condition of ill-being as it relates to his right shoulder is causally related to the injury on 7/14/12, the arbitrator finds that at most, the petitioner sustained a temporary aggravation of a preexisting right shoulder condition that resolved by August of 2013. The arbitrator also finds no evidence to support a finding that petitioner's back, knee, or ankle/foot conditions are casually related to the injury petitioner sustained on 7/14/12.

K. WHAT TEMPORARY BENEFITS ARE IN DISPUTE?

Petitioner is alleging 9 weeks of maintenance benefit, from 8/18/13 through 10/20/13. Petitioner claims that after he was released to restricted duty work by respondent and respondent did not take him back to restricted duty, he looked for work at 5-6 employers a week for 9 weeks. He also testified that after he was released to work, he worked for a few weeks at his wife's florist shop. Petitioner did not testify as to why he stopped working there. Petitioner testified that after that he did not look for any further work because he had no money. However, petitioner did not offer into evidence any job logs related to his job search, and could not identify the name of any employers from which he sought employment, or the dates he looked for employment. Additionally, petitioner never requested any vocational rehabilitation services, and respondent never offered them.

Based on the above, as well as the credible evidence, the arbitrator finds the petitioner has failed to prove by a preponderance of the credible evidence that he is entitled to maintenance benefits from 8/18/13 through 10/20/13.

L. WHAT IS THE NATURE AND EXTENT OF THE INJURY?

Petitioner claims that he is permanently totally disabled. Respondent claims that petitioner is not permanently totally disabled and is only entitled to a permanent partial disability loss pursuant to Section 8(d)2 of the Act.

The arbitrator finds it unrebutted that no doctor medically determined that petitioner was permanently totally disabled. The arbitrator further finds the petitioner has failed to prove by a preponderance of the credible evidence that he is an "odd-lot" permanent total. The arbitrator bases this finding on the fact that when petitioner was found to have reached maximum medical improvement on 8/13/13 Dr. Gurtler did not find him permanently totally disabled, but rather gave him permanent restrictions that included avoiding overhead work; no overhead work over 5 pounds; no pushing or pulling over 5 pounds; and, no repetitive work with the left shoulder.

After being given these permanent restrictions petitioner testified that he looked for 5-6 jobs a week for 9 weeks. However, petitioner failed to offer into evidence any specifics regarding this job search. He had no job search logs could not identify what dates he looked for work, and could not identify one employer he applied at.

On 10/16/18 respondent had Hammond perform a Vocational Report and Labor Market Survey for petitioner. Hammond opined that petitioner possessed the skills that could transfer to other skilled level occupations given petitioner's experience supervising others, managing other mechanics and managing a store. Hammond identified at least 17 specific jobs petitioner could apply for. However, petitioner did not provide any credible evidence that he applied for any of these positions, or that he applied for any other positions. Petitioner also failed to offer into evidence any job search logs.

Given the fact that petitioner has not been medically determined to be permanently totally disabled and has failed to prove by a preponderance of the credible evidence that he is an odd-lot permanent total based on his failure to offer into evidence any job search evidence for the 6 years since he was found to be at maximum medical improvement, the arbitrator finds the petitioner is entitled to a permanent partial disability pursuant to Section 8(d)2 of the Act.

For injuries that occurred after 9/1/11, according to 820 ILCS 305/8.1B(b) the Commission shall base its determination of permanent partial disability based upon five factors including an AMA report, the occupation of the injured employee, the age of the employee at the time of injury, the employee's future earning capacity and evidence of disability corroborated by treating medical records.

With regard to subsection (i) of §8.1b(b), neither party offered into evidence an AMA impairment report into evidence. The Arbitrator therefore gives no weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the petitioner was a 58 year old store manager/mechanic. Although petitioner can no longer perform all the duties of his prior job, Hammond determined that petitioner was capable of supervising others, managing other

mechanics, and managing a store. After Dr. Gurtler gave petitioner permanent restrictions in August of 2013, petitioner offered no credible evidence to support a finding that he looked for any alternate employment within his restrictions. For these reasons the arbitrator gives greater weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator finds the petitioner is currently 65 years old and has not looked for any work within his restrictions for the past 6 years. The arbitrator also finds it unrebutted that he could not return to full duty work for respondent after receiving his permanent restrictions. The arbitrator notes that given petitioner's current age of 65, the number of years petitioner would most likely remain in the workforce is limited. Nonetheless, Hammond did find positions that petitioner, based on his skills and knowledge would be capable of performing, and was of the opinion that petitioner would have an advantage over those less qualified. For these reasons the arbitrator gives lesser weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the arbitrator notes that petitioner was making $33,625.80 a year. Based on the job opportunities identified by Hammond, petitioner would be able to most likely make as much, or more than this, in the positions identified by Hammond. Therefore, the arbitrator gives no weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, resulted in petitioner being given permanent restrictions that that included avoiding overhead work; no overhead work over 5 pounds; no pushing or pulling over 5 pounds; and, no repetitive work with the left shoulder. Petitioner stated his body is "worn out". He complained of torn up knees and back, and problems with his right shoulder. With respect to his left shoulder he complained of aches, pops, creaks, decreased strength, and trouble reaching behind or above. He reported that his motion is good.

Based on the above, as well as the credible evidence the arbitrator finds the petitioner sustained a loss of occupation as a result of the injury he sustained on 7/24/12. Although the petitioner failed to offer any credible evidence of a job search after he received his permanent restrictions, the arbitrator also finds the respondent at no time offered any vocational rehabilitation to petitioner as a result of the permanent restrictions, that precluded petitioner from returning to his regular duty job for respondent.

Based on the above, the arbitrator finds the petitioner sustained a 40% loss of use of his person as a whole pursuant to Section 8(d)2 of the Act for his loss of occupation.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ORALEAN McCLELLON-WILLIAMS,

Petitioner,

vs. NO: 15 WC 39342

CITY OF CHICAGO,

Respondent.

20IWCC0323

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical, prospective medical, temporary total disability (TTD), permanent partial disability (PPD), and penalties, 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 Decision of the Arbitrator and finds that Petitioner's bilateral knee injury and left shoulder injury is causally related to her October 15, 2015 work-related injury. The Commission further modifies the Decision and awards Petitioner TTD benefits from October 16, 2015 through August 31, 2017 and maintenance benefits from September 1, 2017 though July 22, 2018. The Commission awards Petitioner 20% loss of use of the person-as-a-whole. All else is affirmed and adopted.

Petitioner filed a second Application for Adjustment of Claim (18 WC 22610) alleging that she developed carpal tunnel while typing during vocational rehabilitation for claim 15 WC 39342. The claims were consolidated at trial and her claim for carpal tunnel was denied. The Commission affirms and adopts the Decision of the Arbitrator for claim 18 WC 22610 for which a separate decision has been issued.

20IWCC0323

Petitioner sustained an undisputed accident on October 15, 2015 resulting in injuries to her knees and left shoulder. She completed an accident report and went to the hospital where she underwent x-rays of her knees and left shoulder. She first treated with Dr. Josephine Dinkha on October 19, 2015 for her left shoulder and then saw Dr. Chandler on December 7, 2015 for pain in her knees. The MRIs confirmed the presence of a tear in the left shoulder and right knee. Two surgeries were performed on the left shoulder and surgery was recommended but declined for the knee injury. The Arbitrator found too many inconsistencies to justify causal connection with regard to the left shoulder and found that the accident resulted in a temporary aggravation only of her pre-existing bilateral knee condition.

The Commission, however, is not bound by the Arbitrator's findings. The Illinois Supreme Court has long held that it is the Commission's province "to assess the credibility of witnesses, resolve conflicts in the evidence, assign weight to be accorded the evidence and draw reasonable inferences from the evidence." *City of Springfield v. Indus. Comm'n,* 291 Ill. App. 3d 734, 740 (4th Dist. 1997) (citing *Kirkwood v. Indus. Comm'n*, 84 Ill. 2d 14, 20 (1981)). Interpretation of medical testimony is particularly within the province of the Commission. *A. O. Smith Corp. v. Indus. Comm'n,* 51 Ill. 2d 533, 536-37 (1972).

While there may be slight discrepancies in the record as to the exact mechanism of injury, the parties stipulated to the issue of accident. Further, the facts demonstrate that Petitioner's truck broke down causing oil to leak onto the truck step. The injury report confirms that the truck step was slippery because of the presence of oil and that she slipped and injured her left shoulder and knees.

Following the accident, Petitioner underwent a course of treatment that confirmed the left shoulder injury including the tear and the need for the two left shoulder surgeries. Respondent's expert, Dr. Guido Marra, performed a section 12 examination finding causal connection between the accident and her left shoulder injury. Based on the evidence, the Commission finds that Petitioner's left shoulder condition is causally related to her work injury.

Regarding her knee injuries, the evidence supports that the accident caused a strain of the left knee and a tear of the right knee.

A work-related injury need not be the sole or principal causative factor, as long as it was a causative factor in the resulting condition of ill-being. *Sisbro Inc. v. Indus. Comm'n*, 207 Ill. 2d 193, 205 (2003). In preexisting condition cases, recovery will depend on the employee's ability to show that a work-related accidental injury aggravated or accelerated the preexisting disease such that the employee's current condition of ill-being can be said to have been causally-connected to the work-related injury and not simply the result of a normal degenerative process of the preexisting condition. *Id.* at 204-205. It is axiomatic that employers take their employees as they find them. *Id.* at 205. Thus, even though an employee has a preexisting condition which may make him more vulnerable to injury, recovery for an accidental injury will not be denied as long as it can be shown that the employment was also a causative factor. *Sisbro Inc.* at 205.

Further, a chain of events which demonstrates a previous condition of good health, an accident, and a subsequent injury resulting in disability may be sufficient circumstantial evidence

to prove a causal nexus between the accident and the employee's injury." *International Harvester v. Industrial Comm'n*, 93 Ill. 2d 59, 63-64, 442 N.E.2d 908, 66 Ill. Dec. 347 (1982).

The record reveals that Petitioner had mild arthritic changes in her knees prior to the accident. However, there are no records demonstrating that Petitioner had any ongoing issues or limitations with her knees prior to the accident. It was not until after the accident that Petitioner started to have knee pain and the MRI confirmed the presence of a tear in the right knee. Therefore, the Commission finds that Petitioner established that her knee conditions are causally related to the accident.

The parties stipulated to TTD from October 16, 2015 to July 22, 2018 representing 144-3/7 weeks. The record, however, demonstrates that Petitioner is entitled to TTD benefits from October 16, 2015 through August 31, 2017, the date Dr. Salman Chaudri released Petitioner back to work with the restrictions contained within the August 17, 2017 FCE.

Petitioner then participated in vocational rehabilitation through July 20, 2018. At that time, Petitioner informed Vocamotive that she was no longer going to attend vocational rehabilitation as it was aggravating her carpal tunnel syndrome. The Commission agrees with the Arbitrator that Petitioner failed to prove that she developed carpal tunnel as the result of her work-related accident or because of the typing she performed in vocational rehabilitation. The record does not support that her carpal tunnel is related to her typing in vocational rehabilitation. Petitioner was performing typing three days a week from 8:00 a.m. to 3:00 p.m. for a few months to increase her typing skills. She sought medical treatment on July 20, 2018 for hand pain and then stopped vocational rehabilitation. No follow-up records were offered into evidence showing that she continued with any treatment to her right hand. There is no credible medical opinion supporting that she has carpal tunnel or that it is related to vocational rehabilitation. The Respondent sent a letter to Petitioner on July 23, 2018 indicating they were suspending her maintenance benefits as she was not attending vocational rehabilitation. Accordingly, Petitioner is entitled to maintenance benefits from September 1, 2017 though July 22, 2018.

The Commission affirms the Arbitrator's finding that Petitioner failed to prove an entitlement to a wage differential award. The Commission finds that Petitioner's participation in vocational rehabilitation was questionable, at best. While there are some references to job searches and she testified that she performed an independent job search, no job logs were admitted into evidence. The record also reveals that Petitioner was not opening emails from prospective employers requesting that she complete an assessment. She was also behind on her curriculum calendar and she did not send out cover letters with her resumes as she was requested by the vocational counselor. She also stopped participating in vocational rehabilitation in July 2018 due to hand pain. However, the Commission finds that the carpal tunnel is not related to her work-related accident. Based upon the inconsistencies, the Commission finds that Petitioner failed to prove that that she is entitled to a wage differential.

The Commission further affirms the Arbitrator's denial of penalties.

As a result of her injuries, the Commission finds that Petitioner sustained 20% loss of use of the MAW.

20IWCC0323

As Petitioner's accident occurred after September 1, 2011, §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).*

Section 8.1b(b)(i) – §8.1b(a) impairment report

Neither party submitted a §8.1b(a) impairment report. As an impairment report is not a prerequisite to an award of permanent partial disability benefits (*Corn Belt Energy Corp. v. Illinois Workers' Compensation Commission*, 2016 IL App (3d) 150311WC, ¶47, 56 N.E.3d 1101), the Commission will assess Petitioner's permanent disability based upon the remaining enumerated factors.

Section 8.1b(b)(ii) – occupation of the injured employee

The Petitioner worked as a truck driver. She has not returned to work due to her deficiencies. However, any future occupation will be impacted by her injuries. Therefore, the Commission gives moderate weight to this factor.

Section 8.1b(b)(iii) – age of the employee at the time of the injury

Petitioner was 53-years old on the date of her accidental injury. Petitioner is a middle-aged woman and will, therefore, live with her residual complaints for a fair amount of time. The Commission finds that this factor weighs in favor of increased permanent disability.

Section 8.1b(b)(iv) - future earning capacity

Petitioner alleges a wage loss as a result of her injury. However, she did not provide a good faith effort in vocational rehabilitation. Therefore, the Commission cannot assess the impact her injuries have on her future earning capacity. The Commission finds that this has no impact on permanent disability.

Section 8.1b(b)(v) – evidence of disability corroborated by treating medical records

Petitioner sustained multiple injuries as the result of her accident. She underwent two left shoulder surgeries and has documented ongoing issues. She also sustained a tear of the right knee and a sprain of the left knee. She declined the recommended right knee surgery. She has not returned to work. The Commission gives greater weight to this factor.

Based upon the above analysis, the Commission finds that Petitioner sustained 20% loss of use of the person-as-a-whole.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 26, 2019, is hereby modified as stated above, and otherwise affirmed and

20IWCC0323

adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $923.76 per week for a period of 98 weeks, October 16, 2015 through August 31, 2017, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner maintenance benefits of $923.76 per week for a period of 46-3/7 weeks, September 1, 2017 through July 22, 2018, as provided in Section 8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $755.22 per week for a period of 100 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused 20% loss of use of the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner all reasonable and necessary medical expenses related to the left shoulder injury and the left and right knee injury under §8(a) of the Act and subject to the medical fee schedule.

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

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: JUN 11 2020

D. Douglas McCarthy

DDM/tdm
O: 5/6/20
052

Stephen Mathis

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WILLIAMS, ORALEAN
Employee/Petitioner

Case# **15WC039342**

18WC022610

CITY OF CHICAGO
Employer/Respondent

20IWCC0323

On 3/26/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.41% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5191 FAJARDO LAW GROUP LLC
TANYA I FAJARDO
77 W WASHINGTON ST SUITE 1313
CHICAGO, IL 60602

0010 CITY OF CHICAGO LAW DEPT
LUCY HUANG
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Oralean Williams
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **15** WC **39342**

Consolidated cases: **18 WC 022610**

20IWCC0323

An *Application for Adjustment 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**, Illinois on January 10, 2019. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On October 15, 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(s) of ill-being ***is not*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**72,053.42**; the average weekly wage was $**1,385.64**.

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

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

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

Respondent shall be given a credit of $ for TTD, $ 98,055.83 for TPD, $ 35,104.78 for maintenance, and $ 0 for other benefits, for a total credit of $ **133,160.61.**

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

ORDER

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

Respondent is entitled to a credit for all benefits paid.

Respondent is not liable for maintenance benefits after July 23, 2018.

No wage differential is awarded.

Respondent has no liability for permanent partial disability benefits.

No penalties are warranted.

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

03-26-19
Date

MAR 2 6 2019

BEFORE THE ILLINOIS WORKERS COMPENSATION COMMISSION

ORALEAN WILLIAMS	)	
	)	
Petitioner	)	
	)	
V.	)	15 WC 039342
	)	
CITY OF CHICAGO	)	18 WC 022610
	)	
Respondent.	)	

ARBITRATOR'S DECISION

This matter came before the Arbitrator for hearing on January 10, 2019 with Attorney Tanya Fajardo of Fajardo Law Group, LLC appearing on behalf of the Petitioner, Oralean Williams, and Attorney Daniel Kallio, appearing on behalf of the Respondent, The City of Chicago. NOW, THEREFORE, upon consideration of the entire records of proceedings before the Arbitrator, as well as, all records, files, pleadings, and proceedings filed in this action, the Arbitrator finds as follows:

STATEMENT OF FACTS

On October 15, 2015, Petitioner, a 53-year-old female, was working as a motor truck driver in the Department of Streets and Sanitation. She had over 16 years of service time with the City. Petitioner allegedly sustained an injury to her left shoulder and both knees when she slipped and fell while stepping out of her garbage truck. Accident is not disputed in this matter, but the Arbitrator notes that Petitioner gave three versions of how the accident occurred; those will be catalogued later in this document, as they impact the causal connection analysis.

Petitioner initially sought medical treatment at Mercy Hospital (PX #1) and then was directed by her employer to Mercy Works Clinic that same day. There are no Mercy Works medical records in evidence.

Petitioner then went to see her primary care physician, Dr. Josephine Dinkha at Southwest Physicians Group on October 19, 2015. (PX #2) Petitioner stated that she was in pain and unable to lift her left arm. Dr. Dinkha diagnosed left rotator cuff syndrome and referred her to see Dr. Chandler at Southwest Orthopedics for further treatment. (PX #3) Petitioner received no treatment to her knees on this date.

On December 7, 2015, Dr. Chandler examined the Petitioner and recommended MRIs for the left shoulder and knees. The left knee MRI study was performed on December 22, 2015 and showed no tear. "No meniscal injury was detected." (PX #3)

The right knee MRI study was performed on December 28, 2015 stating, "there may be a subtle oblique tear...of the posterior horn of the medial meniscus. There was no significant joint effusion." (PX #3) Nevertheless, Dr. Chandler gave cortisone injections to each knee.

Despite the above limited MRI findings, on January 21, 2016, Dr. Chandler told State Farm that the MRIs confirmed bilateral knee meniscal tears. (PX #4) It bears repeating that the left knee MRI showed no meniscal injury and the right image might have shown a subtle oblique tear. Surprisingly, Dr. Chandler recommended surgery for both knees. (PX #4) Later, utilization review certified surgery for the right knee only. But Petitioner never followed through with it. Moreover, Petitioner never had any additional medical treatment for her knees again. Instead, Petitioner's medical care shifted to her left shoulder.

On January 30, 2016, Southwest records show that the Petitioner was at Advocate Hospital from January 16, 2016 through January 18, 2016 for unrelated right-sided abdominal pain. While on sedatives, she fell and sustained a bump to the right side of her forehead. She stated that her vision was slightly blurry since then, but her optometrist could not find anything wrong with her vision. She

complained of memory loss. It was noted that Petitioner was a realtor and had a closing a few days ago. A concussion was ruled out. (PX #2) The medical records from this fall are not in evidence but appear to be the subject of additional civil litigation captioned, Williams vs. Advocate Christ Medical Center – 17 L 8732. (PX #3) This case may still be pending in Cook County law division.

On February 2, 2016, Southwest records state that Petitioner reported only slightly limited range of motion of the left shoulder by pain. (PX #2)

Petitioner's past medical history on this date shows a motor vehicle accident or MVA with a neck sprain or strain which was resolved and an unspecified psychiatric exam with depressive disorder that was resolved as well. No details of this MVA or medical treatment are in the court record. (PX #2)

Petitioner attended one physical therapy session for her left shoulder and was then discharged for poor attendance on February 3, 2016. (PX #3) At trial, Petitioner stated she "wasn't sure how long it lasted, but it wasn't doing any good." (T. 18) An MRI of the left shoulder was taken on February 5, 2016 and found a low-grade partial undersurface tear of the mid-supraspinatus tendon and a degenerated, but poorly seen, glenoid labrum. (PX #3)

Dr. Chandler recommended left shoulder surgery which was initially denied by utilization review. Upon peer-to-peer consultation, Dr. Chandler justified the surgery for three reasons. First, he explained that Petitioner had undergone three weeks of therapy and the shoulder was getting worse. Second, the MRI was positive, and the Petitioner had no improvement after a cortisone injection.

As a result, the left shoulder surgery was certified and performed on March 24, 2016. (PX #4) The operative report stated that the Patient had a degenerative tear of the labrum, but it was still attached to the glenoid. There was no rotator cuff tear. A limited debridement of the labrum was

performed. A biceps tenotomy was performed. A type 2 spur acromial spur was discovered, so some burring was performed by way of a subacromial decompression. Likewise, some arthritis was discovered at the AC joint, so the distal clavicle was excised with some coplaning of the undersurface. (PX #4)

Postoperatively, Petitioner underwent physical therapy beginning on April 20, 2016. (PX #3) She continued to have ongoing pain and problems with limited range of motion in her left shoulder.

Dr. Chandler departed Advocate Illinois Masonic, leaving Petitioner's left shoulder treatment to Dr. Salman Chaudri on May 12, 2016. (RX #3) He noted no swelling of the left shoulder, but reduced range of motion and strength. In June, Dr. Chaudri prescribed an MR Arthrogram because of decreased range of motion and instability of the left shoulder.

Another left shoulder MRI study was performed on August 8, 2016 which the radiologist thought showed a complete tear of the biceps tendon and a partial tear of the labrum. (PX 4) Dr. Chaudri recommended a second left shoulder surgery for three reasons: pain, restricted range of motion and the MRI findings showing a labral tear. It seems Dr. Chaudri was convinced he'd find and repair a labral tear.

On October 11, 2016 the second left shoulder surgery was performed. Under anesthesia, Dr. Chaudri found two partial tears (less than 10%), but the labrum was still intact. There was no peel back sign. Likewise, there was no SLAP tear. Nevertheless, there was some additional shaving performed. Additionally, there was no biceps tear as there was a previous biceps tenotomy. There were no complications. This procedure was later described as a manipulation under anesthesia or "MUA" and it took five minutes to perform. (PX #4)

Petitioner underwent post-operative occupational therapy at Southwest. The initial assessment was on November 1, 2016. Petitioner continued to be placed off work and Respondent paid TTD benefits. Petitioner's abode changed from an apartment on S. Calumet to a new address on S. Peoria. (PX #4)

Petitioner continued to undergo physical therapy sessions and follow up medical visits with Drs. Dinkha and Chandler.

Petitioner underwent an unrelated surgical procedure in March 3, 2017.

Petitioner's final examination with Dr. Chaudri was on April 3, 2017. At that time, he offered the Petitioner an injection to her left shoulder, but it was refused. He did not think that her physical abilities would be easily determined without a functional capacity exam or "FCE."

Petitioner's final occupational therapy appointment was April 20, 2017. At that time, Petitioner's condition had improved so that her shoulder flexion and external rotation were within functional limits. (PX #3) The plan was to continue with occupational therapy, but Petitioner stopped treating abruptly. She still complained of pain.

On June 6, 2017, Petitioner was seen by Dr. Guido Marra pursuant to Respondent's request (IME). She still complained of pain. Petitioner stated that she injured her left arm trying to break her fall, sustaining a traction injury. Unaware of the accident history discrepancies, Dr. Marra stated that Petitioner's left shoulder condition was causally connected to the work accident. He prescribed an MR Arthrogram and stated that until an FCE was performed, the Petitioner was on light duty. (RX #2) There were no knee exams by Dr. Marra.

On July 28, 2017, Dr. Chaudri authored a letter of medical necessity stating that he last examined the Petitioner on April 3, 2017 and she no longer wanted additional medical treatment from him. He did not place the Petitioner at MMI and stated that in his opinion, without an FCE objective limitations and abilities are difficult to ascertain. (PX #4)

On August 17, 2017, an FCE was performed by Horizon which placed Petitioner on the following permanent restrictions: Petitioner was capable of occasionally lifting 35 pounds from floor to knuckle, 18 pounds frequently and 7 pounds constantly. Overall, her tolerances met the Demand Minimum Functional Capacity requirement of standing, sitting, and walking with the inability to perform balancing activities that require crouching, stooping, kneeling, or crawling. (PX #2) In summary, Petitioner could return to work as a garbage truck driver. The exam was deemed valid even though Petitioner's heart rate never exceeded 94 beats per minute (bpm) during testing.

On August 31, 2017, Dr. Chaudri reviewed the FCE report and agreed that the following permanent restrictions apply:

- No pushing more than 60#s
- No pulling more than 70#s
- Lifting occasionally 35#, frequently 18#, and constant 4#
- Carrying occasionally 20#, frequently 10# and constant 4#

The Petitioner did not return to work for the City of Chicago as a garbage truck driver and it is unclear why. Petitioner was unable to meet some of the Dictionary of Occupational Title (DOT) job tasks but may have been able to meet her actual job requirements. Petitioner's actual job requirements were never put into evidence and are not part of the record. The FCE released Petitioner at a medium level and her city job was at medium level as well. Ostensibly, there was a parameter in the FCE that Petitioner failed to meet to return to her old job. At trial, this was never

explained with any detail. The record is not clear about the specific nature of the unmet restriction(s). Petitioner simply stated she "was not quite capable" of performing her old job. (T. 37) Ostensibly, Petitioner was very close to being able to perform her old job. On direct exam, Petitioner never testified that she had to push 100 lbs., nor pull 80 lbs., crouch, kneel or crawl in performing her City job. In fact, when asked if she was required to bend, kneel or squat, Petitioner replied, "Not really..." (T. 11)

On September 30, 2017, Petitioner sought medical care with Southwest for a possible spider bite. (PX #2)

On October 31, 2017, Petitioner was involved in yet another motor vehicle accident. (PX #3) X-rays of her lumbar spine were taken at Advocate.

Respondent was unable to accommodate Petitioner's permanent restriction(s) and then provided vocational rehabilitation to Petitioner (RX #3), but she was having problems following through on her job searches. (RX #3) Petitioner participated in vocational rehabilitation from March 7, 2018 to July 20, 2018 (RX #3), when she requested to stop because it aggravated her carpal tunnel syndrome.

On July 20, 2018, Petitioner informed Vocamotive that she would no longer attend vocational rehabilitation appointments because she recently received additional restrictions from Dr. Dinkha stating, "limited driving, no work typing." (RX #3) In Petitioner's opinion, all the typing she performed during vocational rehabilitation caused carpal tunnel syndrome. (T. 30) She stated that it caused her "fingers to stick up..." (T. 30) During vocational rehabilitation, Petitioner typed three days a week at a rate of about 25 words per minute. No future return date was provided. At trial, Petitioner stated that she needed an EMG, but could not obtain one, as her group health care benefits

had been terminated in June of 2017 for not paying her portion of the premium. (T. 34) She claimed financial hardship, but the records show Petitioner changed her abode during this time from an apartment on S. Calumet to a residence on S. Peoria in Chicago. Petitioner has been a licensed real estate broker/realtor since 2012 and sold at least one home during the period she was collecting workers' compensation benefits. (PX #2) (01-30-16) Petitioner stated that she could not continue with vocational rehabilitation because she needed an EMG for her hand and no longer had health insurance. (RX #3) It is unclear how the Petitioner was able to change her abode but also allow her group health insurance with Blue Cross to lapse. If the new abode was an upgrade, then how could she afford one and not the other? If she downsized, then group health premiums would be more affordable. Petitioner told the vocational rehabilitation counselor that she could no longer afford to pay her group health insurance premiums. (RX #3)

Petitioner was involved in at least three separate accidents after the occurrence at work.

On July 23, 2018, Respondent sent a letter suspending Petitioner's maintenance benefits due to not attending vocational rehabilitation. As of the time of the hearing, Petitioner had not obtained employment within her restrictions nor has she been paid workers' compensation maintenance benefits as of the above date.

Petitioner stated to her vocational counselor on March 7, 2018 that her CDL-A drivers' license (double and triple endorsements) was currently valid. (RX #3 p.6) The Arbitrator takes judicial notice that the maximum duration of a medical certificate for a valid Illinois CDL is two years. As a result, Petitioner must have renewed her Medical Examiner's Certificate or "MEC" Form MCSA-5876. Drivers must disclose their medical history and undergo a physical exam to renew their certificate and drive commercial vehicles. Petitioner must have passed her exam within two years of March 7, 2018. The earliest this could have occurred was March 7, 2016, which post-dates

the accident. Respondent did not cross-exam the Petitioner about her post-accident medical renewal certificate, but Petitioner said she had a current one.

On or about September 17, 2018, Petitioner applied for Social Security Disability benefits indicating that she had removed herself from the labor force. Her alleged disabilities were: "surgeries on left arm, torn ligaments in both knees, ADD, bipolar and carpal tunnel in right hand." (RX #3) Petitioner is still an employee of the City of Chicago. (T. 34)

CONCLUSIONS OF LAW

CAUSAL CONNECTION

Petitioner testified that she injured her left shoulder and both knees while exiting her truck while at work on October 15, 2015.

The Arbitrator takes note that the initial treatment provider, Mercy Hospital, provided incomplete medical records to the tribunal. (PX #1) The only documents submitted were negative x-ray reports for Petitioner's right knee and left shoulder. Although the subpoenaed records have a certification attached, more records certainly exist. For instance, the intake form is absent (which would include a history of the accident and a clinical exam). Also missing are the discharge form, list of prescription medications, and billing forms. As a result, this document is incomplete. Of note, the radiologists compared x-rays of the right knee taken previously on 05-17-11 (four years prior to the occurrence). There is no documentation of the left knee x-ray, although there is some evidence that it probably occurred. (PX #1)

Despite representations to the contrary, no Mercy Works records were submitted into evidence. The Arbitrator takes judicial notice that all City of Chicago employees are encouraged to treat at Mercy Works Clinic after each work injury. This case is no different, as Dr. Dinkha's

records state Petitioner treated with company doctors (Mercy Works) where they prescribed an MRI, but there are no Mercy Works records in evidence. Once again, the record is deprived of a vital treatment record to establish the very foundation of Petitioner's claim. What was the initial accident history at Mercy Works? Clinical exam? Were there comparison x-rays or MRIs? It is no overstatement that the first treatment records often corroborate or discredit a Petitioner's claim, especially involving orthopedic injuries.

In summary, Mercy Hospital records are incomplete, and Mercy Works was never properly subpoenaed. There are no Mercy Works records in evidence. The Arbitrator notes that these are the first two medical care providers involved in the case and they provide no insight about how the accident occurred or the nature and extent of Petitioner's immediate injuries. There is nothing to document any abrasions, bruises, cuts, or contusions to Petitioner's body. There are no independent corroborating histories of the accident.

Nevertheless, accident was not disputed by Respondent. (Arb. Ex #1) However, causation was disputed for the following injuries: left shoulder, bilateral knees and carpal tunnel syndrome. (Id.) The burden is upon the party seeking an award to prove by the preponderance of the credible evidence the elements of the claim. Peoria City Nursing Home v. Industrial Comm., 115 Ill.2d. 524, 505 N.E.2d 1026 (1987).

Left shoulder

The most compelling support of causation for the left shoulder is a copy of Petitioner's accident report of occupational injury dated October 15, 2015. (RX #1) It states the following,

"Slipped getting out of truck to check blade operation, fell on knees while trying to stand up door struck me on the left shoulder causing pain. Step was slippery from the leak."

The first medical history is in Dr. Dinkha's records on October 19, 2015 and it is consistent with the above. In fact, it is identical.

However, on December 7, 2015, Dr. Chandler wrote "they injured themselves when her

work truck broke. She states she was getting out of her work truck and slid on the steps falling and hitting her knees on the steps. She states the ground was covered in oil due to the truck breaking and fell again and hit her shoulder."

Furthermore, On June 7, 2017, Respondent's Section 12 examiner, Dr. Guido Marra, opined that Petitioner's accident was causally related to her left shoulder condition. (RX #2) But he wrote, "she slipped on the oil and attempted to break her fall with her left arm, sustaining a traction injury." (RX #2) Stated another way, it was a stretch injury.

To summarize, the first known history was that the left shoulder was struck by the door as she tried to stand after the initial fall. The second version was that she fell onto her left shoulder. The third history was that she was hanging on when she slipped from the step. (T. 13)

At trial, Petitioner stated "she was stepping down, stepped into the oil and down I went. I was still holding onto the bars." (T. 13) This history is consistent with the traction history told to Dr. Marra on June 7, 2017, twenty months after the accident. To the trier of fact, it would have been better for Petitioner's credibility if she had stuck with her original version of how the accident occurred. The burden is on the employee to prove that her injuries are causally related to the employment. New Guard v. Industrial Comm., 58 Ill.2d 164, 317 N.E.2d 524 (1974) The first two histories were not stretch or traction injuries. The mechanism of injury differs with each history. Respondent could've disputed accident on this claim but chose instead to dispute causation.

It does not appear that Dr. Marra reviewed the histories contained in the accident report, nor Dr. Dinkha's records. They were not sent to him. He only reviewed Dr. Chandler's records. If he had seen the earlier histories, it is doubtful that he would have provided a causal connection statement in favor of Petitioner. He would have noticed the discrepancies in the accident histories and noticed there is no medical evidence of traumatic injury other than Petitioner's inconsistent narratives. Further, there is no evidence that Dr. Marra was aware of the post-accident MVAs, nor the accident at Advocate. Each of these events could have aggravated the Petitioner's left shoulder and knee conditions. He was unaware that the Petitioner was an unreliable witness. Diagnostically,

Petitioner's initial left shoulder MRI failed to show a compelling traumatic injury. There was no torn labrum, no torn rotator cuff, and no SLAP tear. There were no brachial plexus complaints common in traction injuries. Instead, only degenerative changes were noted in the medical records and no one seemed to notice the weakness of Dr. Chandler's rationalization to perform shoulder surgery. The Arbitrator notes that none of the indicia for surgery turned out to be true. Petitioner had only attended one physical therapy appointment and Dr. Dinkha's record shows Petitioner complained of only "slightly limited range of motion to her left shoulder. No radiation of pain on February 2, 2016. (PX #2) The operative findings do not appear to be traumatic in nature. In summary, Dr. Marra's causal connection statement in favor of Petitioner is rejected by the Arbitrator. It is not credible as it was based on factually incorrect and incomplete information that was vital to his analysis.

Although accident wasn't disputed, it was never clear from the record if there was an oil explosion (RX #2) or oil leak? (RX #1) How was everyone injured in the occurrence? Did they all fall at the same time? If there was an "shaking," "explosion," or "pop" then how did oil from inside the garbage truck get onto the steps of the truck? (T. 13) What exactly combusted? Did the oil come from the blade puncturing an object, or inside the engine hood or from some other hydraulic fluid leak? There was no "explosion" narrative in the occupational injury report which would've triggered urgent vehicular maintenance. (RX #1) This was never explained at trial and the Petitioner's narrative of the accident has an abbreviated, fantastical quality to it, which might be appropriate in some other venue than a court of law. In summary, the Arbitrator finds no causal connection for Petitioner's left shoulder injury. In finding so, the Arbitrator did not expect to find a pristine record, but notes that this record is far too riddled with omissions, discrepancies, untruths and exaggerations to find any room to allow the Petitioner the benefit of doubt in matters of credibility, which will be catalogued in detail later in this document.

Causal connection for knees

It bears repeating that the court record is deprived of vital medical records from Mercy

Hospital and Mercy Works. These were Petitioner's first two medical treatment providers. However, Mercy Hospital records dated October 15, 2015 state: "INDICATION: Fall. Acute bilateral knee pain." Both knees were x-rayed and the results were negative. Petitioner had a prior right knee x-ray on May 17, 2011. (PX #1) This contemporaneous history supports knee injuries.

However, when Petitioner sought care from her primary care physician, Dr. Josephine Dinkha on October 19, 2015 (PX 2), her treatment focused on the left shoulder. Petitioners' knees were not examined. (PX #2)

Dr. Dinkha diagnosed left rotator cuff syndrome and referred Petitioner to see Dr. Chandler at Southwest Orthopedics for further treatment. (PX# 3)

On November 28, 2018, Petitioner sought treatment at Southwest and there were no knee complaints. (PX #3)

On December 7, 2015, Petitioner's knees were examined by Dr. Chandler and Petitioner complained of bilateral knee pain, left worse than right. (PX #3) "She hit her knees on the steps and then fell again." (PX #3) The knees were examined and there were some positive clinical findings, but there was no weakness and range of motion was full. Nevertheless, Dr. Chandler injected both knees (cortisone) and diagnosed mild arthritic changes or sprains of the knees. MRIs were ordered. (PX #3)

The left knee MRI was performed on December 22, 2015. No meniscal tear was detected and there was no effusion. (PX #3) Three days later, the right knee MRI showed no effusion, but there "may be a subtle oblique tear of the posterior horn of the medial meniscus. (PX #3)

On January 6, 2016, Dr. Chandler rechecked the Petitioner and her knees were examined. The clinical exams were mostly negative. The doctor diagnosed left knee sprain with effusion and offered an aspiration, which the Petitioner declined. On the right, the doctor diagnosed a medical meniscus tear, offered a brace, anti-inflammatories, and physical therapy. If those didn't help the next step was arthroscopy. (PX #3)

On January 12, 2016, Petitioner's initial physical therapy evaluation report states that

Petitioner "fell last week on the stairs up to her apartment for which she has 6 flights to climb." She reported difficulty ambulating more than 10 minutes, her standing limit was 10 minutes as well. She reported bilateral decreased range of motion and strength and daily pain of 10/10 on the left and 7/10 on the right. (PX #3) She was not wearing her brace. This is the only physical therapy appointment that Petitioner would attend for her knees.

The medical records from Advocate show that a CT of the abdomen and pelvis was performed on January 17, 2016 and it was negative. There was fecal stasis in the colon. Petitioner may have simply been constipated. (PX #3) Petitioner was not admitted to the hospital.

The above visit to Advocate Hospital is the subject of a civil claim in the Circuit Court of Cook County (law division) captioned, Oralean McClellan v. Advocate Christ Medical Center (17 L 8732). Petitioner allegedly fell from a gurney. The nature and extent of those injuries are unknown. At trial, Petitioner stated it involved injuries only to her right side of her head and right arm. (T. 36)

Despite inconclusive MRI images, a right knee arthroscopy was authorized by utilization review on January 19, 2016. (PX #3) Later that week, Petitioner returned to occupational therapy and stated that she was gone all last week due to being in the hospital for severe right lower abdominal pain and they dropped her on the floor. She wanted to put physical therapy on hold for her knees until she was cleared by the doctor for her right abdominal pain. (PX #3)

Petitioner continued with left shoulder physical therapy.

On January 30, 2016, the Petitioner sought medical treatment at Southwest, but there were no knee complaints. Petitioner told Dr. Dinkha that "she is a realtor and had a closing a few days ago." Petitioner was collecting TTD benefits during this time. Petitioner reported no secondary income at the time of trial. (Arb. Ex. #1)

On February 2, 2016, Petitioner sought medical treatment with Southwest and there was no knee examination. Additionally, there is some evidence that Petitioner may have been involved in a

motor vehicle accident on or about February 2, 2016 as noted in Dr. Dinkha's records. (PX #2)

On February 3, 2016, Petitioner was discharged from knee physical therapy due to poor attendance. She had cancelled on January 15th, 19th, and the 21st. She had attended only one appointment. (PX #3)

On February 8, 2016, Petitioner was examined by Dr. Chandler, who recommended left shoulder arthroscopy. (PX #3) Petitioner's knees were examined as well. Again, most of the clinical signs were negative. The doctor noted that Petitioner's left knee was more painful than the right, but also noted that the left MRI was negative. (PX #3) As a result, he planned to treat that knee conservatively. He still recommended surgery to the right knee. Petitioner did not undergo any additional knee treatment after this date. Petitioner never had right knee surgery.

Petitioner continued to see Dr. Dinkha on a regular basis throughout 2016, 2017 and 2018 without receiving knee treatment.

An FCE was performed on August 17, 2017 and reviewed by Dr. Chaudri. He endorsed restrictions to the Petitioner's left shoulder. No leg (knee) restrictions were prescribed (e.g. squatting, kneeling, bending, crawling). (PX #3)

Petitioner was involved in another motor vehicle accident occurring on October 31, 2017. (PX #3) Those injuries may be limited to Petitioner's lumbar spine. (PX #2) There was no cross-examination about these accidents.

On May 2, 2018, Dr. Chaudri filled out a reasonable accommodation request and added permanent restrictions of no squatting, kneeling, bending/stooping, crawling. (PX #3) The Arbitrator notes that this form was completed without a physical exam and when Petitioner was having difficulty complying with vocational rehabilitation. (PX #3)

In summary, when looking at the entire medical record regarding the Petitioner's knees, the Arbitrator notes that Petitioner's left knee MRI was negative, she had one cortisone injection and a single physical therapy visit. Likewise, Petitioner's right knee MRI may have shown a subtle tear, there was a single cortisone injection, and one physical therapy visit. Historically, these are not the

kind of injuries that usually result in permanent restrictions or a job loss at The Illinois Workers' Compensation Commission.

Upon closer scrutiny, Dr. Chandler's original right knee surgical recommendation is now over three years old and was weak at its inception. No diagnostic study ever corroborated his claim of knee effusion. In fact, the x-ray taken on the alleged date of accident showed no effusion. (PX #1) The right MRI did not show a complete tear, as he claimed. Dr. Chandler's original diagnosis was "mild arthritic changes," which suggests that the work injury, if it did occur, may have only aggravated pre-existing degenerative changes. The entire record supports a temporary aggravation of a pre-existing condition. Additionally, the UR certification for right knee surgery was based upon Dr. Chandler's incorrect representation that Petitioner attended physical therapy with no improvement. In fact, Petitioner had only attended one appointment and was discharged due to noncompliance. Finally, after the alleged work accident, Petitioner was involved in at least two MVAs, a fall from a hospital gurney and a fall from stairs.

Respondent's section 12 examiner, Dr. Guido Marra, did not examine the Petitioner's knees and made no comment on them.

Another causal connection statement in the medical records for Petitioner's knees is from Dr. Chandler on January 21, 2016 when he signed a State Farm form stating that all of Petitioner's conditions are employment related (left shoulder, bilateral knees), but that report has two credibility problems. First, the report states both knee MRIs confirmed medial meniscal tears. (PX #3) This was simply untrue, as neither confirmed such pathology. Second, it doesn't take an expert to see that the handwriting on the form does not match Dr. Chandler's signature. (PX #3) Dr. Chandler did not create the report, he only signed it. As a result, it is not persuasive. The Arbitrator finds no credible causal connection for the Petitioner's current knee condition and the occurrence at work. In looking at the entire court record, it appears that more likely than not, Petitioner's work accident was a temporary aggravation of a pre-existing bilateral knee condition. In summary, Petitioner's initial treatment was delayed. She had very limited treatment and then failed to treat for three years.

Finally, Petitioner had several falls after her alleged work accident. Petitioner failed to present credible evidence that her current knee condition is causally related to the occurrence at work on October 15, 2015.

It should also be noted that a majority of Petitioner's permanent work restrictions are based upon her knee complaints which the Arbitrator finds unrelated to the alleged accident. Petitioner's FCE states the following: no balancing that requires crouching, no crouching, no stooping, kneeling on one knee or crawling. (PX #3) One wonders if Petitioner could have returned to her old job if these restrictions were re-evaluated in a more realistic light.

Carpal Tunnel Syndrome

The workers' compensation claim 18 WC 02216 was consolidated with 15 WC 003934 on December 10, 2018 and alleges that Petitioner's right carpal tunnel syndrome was caused by her vocational rehabilitation (employment) with Respondent.

Petitioner did not finish vocational rehabilitation with Vocamotive because "her right hand was hurting. We did so much typing." (T. 29) In corroboration, Dr. Dinkha's medical records show that on July 20, 2018, Petitioner complained of "right-hand pain for the past couple of months. She started typing in February, three days a week 8 am. to 3 pm." Tinels and Phelans test on the right hand was positive. (PX #2) The assessment was right hand pain. No EMG or brace was prescribed. Petitioner was instructed to follow up in three months. (PX #3)

Petitioner returned to Dr. Dinkha on September 19, 2018 with left eye redness and swelling. She had pink eye. There were no right-hand complaints. (PX #3) This is Petitioner's final treatment record with Dr. Dinkha.

In analyzing the above, Dr. Dinkha's official records never diagnose carpal tunnel syndrome. Instead, her assessment was "right hand pain." (PX #2) Further, there is no prescription for an EMG or brace, nor is there a referral to a hand specialist. (PX #2) Petitioner was told to return to the clinic in three months. Instead, Petitioner returned in two months, but for a new complaint – pink eye. (PX

Anecdotally, the Arbitrator knows of no known workers' compensation cases where the Petitioner developed carpal tunnel syndrome after typing 24 words a minute, three days a week. It may be because the described activity simply isn't perceived by the medical or legal community to be repetitive or forceful enough to warrant a carpal tunnel diagnosis. The most compelling carpal tunnel claims today involve highly repetitive, full-time work as in the case of an assembly line worker who must meet hourly production goals. In contrast, Petitioner was learning how to type on a part-time basis, essentially at her own pace and while it is true that she made some progress, 24 words a minute isn't an impressive rate of typing speed. It's still slow.

Since there is nothing in the medical records to support causal connection for this claim, there is a failure of proof in that no carpal tunnel diagnosis ever made it into Petitioner's official medical record. Also, Petitioner's vocational rehabilitation activities do not appear repetitive or forceful enough to cause such a condition.

It may be true that there is a "To Whom It May Concern" letter by Dr. Dinkha attached to Respondent's motion to consolidate filed on November 19, 2019 that states, "possible carpal tunnel syndrome and limited driving, no work typing." This is not part of the trial record, but part of the court file. "Petitioner is to wear a brace until she has an EMG performed." Again, this is not part of Dr. Dinkha's official medical record, yet it was given to the vocational rehabilitation counselor as justification to no longer continue with the program. The Arbitrator finds it ironic that this document was put into the court file by Respondent, not Petitioner.

Why wasn't the "To Whom It May Concern" letter included in Dr. Dinkha's official medical record? When compared to the official progress note, they are not reconcilable. Which document is more believable? The subpoenaed medical record is a more credible source. It simply states "hand pain," and no EMG nor work restrictions were prescribed. This is the record Dr. Dinkha would give another physician for peer review, if requested. In contrast, the "To Whom It May Concern" letter is less credible as it appears to have been prepared in anticipation of litigation. It's not part of the

subpoenaed medical records. In fact, it appears to be a form of claim manipulation in that the doctor has become a legal advocate for her patient, instead of a medical advocate. In July of 2018, when the "To Whom It May Concern" was authored, Petitioner knew she had not made a good faith effort in vocational rehabilitation and wanted a doctor's note to absolve her of non-compliance prior to trial before The Illinois Workers' Compensation Commission.

Petitioner exaggerated her carpal tunnel syndrome symptoms before the Arbitrator. At trial, Petitioner indicated that her hand pain was causing her fingers to stick up and gave an impromtu demonstration. (T. p.30) This "trigger-fingering" was not documented in Dr. Dinkha's medical records, nor observed at any other time in the court proceeding. She was not wearing her wrist brace as instructed by Dr. Dinkha. If Petitioner was willing to exaggerate her hand symptoms before the court, did she do likewise with her doctors regarding her knees and left shoulder? If you look at the entirety of the medical records, it's more probable than not.

In summary, the Arbitrator finds no causal connection linking Petitioner's vocational rehabilitation activities (typing) and her alleged carpal tunnel syndrome.

Petitioner's Credibility

The Arbitrator does not find the Petitioner to be a credible witness in this case. The following is a list of some of the factual discrepancies noted in the medical records, trial exhibits and testimony before the court.

The Petitioner gave three different histories of how the accident happened.

Petitioner warranted that she had not received income from outside employment while she was on disability income, but she had performed at least one real estate closing on or about January 27, 2016. (PX #2) On March 7, 2018, she told Vocamotive that she had not sold any houses since her injury, but this was not true. (RX #3) Petitioner earned a secondary income before and after the accident.

Petitioner reported to Vocamotive that she had a hard time turning the steering wheel in her

car and reported that she was no longer able to handle a larger car. In contrast, she also said that she had a valid Illinois CDL-A driver's license with double and triple endorsements. (RX #3) Commercial Drivers' Licenses are governed by the U.S. Department of Transportation. The Arbitrator takes judicial notice that drivers must undergo a medical examination every two years to remain commercially certified. If the Petitioner's statement is true, then what could she have told the CDL physician about her medical condition to keep her CDL certificate current?

With regard to her left upper extremity, Petitioner told Vocamotive that she was unable to elevate her arms out to the side and forward without assistance. She could not extend her elbows. (RX #3) The Arbitrator notes that there is nothing wrong with Petitioner's right arm or either elbow. Compare and contrast this with Petitioner's final occupational therapy appointment on April 20, 2017 which showed that her shoulder flexion was within functional limits. She could perform shoulder rows and lower rows indicating significant elbow flexion. (PX #3) Petitioner horribly exaggerated her functional abilities to Vocamotive, which had an impact on their report.

On March 7, 2018, Petitioner told Vocamotive that she had completed some college courses but denied ever receiving any diplomas or certifications. (RX #3) Later on May 7, she admitted having an associates' degree. (RX #3 p.12) Petitioner had to be reminded not to include her GED certificate during her job searches, as she had an associates' degree.

On January 12, 2016, Petitioner told her physical therapist that she lived in an apartment for which she has six flights to climb. (PX # 3) The Arbitrator takes judicial notice that there are no "six story walk-up" apartment buildings in Chicago.

On May 18, 2018, Petitioner told Vocamotive that she had meniscus tears in both knees, (RX #3) but as stated earlier, the MRIs do not corroborate this fact. Instead, she might have one.

On May 18, 2018, Petitioner told Vocamotive that she was unable to lift over 2 pounds with her left arm, but the FCE stated she is can occasionally lift to 35 lbs. and frequently lift 18 pounds. (PX #3)

On May 18, 2018, Petitioner stated she taught a Hendricks Academy, a private school in

Chicago that required no teaching certificate. (RX #3 p. 3 of 10) However, the Arbitrator takes judicial notice that Hendricks is run by Chicago Public Schools. At trial, Petitioner stated that she taught at the "Board of Education" for eight years. (T. 10) The Chicago Board of Education governs Chicago Public Schools, not private ones. As a result, it is likely that Petitioner had a teaching certificate that she did not wish to disclose to Vocamotive.

During a Vocamotive physical evaluation on May 18, 2018, Petitioner was unable to perform reaching and manipulative tasks with her right arm and hand. (RX #3 p.7/10) Petitioner has no known injuries or restrictions to her right shoulder or hand that would prevent her from performing these tasks.

On June 19, 2018, Petitioner told Vocamotive that she heard "voices" in her head. (RX #3) Petitioner was never diagnosed with schizophrenia, which is commonly associated with auditory hallucinations. Petitioner did not claim to hear voices in her head when applying for social security disability benefits. (nor is it likely that she told the same to the medical examiner during her CDL recertification.) Later that day, Petitioner told Vocamotive that she had been ill for the past week, and "when she went to the clinic, she had a temperature of 102 degrees. She reported that she had immediately been given a shot and had been advised that she might be transferred to the hospital." (RX #3) In contrast, Dr. Dinkha's medical records show that on June 11, Petitioner had a normal temperature of "98.1 degrees." Petitioner was given a vitamin B12 injection and told to follow up in three months. The STREP test was negative. (PX #2)

At trial, Petitioner stated she had never injured her knees before the accident, but the Mercy Hospital records shows right knee x-rays taken on May 17, 2011. (PX #1) Petitioner may have had a problem with her right knee in the past.

Petitioner testified at trial that both her knees had meniscus tears, but this is not true. (T. 17)

Petitioner testified at trial that her left shoulder had rotator cuff tears, but this was not true. At times, the doctors suspected a cuff tear, but one was never found. (RX #3 & 4)

Petitioner stated that physical therapy for her left shoulder was unhelpful, (T. 19) but she

attended only one session and was discharged for "poor attendance" on February 3, 2016. (PX #3) She described her treatment where "they would put different kind of glass tubings onto your arms, suction cups. They would do some kind of stem treatments." (T. 19) The medical records do not support these fantastic claims.

Petitioner stated at trial that she had two injections per knee, but the record only supports one injection. (T. 21) (PX #3) Petitioner stated that surgery was recommended for both knees, but the record only supports one prescription. (T. 21) (PX #3)

Petitioner stated that she had never worked in customer service (T.25) but the Vocamotive record states she taught music at Hendricks Academy for eight years and also moonlit as a real estate broker. (RX #3) Both jobs require a significant amount of customer service.

Petitioner denied being uncooperative in vocational rehabilitation, but those records state otherwise. (RX #3) To catalogue the multiple instances of poor effort would create yet another exhaustive list of inconsistences, exaggerations and half measures, which were documented by the vocational rehabilitation counselor in her reports. (RX #3) When there is a lack of "good faith" cooperation with vocational rehabilitation, the termination of benefits is justified. Hayden v. Industrial Comm. 214 Ill.App3d 749, 575 N.E.2d 99, 158 Ill.Dec. 305 (1st Dist. 1991) Ultimately, Petitioner stopped participating because of the specious carpal tunnel claim. She refused to type or drive a car for her job interviews or counselor meetings.

The medical records show that Petitioner's residence in Chicago changed from an apartment located at South Calumet to a home located at South Peoria. (PX #3) This occurred sometime in the winter or spring of 2017. (PX #2 3, & 4) Petitioner claimed that her TTD checks were irregularly sent to her in the Spring of 2017, (T. 33) but this was contradicted by Respondent's payment listing showing checks timely dated. (RX #4 p.4 of 7) Perhaps they sent them to the old address, but in that case, Petitioner did not properly update her employer. The City disability warrant form allows a claimant to change their address each month. (PX #3 e.g. 05-29-16)

Despite the above, Petitioner "lost" her group health insurance (BCBS) later that year due to

nonpayment of her premium and Dr. Dinkha's medical records show this may have occurred in the fall or winter of 2017. The last recorded bill payment from Blue Cross was on October 30, 2017. (PX #2) Respondent's payment ledger shows maintenance checks issued to Petitioner on a regular basis during this time until July 20, 2018. (RX #4 p.6 of 7)

It is unclear to the Arbitrator how Petitioner's loss of health insurance could be caused by anything but poor money management. As stated earlier, if the new abode was an upgrade, the decision to buy a home was ill advised. If the new abode was a downgrade, the health insurance payment would've been more affordable. Petitioner told similar story about her bifocals. On February 17, 2016, an ophthalmologist told Petitioner to stop wearing contacts. (PX #3) Petitioner had health insurance during this time. The pre-operative records for the second left shoulder surgery on October 11, 2016 showed she wore glasses. (PX #4) Yet on March 27, 2018, she told Vocamotive that she was unable to afford bifocals. (RX #3) Petitioner was still receiving weekly benefits during this time.

On September 18, 2018, Petitioner applied for Social Security Disability benefits, indicating that she had removed herself from the job market. (PX #3) As a result, no maintenance benefits are warranted. Petitioner is no longer actively seeking work and has affirmatively left the job market.

In summary, the Arbitrator finds that the Petitioner is a remarkably unreliable witness. Many of her claims are false, many are exaggerations and some of them are incredible. If the doctors involved in her treatment had reviewed all the records and listened to her statements and sworn testimony about "hearing voices," "stem treatments," or "glass tubings," they would've had second thoughts about her accident narrative. They would have wondered if any significant injuries occurred, whether her current complaints were genuine and causally connected to the accident. Further, they would have doubted that the FCE results were a true representation of her current abilities. Instead, it appears that Petitioner was "shining us on" for monetary gain. Perhaps she was dissatisfied with the amount of pension benefits she had accrued with Respondent. It should be noted that treating physicians benefited from her narrative as well.

UNPAID MEDICAL BILLS

Based on the above, Respondent has no liability for the outstanding medical bill from Advocate Illinois Masonic Medical Center (2nd left shoulder surgery) in the amount of $35,089.00. (PX #4) Additionally, the Arbitrator notes that prior to surgery, it appears that utilization review Dr. Rubenstein specifically non-certified the left shoulder subacromial decompression, but it was performed anyway. (PX #4) There is no evidence in the record that a peer-to-peer review occurred resolving their differences of opinion. Finally, Respondent argues that the bill is already paid pursuant to the fee schedule. (RX #5)

NATURE AND EXTENT

Petitioner is not entitled to a wage differential award under Section 8(d)(1) nor a specific loss award under the Workers' Compensation Act as the Arbitrator finds no causal connection between the Petitioner's left shoulder injuries, knee injuries, right hand carpal tunnel and the alleged work accident. Petitioner's accident history was contradictory leading anyone to doubt the mechanism of injury and causation. The first left shoulder operative report showed mild fraying and degenerative changes. As a result, her condition appears to be non-traumatic in nature. There was no traumatic pathology discovered during her initial treatment nor in the operative report and the original basis to perform left shoulder surgery was weak.

Petitioner hasn't treated for her knees in nearly three years and never obtain much medical treatment for them throughout the course of her claim. There are several potential superseding, intervening accidents that occurred after the accident. Petitioner constantly exaggerated the nature and extent of her knee condition but did not obtain medical treatment for them, nor did she ever wear her knee brace. In contrast, the Arbitrator notes she was willing to see Dr. Dinkha about a bug bite on October 30, 2017. (PX #2)

Finally, the carpal tunnel claim appears to have been created to circumvent vocational

rehabilitation efforts by Respondent and save the wage differential demand.

The FCE at Horizon is unpersuasive. The person who performed the FCE is a designated "Doctor of Physical Therapy" or DPT which is neither a doctor nor a physical therapist. The report only states conclusions and does not go into any detail about Petitioner's performance during passive or active range of motion exercises with certain weights or stretches. The report concludes that the results were valid, but there were no details given about validity testing. Instead, the report seems to rely upon Petitioner's verbally stated tolerances, which are patently unreliable. Further, Petitioner's maximum heart rate never exceeded 94 beats per minutes, which shows she did not exert herself significantly during the exam. It doesn't take an expert to know that most adults would exceed 94 beats per minutes by walking up two flights of stairs. The FCE report also gave significant leg restrictions which are not congruent with Petitioner's knee pathology and treatment. Finally, one cannot compare the FCE report with Petitioner's discharge summary from occupational therapy because the Petitioner abruptly stopped attending those sessions. In summary, the FCE report is not credible.

WAGE DIFFERENTIAL AWARD

As a result of the prior findings of fact and conclusions of law, Petitioner failed to prove she is entitled to a wage differential award under Section 8(d)(1) of The Illinois Workers' Compensation Act.

CREDIT

As a result of the prior findings of fact and conclusions of law, Respondent is entitled to an 8(j) credit in the amount of $133,160.61.

PENALTIES

No penalties are awarded in this matter.

Dated this 26th day of MARCH 2019.

Arbitrator Kurt A. Carlson

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

ORALEAN McCLELLON WILLIAMS,

Petitioner,

vs. NO: 18 WC 22610

CITY OF CHICAGO,

Respondent.

20IWCC0324

DECISION AND OPINION ON REVIEW

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

A separate decision has been issued for claim 15 WC 39342.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 26, 2019 is hereby affirmed and adopted.

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

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

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

DATED: JUN 11 2020

DDM/tdm
O: 5/6/20
052

D. Douglas McCarthy

Stephen Mathis

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WILLIAMS, ORALEAN
Employee/Petitioner

Case# **15WC039342**
18WC022610

CITY OF CHICAGO
Employer/Respondent

20IWCC0324

On 3/26/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.41% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5191 FAJARDO LAW GROUP LLC
TANYA I FAJARDO
77 W WASHINGTON ST SUITE 1313
CHICAGO, IL 60602

0010 CITY OF CHICAGO LAW DEPT
LUCY HUANG
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Oralean Williams
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **15** WC **39342**

Consolidated cases: **18 WC 022610**

20IWCC0324

An *Application for Adjustment 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**, Illinois on January 10, 2019. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On October 15, 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(s) of ill-being ***is not*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**72,053.42**; the average weekly wage was $**1,385.64**.

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

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

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

Respondent shall be given a credit of $ for TTD, $ 98,055.83 for TPD, $ 35,104.78 for maintenance, and $ 0 for other benefits, for a total credit of $ **133,160.61.**

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

ORDER

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

Respondent is entitled to a credit for all benefits paid.

Respondent is not liable for maintenance benefits after July 23, 2018.

No wage differential is awarded.

Respondent has no liability for permanent partial disability benefits.

No penalties are warranted.

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

03-26-19
Date

MAR 2 6 2019

20IWCC0324

BEFORE THE ILLINOIS WORKERS COMPENSATION COMMISSION

ORALEAN WILLIAMS Petitioner V. CITY OF CHICAGO Respondent.	)	15 WC 039342 18 WC 022610

ARBITRATOR'S DECISION

This matter came before the Arbitrator for hearing on January 10, 2019 with Attorney Tanya Fajardo of Fajardo Law Group, LLC appearing on behalf of the Petitioner, Oralean Williams, and Attorney Daniel Kallio, appearing on behalf of the Respondent, The City of Chicago. NOW, THEREFORE, upon consideration of the entire records of proceedings before the Arbitrator, as well as, all records, files, pleadings, and proceedings filed in this action, the Arbitrator finds as follows:

STATEMENT OF FACTS

On October 15, 2015, Petitioner, a 53-year-old female, was working as a motor truck driver in the Department of Streets and Sanitation. She had over 16 years of service time with the City. Petitioner allegedly sustained an injury to her left shoulder and both knees when she slipped and fell while stepping out of her garbage truck. Accident is not disputed in this matter, but the Arbitrator notes that Petitioner gave three versions of how the accident occurred; those will be catalogued later in this document, as they impact the causal connection analysis.

Petitioner initially sought medical treatment at Mercy Hospital (PX #1) and then was directed by her employer to Mercy Works Clinic that same day. There are no Mercy Works medical records in evidence.

Petitioner then went to see her primary care physician, Dr. Josephine Dinkha at Southwest Physicians Group on October 19, 2015. (PX #2) Petitioner stated that she was in pain and unable to lift her left arm. Dr. Dinkha diagnosed left rotator cuff syndrome and referred her to see Dr. Chandler at Southwest Orthopedics for further treatment. (PX #3) Petitioner received no treatment to her knees on this date.

On December 7, 2015, Dr. Chandler examined the Petitioner and recommended MRIs for the left shoulder and knees. The left knee MRI study was performed on December 22, 2015 and showed no tear. "No meniscal injury was detected." (PX #3)

The right knee MRI study was performed on December 28, 2015 stating, "there may be a subtle oblique tear...of the posterior horn of the medial meniscus. There was no significant joint effusion." (PX #3) Nevertheless, Dr. Chandler gave cortisone injections to each knee.

Despite the above limited MRI findings, on January 21, 2016, Dr. Chandler told State Farm that the MRIs confirmed bilateral knee meniscal tears. (PX #4) It bears repeating that the left knee MRI showed no meniscal injury and the right image might have shown a subtle oblique tear. Surprisingly, Dr. Chandler recommended surgery for both knees. (PX #4) Later, utilization review certified surgery for the right knee only. But Petitioner never followed through with it. Moreover, Petitioner never had any additional medical treatment for her knees again. Instead, Petitioner's medical care shifted to her left shoulder.

On January 30, 2016, Southwest records show that the Petitioner was at Advocate Hospital from January 16, 2016 through January 18, 2016 for unrelated right-sided abdominal pain. While on sedatives, she fell and sustained a bump to the right side of her forehead. She stated that her vision was slightly blurry since then, but her optometrist could not find anything wrong with her vision. She

complained of memory loss. It was noted that Petitioner was a realtor and had a closing a few days ago. A concussion was ruled out. (PX #2) The medical records from this fall are not in evidence but appear to be the subject of additional civil litigation captioned, Williams vs. Advocate Christ Medical Center – 17 L 8732. (PX #3) This case may still be pending in Cook County law division.

On February 2, 2016, Southwest records state that Petitioner reported only slightly limited range of motion of the left shoulder by pain. (PX #2)

Petitioner's past medical history on this date shows a motor vehicle accident or MVA with a neck sprain or strain which was resolved and an unspecified psychiatric exam with depressive disorder that was resolved as well. No details of this MVA or medical treatment are in the court record. (PX #2)

Petitioner attended one physical therapy session for her left shoulder and was then discharged for poor attendance on February 3, 2016. (PX #3) At trial, Petitioner stated she "wasn't sure how long it lasted, but it wasn't doing any good." (T. 18) An MRI of the left shoulder was taken on February 5, 2016 and found a low-grade partial undersurface tear of the mid-supraspinatus tendon and a degenerated, but poorly seen, glenoid labrum. (PX #3)

Dr. Chandler recommended left shoulder surgery which was initially denied by utilization review. Upon peer-to-peer consultation, Dr. Chandler justified the surgery for three reasons. First, he explained that Petitioner had undergone three weeks of therapy and the shoulder was getting worse. Second, the MRI was positive, and the Petitioner had no improvement after a cortisone injection.

As a result, the left shoulder surgery was certified and performed on March 24, 2016. (PX #4) The operative report stated that the Patient had a degenerative tear of the labrum, but it was still attached to the glenoid. There was no rotator cuff tear. A limited debridement of the labrum was

performed. A biceps tenotomy was performed. A type 2 spur acromial spur was discovered, so some burring was performed by way of a subacromial decompression. Likewise, some arthritis was discovered at the AC joint, so the distal clavicle was excised with some coplaning of the undersurface. (PX #4)

Postoperatively, Petitioner underwent physical therapy beginning on April 20, 2016. (PX #3) She continued to have ongoing pain and problems with limited range of motion in her left shoulder.

Dr. Chandler departed Advocate Illinois Masonic, leaving Petitioner's left shoulder treatment to Dr. Salman Chaudri on May 12, 2016. (RX #3) He noted no swelling of the left shoulder, but reduced range of motion and strength. In June, Dr. Chaudri prescribed an MR Arthrogram because of decreased range of motion and instability of the left shoulder.

Another left shoulder MRI study was performed on August 8, 2016 which the radiologist thought showed a complete tear of the biceps tendon and a partial tear of the labrum. (PX 4) Dr. Chaudri recommended a second left shoulder surgery for three reasons: pain, restricted range of motion and the MRI findings showing a labral tear. It seems Dr. Chaudri was convinced he'd find and repair a labral tear.

On October 11, 2016 the second left shoulder surgery was performed. Under anesthesia, Dr. Chaudri found two partial tears (less than 10%), but the labrum was still intact. There was no peel back sign. Likewise, there was no SLAP tear. Nevertheless, there was some additional shaving performed. Additionally, there was no biceps tear as there was a previous biceps tenotomy. There were no complications. This procedure was later described as a manipulation under anesthesia or "MUA" and it took five minutes to perform. (PX #4)

Petitioner underwent post-operative occupational therapy at Southwest. The initial assessment was on November 1, 2016. Petitioner continued to be placed off work and Respondent paid TTD benefits. Petitioner's abode changed from an apartment on S. Calumet to a new address on S. Peoria. (PX #4)

Petitioner continued to undergo physical therapy sessions and follow up medical visits with Drs. Dinkha and Chandler.

Petitioner underwent an unrelated surgical procedure in March 3, 2017.

Petitioner's final examination with Dr. Chaudri was on April 3, 2017. At that time, he offered the Petitioner an injection to her left shoulder, but it was refused. He did not think that her physical abilities would be easily determined without a functional capacity exam or "FCE."

Petitioner's final occupational therapy appointment was April 20, 2017. At that time, Petitioner's condition had improved so that her shoulder flexion and external rotation were within functional limits. (PX #3) The plan was to continue with occupational therapy, but Petitioner stopped treating abruptly. She still complained of pain.

On June 6, 2017, Petitioner was seen by Dr. Guido Marra pursuant to Respondent's request (IME). She still complained of pain. Petitioner stated that she injured her left arm trying to break her fall, sustaining a traction injury. Unaware of the accident history discrepancies, Dr. Marra stated that Petitioner's left shoulder condition was causally connected to the work accident. He prescribed an MR Arthrogram and stated that until an FCE was performed, the Petitioner was on light duty. (RX #2) There were no knee exams by Dr. Marra.

On July 28, 2017, Dr. Chaudri authored a letter of medical necessity stating that he last examined the Petitioner on April 3, 2017 and she no longer wanted additional medical treatment from him. He did not place the Petitioner at MMI and stated that in his opinion, without an FCE objective limitations and abilities are difficult to ascertain. (PX #4)

On August 17, 2017, an FCE was performed by Horizon which placed Petitioner on the following permanent restrictions: Petitioner was capable of occasionally lifting 35 pounds from floor to knuckle, 18 pounds frequently and 7 pounds constantly. Overall, her tolerances met the Demand Minimum Functional Capacity requirement of standing, sitting, and walking with the inability to perform balancing activities that require crouching, stooping, kneeling, or crawling. (PX #2) In summary, Petitioner could return to work as a garbage truck driver. The exam was deemed valid even though Petitioner's heart rate never exceeded 94 beats per minute (bpm) during testing.

On August 31, 2017, Dr. Chaudri reviewed the FCE report and agreed that the following permanent restrictions apply:

- No pushing more than 60#s
- No pulling more than 70#s
- Lifting occasionally 35#, frequently 18#, and constant 4#
- Carrying occasionally 20#, frequently 10# and constant 4#

The Petitioner did not return to work for the City of Chicago as a garbage truck driver and it is unclear why. Petitioner was unable to meet some of the Dictionary of Occupational Title (DOT) job tasks but may have been able to meet her actual job requirements. Petitioner's actual job requirements were never put into evidence and are not part of the record. The FCE released Petitioner at a medium level and her city job was at medium level as well. Ostensibly, there was a parameter in the FCE that Petitioner failed to meet to return to her old job. At trial, this was never

explained with any detail. The record is not clear about the specific nature of the unmet restriction(s). Petitioner simply stated she "was not quite capable" of performing her old job. (T. 37) Ostensibly, Petitioner was very close to being able to perform her old job. On direct exam, Petitioner never testified that she had to push 100 lbs., nor pull 80 lbs., crouch, kneel or crawl in performing her City job. In fact, when asked if she was required to bend, kneel or squat, Petitioner replied, "Not really..." (T. 11)

On September 30, 2017, Petitioner sought medical care with Southwest for a possible spider bite. (PX #2)

On October 31, 2017, Petitioner was involved in yet another motor vehicle accident. (PX #3) X-rays of her lumbar spine were taken at Advocate.

Respondent was unable to accommodate Petitioner's permanent restriction(s) and then provided vocational rehabilitation to Petitioner (RX #3), but she was having problems following through on her job searches. (RX #3) Petitioner participated in vocational rehabilitation from March 7, 2018 to July 20, 2018 (RX #3), when she requested to stop because it aggravated her carpal tunnel syndrome.

On July 20, 2018, Petitioner informed Vocamotive that she would no longer attend vocational rehabilitation appointments because she recently received additional restrictions from Dr. Dinkha stating, "limited driving, no work typing." (RX #3) In Petitioner's opinion, all the typing she performed during vocational rehabilitation caused carpal tunnel syndrome. (T. 30) She stated that it caused her "fingers to stick up..." (T. 30) During vocational rehabilitation, Petitioner typed three days a week at a rate of about 25 words per minute. No future return date was provided. At trial, Petitioner stated that she needed an EMG, but could not obtain one, as her group health care benefits

had been terminated in June of 2017 for not paying her portion of the premium. (T. 34) She claimed financial hardship, but the records show Petitioner changed her abode during this time from an apartment on S. Calumet to a residence on S. Peoria in Chicago. Petitioner has been a licensed real estate broker/realtor since 2012 and sold at least one home during the period she was collecting workers' compensation benefits. (PX #2) (01-30-16) Petitioner stated that she could not continue with vocational rehabilitation because she needed an EMG for her hand and no longer had health insurance. (RX #3) It is unclear how the Petitioner was able to change her abode but also allow her group health insurance with Blue Cross to lapse. If the new abode was an upgrade, then how could she afford one and not the other? If she downsized, then group health premiums would be more affordable. Petitioner told the vocational rehabilitation counselor that she could no longer afford to pay her group health insurance premiums. (RX #3)

Petitioner was involved in at least three separate accidents after the occurrence at work.

On July 23, 2018, Respondent sent a letter suspending Petitioner's maintenance benefits due to not attending vocational rehabilitation. As of the time of the hearing, Petitioner had not obtained employment within her restrictions nor has she been paid workers' compensation maintenance benefits as of the above date.

Petitioner stated to her vocational counselor on March 7, 2018 that her CDL-A drivers' license (double and triple endorsements) was currently valid. (RX #3 p.6) The Arbitrator takes judicial notice that the maximum duration of a medical certificate for a valid Illinois CDL is two years. As a result, Petitioner must have renewed her Medical Examiner's Certificate or "MEC" Form MCSA-5876. Drivers must disclose their medical history and undergo a physical exam to renew their certificate and drive commercial vehicles. Petitioner must have passed her exam within two years of March 7, 2018. The earliest this could have occurred was March 7, 2016, which post-dates

the accident. Respondent did not cross-exam the Petitioner about her post-accident medical renewal certificate, but Petitioner said she had a current one.

On or about September 17, 2018, Petitioner applied for Social Security Disability benefits indicating that she had removed herself from the labor force. Her alleged disabilities were: "surgeries on left arm, torn ligaments in both knees, ADD, bipolar and carpal tunnel in right hand." (RX #3) Petitioner is still an employee of the City of Chicago. (T. 34)

CONCLUSIONS OF LAW

CAUSAL CONNECTION

Petitioner testified that she injured her left shoulder and both knees while exiting her truck while at work on October 15, 2015.

The Arbitrator takes note that the initial treatment provider, Mercy Hospital, provided incomplete medical records to the tribunal. (PX #1) The only documents submitted were negative x-ray reports for Petitioner's right knee and left shoulder. Although the subpoenaed records have a certification attached, more records certainly exist. For instance, the intake form is absent (which would include a history of the accident and a clinical exam). Also missing are the discharge form, list of prescription medications, and billing forms. As a result, this document is incomplete. Of note, the radiologists compared x-rays of the right knee taken previously on 05-17-11 (four years prior to the occurrence). There is no documentation of the left knee x-ray, although there is some evidence that it probably occurred. (PX #1)

Despite representations to the contrary, no Mercy Works records were submitted into evidence. The Arbitrator takes judicial notice that all City of Chicago employees are encouraged to treat at Mercy Works Clinic after each work injury. This case is no different, as Dr. Dinkha's

records state Petitioner treated with company doctors (Mercy Works) where they prescribed an MRI, but there are no Mercy Works records in evidence. Once again, the record is deprived of a vital treatment record to establish the very foundation of Petitioner's claim. What was the initial accident history at Mercy Works? Clinical exam? Were there comparison x-rays or MRIs? It is no overstatement that the first treatment records often corroborate or discredit a Petitioner's claim, especially involving orthopedic injuries.

In summary, Mercy Hospital records are incomplete, and Mercy Works was never properly subpoenaed. There are no Mercy Works records in evidence. The Arbitrator notes that these are the first two medical care providers involved in the case and they provide no insight about how the accident occurred or the nature and extent of Petitioner's immediate injuries. There is nothing to document any abrasions, bruises, cuts, or contusions to Petitioner's body. There are no independent corroborating histories of the accident.

Nevertheless, accident was not disputed by Respondent. (Arb. Ex #1) However, causation was disputed for the following injuries: left shoulder, bilateral knees and carpal tunnel syndrome. (Id.) The burden is upon the party seeking an award to prove by the preponderance of the credible evidence the elements of the claim. Peoria City Nursing Home v. Industrial Comm., 115 Ill.2d. 524, 505 N.E.2d 1026 (1987).

Left shoulder

The most compelling support of causation for the left shoulder is a copy of Petitioner's accident report of occupational injury dated October 15, 2015. (RX #1) It states the following,

"Slipped getting out of truck to check blade operation, fell on knees while trying to stand up door struck me on the left shoulder causing pain. Step was slippery from the leak."

The first medical history is in Dr. Dinkha's records on October 19, 2015 and it is consistent with the above. In fact, it is identical.

However, on December 7, 2015, Dr. Chandler wrote "they injured themselves when her

work truck broke. She states she was getting out of her work truck and slid on the steps falling and hitting her knees on the steps. She states the ground was covered in oil due to the truck breaking and fell again and hit her shoulder."

Furthermore, On June 7, 2017, Respondent's Section 12 examiner, Dr. Guido Marra, opined that Petitioner's accident was causally related to her left shoulder condition. (RX #2) But he wrote, "she slipped on the oil and attempted to break her fall with her left arm, sustaining a traction injury." (RX #2) Stated another way, it was a stretch injury.

To summarize, the first known history was that the left shoulder was struck by the door as she tried to stand after the initial fall. The second version was that she fell onto her left shoulder. The third history was that she was hanging on when she slipped from the step. (T. 13)

At trial, Petitioner stated "she was stepping down, stepped into the oil and down I went. I was still holding onto the bars." (T. 13) This history is consistent with the traction history told to Dr. Marra on June 7, 2017, twenty months after the accident. To the trier of fact, it would have been better for Petitioner's credibility if she had stuck with her original version of how the accident occurred. The burden is on the employee to prove that her injuries are causally related to the employment. New Guard v. Industrial Comm., 58 Ill.2d 164, 317 N.E.2d 524 (1974) The first two histories were not stretch or traction injuries. The mechanism of injury differs with each history. Respondent could've disputed accident on this claim but chose instead to dispute causation.

It does not appear that Dr. Marra reviewed the histories contained in the accident report, nor Dr. Dinkha's records. They were not sent to him. He only reviewed Dr. Chandler's records. If he had seen the earlier histories, it is doubtful that he would have provided a causal connection statement in favor of Petitioner. He would have noticed the discrepancies in the accident histories and noticed there is no medical evidence of traumatic injury other than Petitioner's inconsistent narratives. Further, there is no evidence that Dr. Marra was aware of the post-accident MVAs, nor the accident at Advocate. Each of these events could have aggravated the Petitioner's left shoulder and knee conditions. He was unaware that the Petitioner was an unreliable witness. Diagnostically,

Petitioner's initial left shoulder MRI failed to show a compelling traumatic injury. There was no torn labrum, no torn rotator cuff, and no SLAP tear. There were no brachial plexus complaints common in traction injuries. Instead, only degenerative changes were noted in the medical records and no one seemed to notice the weakness of Dr. Chandler's rationalization to perform shoulder surgery. The Arbitrator notes that none of the indicia for surgery turned out to be true. Petitioner had only attended one physical therapy appointment and Dr. Dinkha's record shows Petitioner complained of only "slightly limited range of motion to her left shoulder. No radiation of pain on February 2, 2016. (PX #2) The operative findings do not appear to be traumatic in nature. In summary, Dr. Marra's causal connection statement in favor of Petitioner is rejected by the Arbitrator. It is not credible as it was based on factually incorrect and incomplete information that was vital to his analysis.

Although accident wasn't disputed, it was never clear from the record if there was an oil explosion (RX #2) or oil leak? (RX #1) How was everyone injured in the occurrence? Did they all fall at the same time? If there was an "shaking," "explosion," or "pop" then how did oil from inside the garbage truck get onto the steps of the truck? (T. 13) What exactly combusted? Did the oil come from the blade puncturing an object, or inside the engine hood or from some other hydraulic fluid leak? There was no "explosion" narrative in the occupational injury report which would've triggered urgent vehicular maintenance. (RX #1) This was never explained at trial and the Petitioner's narrative of the accident has an abbreviated, fantastical quality to it, which might be appropriate in some other venue than a court of law. In summary, the Arbitrator finds no causal connection for Petitioner's left shoulder injury. In finding so, the Arbitrator did not expect to find a pristine record, but notes that this record is far too riddled with omissions, discrepancies, untruths and exaggerations to find any room to allow the Petitioner the benefit of doubt in matters of credibility, which will be catalogued in detail later in this document.

Causal connection for knees

It bears repeating that the court record is deprived of vital medical records from Mercy

Hospital and Mercy Works. These were Petitioner's first two medical treatment providers. However, Mercy Hospital records dated October 15, 2015 state: "INDICATION: Fall. Acute bilateral knee pain." Both knees were x-rayed and the results were negative. Petitioner had a prior right knee x-ray on May 17, 2011. (PX #1) This contemporaneous history supports knee injuries.

However, when Petitioner sought care from her primary care physician, Dr. Josephine Dinkha on October 19, 2015 (PX 2), her treatment focused on the left shoulder. Petitioners' knees were not examined. (PX #2)

Dr. Dinkha diagnosed left rotator cuff syndrome and referred Petitioner to see Dr. Chandler at Southwest Orthopedics for further treatment. (PX# 3)

On November 28, 2018, Petitioner sought treatment at Southwest and there were no knee complaints. (PX #3)

On December 7, 2015, Petitioner's knees were examined by Dr. Chandler and Petitioner complained of bilateral knee pain, left worse than right. (PX #3) "She hit her knees on the steps and then fell again." (PX #3) The knees were examined and there were some positive clinical findings, but there was no weakness and range of motion was full. Nevertheless, Dr. Chandler injected both knees (cortisone) and diagnosed mild arthritic changes or sprains of the knees. MRIs were ordered. (PX #3)

The left knee MRI was performed on December 22, 2015. No meniscal tear was detected and there was no effusion. (PX #3) Three days later, the right knee MRI showed no effusion, but there "may be a subtle oblique tear of the posterior horn of the medial meniscus. (PX #3)

On January 6, 2016, Dr. Chandler rechecked the Petitioner and her knees were examined. The clinical exams were mostly negative. The doctor diagnosed left knee sprain with effusion and offered an aspiration, which the Petitioner declined. On the right, the doctor diagnosed a medical meniscus tear, offered a brace, anti-inflammatories, and physical therapy. If those didn't help the next step was arthroscopy. (PX #3)

On January 12, 2016, Petitioner's initial physical therapy evaluation report states that

Petitioner "fell last week on the stairs up to her apartment for which she has 6 flights to climb." She reported difficulty ambulating more than 10 minutes, her standing limit was 10 minutes as well. She reported bilateral decreased range of motion and strength and daily pain of 10/10 on the left and 7/10 on the right. (PX #3) She was not wearing her brace. This is the only physical therapy appointment that Petitioner would attend for her knees.

The medical records from Advocate show that a CT of the abdomen and pelvis was performed on January 17, 2016 and it was negative. There was fecal stasis in the colon. Petitioner may have simply been constipated. (PX #3) Petitioner was not admitted to the hospital.

The above visit to Advocate Hospital is the subject of a civil claim in the Circuit Court of Cook County (law division) captioned, Oralean McClellan v. Advocate Christ Medical Center (17 L 8732). Petitioner allegedly fell from a gurney. The nature and extent of those injuries are unknown. At trial, Petitioner stated it involved injuries only to her right side of her head and right arm. (T. 36)

Despite inconclusive MRI images, a right knee arthroscopy was authorized by utilization review on January 19, 2016. (PX #3) Later that week, Petitioner returned to occupational therapy and stated that she was gone all last week due to being in the hospital for severe right lower abdominal pain and they dropped her on the floor. She wanted to put physical therapy on hold for her knees until she was cleared by the doctor for her right abdominal pain. (PX #3)

Petitioner continued with left shoulder physical therapy.

On January 30, 2016, the Petitioner sought medical treatment at Southwest, but there were no knee complaints. Petitioner told Dr. Dinkha that "she is a realtor and had a closing a few days ago." Petitioner was collecting TTD benefits during this time. Petitioner reported no secondary income at the time of trial. (Arb. Ex. #1)

On February 2, 2016, Petitioner sought medical treatment with Southwest and there was no knee examination. Additionally, there is some evidence that Petitioner may have been involved in a

motor vehicle accident on or about February 2, 2016 as noted in Dr. Dinkha's records. (PX #2)

On February 3, 2016, Petitioner was discharged from knee physical therapy due to poor attendance. She had cancelled on January 15th, 19th, and the 21st. She had attended only one appointment. (PX #3)

On February 8, 2016, Petitioner was examined by Dr. Chandler, who recommended left shoulder arthroscopy. (PX #3) Petitioner's knees were examined as well. Again, most of the clinical signs were negative. The doctor noted that Petitioner's left knee was more painful than the right, but also noted that the left MRI was negative. (PX #3) As a result, he planned to treat that knee conservatively. He still recommended surgery to the right knee. Petitioner did not undergo any additional knee treatment after this date. Petitioner never had right knee surgery.

Petitioner continued to see Dr. Dinkha on a regular basis throughout 2016, 2017 and 2018 without receiving knee treatment.

An FCE was performed on August 17, 2017 and reviewed by Dr. Chaudri. He endorsed restrictions to the Petitioner's left shoulder. No leg (knee) restrictions were prescribed (e.g. squatting, kneeling, bending, crawling). (PX #3)

Petitioner was involved in another motor vehicle accident occurring on October 31, 2017. (PX #3) Those injuries may be limited to Petitioner's lumbar spine. (PX #2) There was no cross-examination about these accidents.

On May 2, 2018, Dr. Chaudri filled out a reasonable accommodation request and added permanent restrictions of no squatting, kneeling, bending/stooping, crawling. (PX #3) The Arbitrator notes that this form was completed without a physical exam and when Petitioner was having difficulty complying with vocational rehabilitation. (PX #3)

In summary, when looking at the entire medical record regarding the Petitioner's knees, the Arbitrator notes that Petitioner's left knee MRI was negative, she had one cortisone injection and a single physical therapy visit. Likewise, Petitioner's right knee MRI may have shown a subtle tear, there was a single cortisone injection, and one physical therapy visit. Historically, these are not the

kind of injuries that usually result in permanent restrictions or a job loss at The Illinois Workers' Compensation Commission.

Upon closer scrutiny, Dr. Chandler's original right knee surgical recommendation is now over three years old and was weak at its inception. No diagnostic study ever corroborated his claim of knee effusion. In fact, the x-ray taken on the alleged date of accident showed no effusion. (PX #1) The right MRI did not show a complete tear, as he claimed. Dr. Chandler's original diagnosis was "mild arthritic changes," which suggests that the work injury, if it did occur, may have only aggravated pre-existing degenerative changes. The entire record supports a temporary aggravation of a pre-existing condition. Additionally, the UR certification for right knee surgery was based upon Dr. Chandler's incorrect representation that Petitioner attended physical therapy with no improvement. In fact, Petitioner had only attended one appointment and was discharged due to noncompliance. Finally, after the alleged work accident, Petitioner was involved in at least two MVAs, a fall from a hospital gurney and a fall from stairs.

Respondent's section 12 examiner, Dr. Guido Marra, did not examine the Petitioner's knees and made no comment on them.

Another causal connection statement in the medical records for Petitioner's knees is from Dr. Chandler on January 21, 2016 when he signed a State Farm form stating that all of Petitioner's conditions are employment related (left shoulder, bilateral knees), but that report has two credibility problems. First, the report states both knee MRIs confirmed medial meniscal tears. (PX #3) This was simply untrue, as neither confirmed such pathology. Second, it doesn't take an expert to see that the handwriting on the form does not match Dr. Chandler's signature. (PX #3) Dr. Chandler did not create the report, he only signed it. As a result, it is not persuasive. The Arbitrator finds no credible causal connection for the Petitioner's current knee condition and the occurrence at work. In looking at the entire court record, it appears that more likely than not, Petitioner's work accident was a temporary aggravation of a pre-existing bilateral knee condition. In summary, Petitioner's initial treatment was delayed. She had very limited treatment and then failed to treat for three years.

Finally, Petitioner had several falls after her alleged work accident. Petitioner failed to present credible evidence that her current knee condition is causally related to the occurrence at work on October 15, 2015.

It should also be noted that a majority of Petitioner's permanent work restrictions are based upon her knee complaints which the Arbitrator finds unrelated to the alleged accident. Petitioner's FCE states the following: no balancing that requires crouching, no crouching, no stooping, kneeling on one knee or crawling. (PX #3) One wonders if Petitioner could have returned to her old job if these restrictions were re-evaluated in a more realistic light.

Carpal Tunnel Syndrome

The workers' compensation claim 18 WC 02216 was consolidated with 15 WC 003934 on December 10, 2018 and alleges that Petitioner's right carpal tunnel syndrome was caused by her vocational rehabilitation (employment) with Respondent.

Petitioner did not finish vocational rehabilitation with Vocamotive because "her right hand was hurting. We did so much typing." (T. 29) In corroboration, Dr. Dinkha's medical records show that on July 20, 2018, Petitioner complained of "right-hand pain for the past couple of months. She started typing in February, three days a week 8 am. to 3 pm." Tinels and Phelans test on the right hand was positive. (PX #2) The assessment was right hand pain. No EMG or brace was prescribed. Petitioner was instructed to follow up in three months. (PX #3)

Petitioner returned to Dr. Dinkha on September 19, 2018 with left eye redness and swelling. She had pink eye. There were no right-hand complaints. (PX #3) This is Petitioner's final treatment record with Dr. Dinkha.

In analyzing the above, Dr. Dinkha's official records never diagnose carpal tunnel syndrome. Instead, her assessment was "right hand pain." (PX #2) Further, there is no prescription for an EMG or brace, nor is there a referral to a hand specialist. (PX #2) Petitioner was told to return to the clinic in three months. Instead, Petitioner returned in two months, but for a new complaint – pink eye. (PX

#2)

Anecdotally, the Arbitrator knows of no known workers' compensation cases where the Petitioner developed carpal tunnel syndrome after typing 24 words a minute, three days a week. It may be because the described activity simply isn't perceived by the medical or legal community to be repetitive or forceful enough to warrant a carpal tunnel diagnosis. The most compelling carpal tunnel claims today involve highly repetitive, full-time work as in the case of an assembly line worker who must meet hourly production goals. In contrast, Petitioner was learning how to type on a part-time basis, essentially at her own pace and while it is true that she made some progress, 24 words a minute isn't an impressive rate of typing speed. It's still slow.

Since there is nothing in the medical records to support causal connection for this claim, there is a failure of proof in that no carpal tunnel diagnosis ever made it into Petitioner's official medical record. Also, Petitioner's vocational rehabilitation activities do not appear repetitive or forceful enough to cause such a condition.

It may be true that there is a "To Whom It May Concern" letter by Dr. Dinkha attached to Respondent's motion to consolidate filed on November 19, 2019 that states, "possible carpal tunnel syndrome and limited driving, no work typing." This is not part of the trial record, but part of the court file. "Petitioner is to wear a brace until she has an EMG performed." Again, this is not part of Dr. Dinkha's official medical record, yet it was given to the vocational rehabilitation counselor as justification to no longer continue with the program. The Arbitrator finds it ironic that this document was put into the court file by Respondent, not Petitioner.

Why wasn't the "To Whom It May Concern" letter included in Dr. Dinkha's official medical record? When compared to the official progress note, they are not reconcilable. Which document is more believable? The subpoenaed medical record is a more credible source. It simply states "hand pain," and no EMG nor work restrictions were prescribed. This is the record Dr. Dinkha would give another physician for peer review, if requested. In contrast, the "To Whom It May Concern" letter is less credible as it appears to have been prepared in anticipation of litigation. It's not part of the

subpoenaed medical records. In fact, it appears to be a form of claim manipulation in that the doctor has become a legal advocate for her patient, instead of a medical advocate. In July of 2018, when the "To Whom It May Concern" was authored, Petitioner knew she had not made a good faith effort in vocational rehabilitation and wanted a doctor's note to absolve her of non-compliance prior to trial before The Illinois Workers' Compensation Commission.

Petitioner exaggerated her carpal tunnel syndrome symptoms before the Arbitrator. At trial, Petitioner indicated that her hand pain was causing her fingers to stick up and gave an impromtu demonstration. (T. p.30) This "trigger-fingering" was not documented in Dr. Dinkha's medical records, nor observed at any other time in the court proceeding. She was not wearing her wrist brace as instructed by Dr. Dinkha. If Petitioner was willing to exaggerate her hand symptoms before the court, did she do likewise with her doctors regarding her knees and left shoulder? If you look at the entirety of the medical records, it's more probable than not.

In summary, the Arbitrator finds no causal connection linking Petitioner's vocational rehabilitation activities (typing) and her alleged carpal tunnel syndrome.

Petitioner's Credibility

The Arbitrator does not find the Petitioner to be a credible witness in this case. The following is a list of some of the factual discrepancies noted in the medical records, trial exhibits and testimony before the court.

The Petitioner gave three different histories of how the accident happened.

Petitioner warranted that she had not received income from outside employment while she was on disability income, but she had performed at least one real estate closing on or about January 27, 2016. (PX #2) On March 7, 2018, she told Vocamotive that she had not sold any houses since her injury, but this was not true. (RX #3) Petitioner earned a secondary income before and after the accident.

Petitioner reported to Vocamotive that she had a hard time turning the steering wheel in her

car and reported that she was no longer able to handle a larger car. In contrast, she also said that she had a valid Illinois CDL-A driver's license with double and triple endorsements. (RX #3) Commercial Drivers' Licenses are governed by the U.S. Department of Transportation. The Arbitrator takes judicial notice that drivers must undergo a medical examination every two years to remain commercially certified. If the Petitioner's statement is true, then what could she have told the CDL physician about her medical condition to keep her CDL certificate current?

With regard to her left upper extremity, Petitioner told Vocamotive that she was unable to elevate her arms out to the side and forward without assistance. She could not extend her elbows. (RX #3) The Arbitrator notes that there is nothing wrong with Petitioner's right arm or either elbow. Compare and contrast this with Petitioner's final occupational therapy appointment on April 20, 2017 which showed that her shoulder flexion was within functional limits. She could perform shoulder rows and lower rows indicating significant elbow flexion. (PX #3) Petitioner horribly exaggerated her functional abilities to Vocamotive, which had an impact on their report.

On March 7, 2018, Petitioner told Vocamotive that she had completed some college courses but denied ever receiving any diplomas or certifications. (RX #3) Later on May 7, she admitted having an associates' degree. (RX #3 p.12) Petitioner had to be reminded not to include her GED certificate during her job searches, as she had an associates' degree.

On January 12, 2016, Petitioner told her physical therapist that she lived in an apartment for which she has six flights to climb. (PX # 3) The Arbitrator takes judicial notice that there are no "six story walk-up" apartment buildings in Chicago.

On May 18, 2018, Petitioner told Vocamotive that she had meniscus tears in both knees, (RX #3) but as stated earlier, the MRIs do not corroborate this fact. Instead, she might have one.

On May 18, 2018, Petitioner told Vocamotive that she was unable to lift over 2 pounds with her left arm, but the FCE stated she is can occasionally lift to 35 lbs. and frequently lift 18 pounds. (PX #3)

On May 18, 2018, Petitioner stated she taught a Hendricks Academy, a private school in

Chicago that required no teaching certificate. (RX #3 p. 3 of 10) However, the Arbitrator takes judicial notice that Hendricks is run by Chicago Public Schools. At trial, Petitioner stated that she taught at the "Board of Education" for eight years. (T. 10) The Chicago Board of Education governs Chicago Public Schools, not private ones. As a result, it is likely that Petitioner had a teaching certificate that she did not wish to disclose to Vocamotive.

During a Vocamotive physical evaluation on May 18, 2018, Petitioner was unable to perform reaching and manipulative tasks with her right arm and hand. (RX #3 p.7/10) Petitioner has no known injuries or restrictions to her right shoulder or hand that would prevent her from performing these tasks.

On June 19, 2018, Petitioner told Vocamotive that she heard "voices" in her head. (RX #3) Petitioner was never diagnosed with schizophrenia, which is commonly associated with auditory hallucinations. Petitioner did not claim to hear voices in her head when applying for social security disability benefits. (nor is it likely that she told the same to the medical examiner during her CDL recertification.) Later that day, Petitioner told Vocamotive that she had been ill for the past week, and "when she went to the clinic, she had a temperature of 102 degrees. She reported that she had immediately been given a shot and had been advised that she might be transferred to the hospital." (RX #3) In contrast, Dr. Dinkha's medical records show that on June 11, Petitioner had a normal temperature of "98.1 degrees." Petitioner was given a vitamin B12 injection and told to follow up in three months. The STREP test was negative. (PX #2)

At trial, Petitioner stated she had never injured her knees before the accident, but the Mercy Hospital records shows right knee x-rays taken on May 17, 2011. (PX #1) Petitioner may have had a problem with her right knee in the past.

Petitioner testified at trial that both her knees had meniscus tears, but this is not true. (T. 17)

Petitioner testified at trial that her left shoulder had rotator cuff tears, but this was not true. At times, the doctors suspected a cuff tear, but one was never found. (RX #3 & 4)

Petitioner stated that physical therapy for her left shoulder was unhelpful, (T. 19) but she

attended only one session and was discharged for "poor attendance" on February 3, 2016. (PX #3) She described her treatment where "they would put different kind of glass tubings onto your arms, suction cups. They would do some kind of stem treatments." (T. 19) The medical records do not support these fantastic claims.

Petitioner stated at trial that she had two injections per knee, but the record only supports one injection. (T. 21) (PX #3) Petitioner stated that surgery was recommended for both knees, but the record only supports one prescription. (T. 21) (PX #3)

Petitioner stated that she had never worked in customer service (T.25) but the Vocamotive record states she taught music at Hendricks Academy for eight years and also moonlit as a real estate broker. (RX #3) Both jobs require a significant amount of customer service.

Petitioner denied being uncooperative in vocational rehabilitation, but those records state otherwise. (RX #3) To catalogue the multiple instances of poor effort would create yet another exhaustive list of inconsistences, exaggerations and half measures, which were documented by the vocational rehabilitation counselor in her reports. (RX #3) When there is a lack of "good faith" cooperation with vocational rehabilitation, the termination of benefits is justified. Hayden v. Industrial Comm. 214 Ill.App3d 749, 575 N.E.2d 99, 158 Ill.Dec. 305 (1st Dist. 1991) Ultimately, Petitioner stopped participating because of the specious carpal tunnel claim. She refused to type or drive a car for her job interviews or counselor meetings.

The medical records show that Petitioner's residence in Chicago changed from an apartment located at South Calumet to a home located at South Peoria. (PX #3) This occurred sometime in the winter or spring of 2017. (PX #2 3, & 4) Petitioner claimed that her TTD checks were irregularly sent to her in the Spring of 2017, (T. 33) but this was contradicted by Respondent's payment listing showing checks timely dated. (RX #4 p.4 of 7) Perhaps they sent them to the old address, but in that case, Petitioner did not properly update her employer. The City disability warrant form allows a claimant to change their address each month. (PX #3 e.g. 05-29-16)

Despite the above, Petitioner "lost" her group health insurance (BCBS) later that year due to

nonpayment of her premium and Dr. Dinkha's medical records show this may have occurred in the fall or winter of 2017. The last recorded bill payment from Blue Cross was on October 30, 2017. (PX #2) Respondent's payment ledger shows maintenance checks issued to Petitioner on a regular basis during this time until July 20, 2018. (RX #4 p.6 of 7)

It is unclear to the Arbitrator how Petitioner's loss of health insurance could be caused by anything but poor money management. As stated earlier, if the new abode was an upgrade, the decision to buy a home was ill advised. If the new abode was a downgrade, the health insurance payment would've been more affordable. Petitioner told similar story about her bifocals. On February 17, 2016, an ophthalmologist told Petitioner to stop wearing contacts. (PX #3) Petitioner had health insurance during this time. The pre-operative records for the second left shoulder surgery on October 11, 2016 showed she wore glasses. (PX #4) Yet on March 27, 2018, she told Vocamotive that she was unable to afford bifocals. (RX #3) Petitioner was still receiving weekly benefits during this time.

On September 18, 2018, Petitioner applied for Social Security Disability benefits, indicating that she had removed herself from the job market. (PX #3) As a result, no maintenance benefits are warranted. Petitioner is no longer actively seeking work and has affirmatively left the job market.

In summary, the Arbitrator finds that the Petitioner is a remarkably unreliable witness. Many of her claims are false, many are exaggerations and some of them are incredible. If the doctors involved in her treatment had reviewed all the records and listened to her statements and sworn testimony about "hearing voices," "stem treatments," or "glass tubings," they would've had second thoughts about her accident narrative. They would have wondered if any significant injuries occurred, whether her current complaints were genuine and causally connected to the accident. Further, they would have doubted that the FCE results were a true representation of her current abilities. Instead, it appears that Petitioner was "shining us on" for monetary gain. Perhaps she was dissatisfied with the amount of pension benefits she had accrued with Respondent. It should be noted that treating physicians benefited from her narrative as well.

UNPAID MEDICAL BILLS

Based on the above, Respondent has no liability for the outstanding medical bill from Advocate Illinois Masonic Medical Center (2nd left shoulder surgery) in the amount of $35,089.00. (PX #4) Additionally, the Arbitrator notes that prior to surgery, it appears that utilization review Dr. Rubenstein specifically non-certified the left shoulder subacromial decompression, but it was performed anyway. (PX #4) There is no evidence in the record that a peer-to-peer review occurred resolving their differences of opinion. Finally, Respondent argues that the bill is already paid pursuant to the fee schedule. (RX #5)

NATURE AND EXTENT

Petitioner is not entitled to a wage differential award under Section 8(d)(1) nor a specific loss award under the Workers' Compensation Act as the Arbitrator finds no causal connection between the Petitioner's left shoulder injuries, knee injuries, right hand carpal tunnel and the alleged work accident. Petitioner's accident history was contradictory leading anyone to doubt the mechanism of injury and causation. The first left shoulder operative report showed mild fraying and degenerative changes. As a result, her condition appears to be non-traumatic in nature. There was no traumatic pathology discovered during her initial treatment nor in the operative report and the original basis to perform left shoulder surgery was weak.

Petitioner hasn't treated for her knees in nearly three years and never obtain much medical treatment for them throughout the course of her claim. There are several potential superseding, intervening accidents that occurred after the accident. Petitioner constantly exaggerated the nature and extent of her knee condition but did not obtain medical treatment for them, nor did she ever wear her knee brace. In contrast, the Arbitrator notes she was willing to see Dr. Dinkha about a bug bite on October 30, 2017. (PX #2)

Finally, the carpal tunnel claim appears to have been created to circumvent vocational

rehabilitation efforts by Respondent and save the wage differential demand.

The FCE at Horizon is unpersuasive. The person who performed the FCE is a designated "Doctor of Physical Therapy" or DPT which is neither a doctor nor a physical therapist. The report only states conclusions and does not go into any detail about Petitioner's performance during passive or active range of motion exercises with certain weights or stretches. The report concludes that the results were valid, but there were no details given about validity testing. Instead, the report seems to rely upon Petitioner's verbally stated tolerances, which are patently unreliable. Further, Petitioner's maximum heart rate never exceeded 94 beats per minutes, which shows she did not exert herself significantly during the exam. It doesn't take an expert to know that most adults would exceed 94 beats per minutes by walking up two flights of stairs. The FCE report also gave significant leg restrictions which are not congruent with Petitioner's knee pathology and treatment. Finally, one cannot compare the FCE report with Petitioner's discharge summary from occupational therapy because the Petitioner abruptly stopped attending those sessions. In summary, the FCE report is not credible.

WAGE DIFFERENTIAL AWARD

As a result of the prior findings of fact and conclusions of law, Petitioner failed to prove she is entitled to a wage differential award under Section 8(d)(1) of The Illinois Workers' Compensation Act.

CREDIT

As a result of the prior findings of fact and conclusions of law, Respondent is entitled to an 8(j) credit in the amount of $133,160.61.

PENALTIES

No penalties are awarded in this matter.

Dated this 26th day of MARCH 2019.

Arbitrator Kurt A. Carlson

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 up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jenny Williams,

Petitioner,

vs. NO: 15 WC 35422

Van Matre Health South Rehab,

Respondent.

20IWCC0325

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19b having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issue of penalties and fees and being advised of the facts and law, modifies the corrected Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill.2d 327 (1980).

I. FINDINGS OF FACT

Petitioner had previously injured her right shoulder and neck in a 2008 injury, subsequently undergoing right shoulder surgery on November 23, 2010 with Dr. Whitehurst. She treated for these injuries post-operatively until the fall of 2011, including an epidural injection in her neck. Petitioner thereafter worked continuously as a full-time registered nurse for other employers until she was hired by Respondent.

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Petitioner began working for Respondent as a Registered Nurse on August 17, 2015. In this position, Petitioner performed patient assessments and direct patient care including transferring patients, helping them bathe and eat, administering medications, and communicating with physicians regarding any updates for care.

On September 29, 2015, Petitioner suffered a stipulated accident while assisting co-workers with the lifting of a 250-pound patient. She presented at Swedish American Immediate Care Clinic on the date of accident and described the incident, complaining of a right shoulder and right upper back injury. She was diagnosed with a back injury, prescribed a muscle relaxer, and given work restrictions of no heavy lifting, pushing or pulling until recheck. Temporary total disability benefits were paid by Respondent when Petitioner was either taken off work or her restrictions could not be accommodated by Respondent.

Petitioner's complaints and treatment continued through June 22, 2016 when she underwent a section 12 examination with Dr. Milos at Respondent's request. After the examination, Dr. Milos opined that Petitioner had suffered from work-related cervicalgia, myofascial pain, right shoulder strain, biceps tendinitis, and left shoulder pain secondary to myofascial pain. Dr. Milos recommended a right shoulder steroid injection, an injection into the right biceps tendon, and medications. Dr. Milos opined that Petitioner would likely require permanent restrictions including lifting up to five pounds frequently and only occasional lifting up to 10 pounds. Respondent paid all temporary total disability benefits following this exam and continued doing so through September 25, 2018.

Petitioner then underwent a repeat section 12 examination at Respondent's request with Dr. Milos on March 22, 2017. After reviewing a recent cervical MRI and re-examining Petitioner, Dr. Milos diagnosed cervicalgia with cervical stenosis, fibromyalgia, right shoulder mild adhesive capsulitis, and left shoulder AC joint arthritis. He found no symptom magnification. Dr. Milos recommended left shoulder therapy followed by a home exercise program, a possible left shoulder cortisone injection, and an evaluation by a cervical specialist. He recommended the same work restrictions.

On September 26, 2018, Petitioner underwent a section 12 examination at Respondent's request with another examiner, Dr. Zelby. Dr. Zelby opined that Petitioner suffered a work related cervical strain but further opined that she was able to return to work full duty within four-to-six weeks of the accident and that she had reached maximum medical improvement by late January of 2016. Dr. Zelby rendered no opinions regarding Petitioner's bilateral shoulder condition.

Respondent terminated payment of temporary total disability benefits effective September 26, 2018. Petitioner made several written demands for continuation of temporary total disability benefits as Respondent had no medical opinion controverting the medical records or the causal connection opinion of its first section 12 examiner, Dr. Milos, relating to Petitioner's shoulders. There is no evidence that Respondent responded to the demands.

Instead, Respondent engaged Dr. Verma to perform a records review on November 7, 2018 related to Petitioner's bilateral shoulder condition. He reviewed various records and surveillance reports then diagnosed Petitioner with myofascial pain and a right shoulder sprain/strain, which he opined should have resolved within four weeks. Dr. Verma found that the right shoulder MRI was non-focal and that the only necessary shoulder treatment included anti-inflammatories, activity modification, and therapy for four-to-six weeks. Dr. Verma opined that no acute left shoulder injury occurred, and that Petitioner reached maximum medical improvement within four-to-six weeks of the accident. Dr. Verma further opined that any ongoing subjective complaints were out of proportion with objective findings.

On January 18, 2019, Petitioner underwent a section 12 exam at Respondent's request with Dr. Verma. He diagnosed subjective bilateral shoulder pain and noted Petitioner's complaints were subjectively out of proportion with the objective findings. Regarding her shoulders, Dr. Verma opined Petitioner reached maximum medical improvement four weeks after the accident and could return to full duty. Respondent provided Dr. Zelby's report to Petitioner November 2, 2018 and Dr. Verma's report to Petitioner on February 1, 2019.

II. CONCLUSIONS OF LAW

Petitioner filed a motion for penalties and attorney fees pursuant to Sections 16, 19(k), and 19(l) of the Act. Section 19(l) provides in pertinent part, as follows:

"In case the employer or his or her insurance carrier shall *without good and just cause* fail, neglect, refuse, or unreasonably delay the payment of benefits under Section 8(a) or Section 8(b), the Arbitrator or the Commission *shall* allow to the employee additional compensation in the sum of $30 per day for each day that the benefits under Section 8(a) or Section 8(b) have been so withheld or refused, not to exceed $10,000. A delay in payment of 14 days or more shall create a rebuttable presumption of unreasonable delay." (Emphases added.) 820 ILCS 305/19(l) (West 2012).

Penalties under section 19(l) are in the nature of a late fee. *Mechanical Devices v. Industrial Comm'n*, 344 Ill. App. 3d 752, 763 (2003). In addition, the assessment of a penalty under section 19(l) is mandatory "[i]f the payment is late, for whatever reason, and the employer or its carrier cannot show an adequate justification for the delay." *McMahan v. Industrial Comm'n*, 183 Ill. 2d 499, 515 (1998). The standard for determining whether an employer has good and just cause for a delay in payment is defined in terms of reasonableness. *Mechanical Devices*, 344 Ill. App. 3d at 763. The employer has the burden of justifying the delay, and the employer's justification for the delay is sufficient only if a reasonable person in the employer's position would have believed that the delay was justified. *Board of Education of the City of Chicago v. Industrial Comm'n*, 93 Ill. 2d 1, 9-10 (1982).

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The standard for awarding penalties under section 19(k) is higher than the standard under 19(l). Section 19(k) of the Act provides, in pertinent part, as follows:

"In case where there has been any *unreasonable or vexatious delay* of payment or intentional underpayment of compensation *** then the Commission *may* award compensation additional to that otherwise payable under the Act equal to 50% of the amount payable at the time of such award." (Emphases added.) 820 ILCS 305/19(k) (West 2012).

Section 16 of the Act provides for an award of attorney fees when an award of additional compensation under section 19(k) is appropriate. 820 ILCS 305/16 (West 2012). "The amount of [attorney] fees to be assessed is a matter committed to the discretion of the Commission." *Williams v. Industrial Comm'n*, 336 Ill. App. 3d 513, 516 (2003). The calculation of a penalty award under section 19(k) is simply a mathematical computation of 50% of the amount payable at the time of the award. *Williams*, 366 Ill. App. 3d at 516.

The standard for awarding penalties and attorney fees under sections 19(k) and 16 of the Act is higher than the standard for awarding penalties under section 19(l) because sections 19(k) and 16 require more than an "unreasonable delay" in payment of an award. *McMahan v. Industrial Comm'n*, 183 Ill. 2d 499, 514-15 (1998). It is not enough for the claimant to show that the employer simply failed, neglected, or refused to make payment or unreasonably delayed payment without good and just cause. *Id.* at 515. Instead, section 19(k) penalties and section 16 fees are "intended to address situations where there is not only a delay, but the delay is deliberate or the result of bad faith or improper purpose." *Id.* In addition, while section 19(l) penalties are mandatory, the imposition of penalties and attorney fees under sections 19(k) and section 16 fees is discretionary. *Id.*

In this case, the Arbitrator denied Petitioner's request for penalties and attorney fees. In so doing, the Arbitrator concluded that "respondent's behavior in this case [was not] unreasonable and vexatious. The Arbitrator notes that the respondent based its denial of benefits on the medical opinions of Dr. Zelby and Dr. Verma. Therefore, the Arbitrator believes that respondent's conduct was 'not merely frivolous or for delay[']but instead did present ['']a real controversy[.'"] Arb Dec. at 30. The Commission views the evidence differently.

Petitioner had undergone several years of treatment related to her bilateral shoulder injury during which time she had either been taken off work completely or was unable to have her restrictions accommodated by Respondent. The first section 12 examiner engaged by Respondent, Dr. Milos, opined that Petitioner's bilateral shoulder condition was causally related to her accident at work. His opinion was uncontroverted until November 2, 2018 when Respondent disclosed the opinions of Dr. Zelby, related to Petitioner's cervical condition, and later the opinions of Dr. Verma, related to Petitioner's bilateral shoulder condition. Respondent terminated Petitioner's temporary total disability benefits after Dr. Zelby's examination on September 26, 2018, but failed to explain the basis on which the benefits were being terminated.

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Dr. Zelby's September 26, 2018 exam and his report related only to Petitioner's cervical condition. He rendered no opinions relative to Petitioner's bilateral shoulder condition, which continued to prevent Petitioner from returning to work as a nurse. Respondent then obtained a records review from Dr. Verma, its third section 12 examiner, related to Petitioner's bilateral shoulder condition. He opined that the records did not reveal anything more than myofascial pain and a right shoulder sprain/strain that he believed had resolved within four-to-six weeks of the accident. Dr. Verma was later engaged by Respondent to perform a section 12 examination of Petitioner on January 18, 2019. He diagnosed Petitioner with subjective bilateral shoulder pain and noted Petitioner's complaints were subjectively out of proportion with the objective findings. Regarding her shoulders, Dr. Verma opined Petitioner reached maximum medical improvement four weeks after the accident and could return to full duty. Respondent did not disclose Dr. Verma's report until February 1, 2019.

Petitioner's inquiries regarding her benefits termination also went unanswered through February 1, 2019. Petitioner made several written demands for continuation of benefits after her benefits were terminated effective September 26, 2018. Although Respondent had Petitioner evaluated by Dr. Zelby, he provided no opinion refuting Petitioner's bilateral shoulder condition. Indeed, the opinions of Respondent's first section 12 examiner, Dr. Milos, who believed that Petitioner's bilateral shoulder condition prevented her from returning to full duty work remained uncontroverted until February 1, 2019.

The Commission finds *Southwest Airlines v. Illinois Workers' Comp. Comm'n* instructive given the facts in this case. 2016 IL App (1st) 153126WC-U. In *Southwest Airlines*, "the employer initially paid the claimant TTD benefits after the August 7, 2011, work accident. However, it stopped paying TTD benefits on December 4, 2011, and stopped authorizing additional medical treatment after that date. At that time, no doctor had placed the claimant at MMI for her injuries or released her from care, and the claimant continued to report symptoms related to her injuries to her doctors. The employer's IME doctors [] had not yet examined the claimant. When they did examine her, neither doctor placed the claimant at MMI *for all of her injuries*, and both said that the claimant needed to undergo further treatment before she could be placed at MMI." *Southwest Airlines*, 2016 IL App (1st) 153126WC-U, ¶ 77 (Emphasis added). The court went on to conclude that "the employer's decision to terminate TTD benefits and to stop authorizing medical treatment … was objectively unreasonable and entirely without justification." *Id.*

Respondent attempts to rebut the presumption highlighted in Section 19(l) of the Act, arguing that Petitioner failed to allege facts supporting her entitlement to temporary total disability benefits in light of her prior neck and right shoulder injury in 2008 and follow-up treatment including right shoulder surgery on November 23, 2010. Respondent also notes that a November 18, 2016 vocational assessment from Vocamotive indicated that Petitioner was employable and capable of medium physical demand level work. The Commission is not persuaded by Respondent's arguments.

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Although Petitioner has a prior injury history relative to her right shoulder and neck, the Commission notes that Petitioner was able to recover to the point where she was able to work as a full-time registered nurse until her accident at work. Moreover, the Commission finds the June 22, 2016 report of Respondent's own section 12 examiner, Dr. Milos, to be persuasive. Dr. Milos opined that Petitioner's conditions, inclusive of her bilateral shoulder condition, were causally related to the accident at work and prevented her from working full duty. This evidence is uncontroverted through February 1, 2019 when Respondent provided Petitioner with an opinion to the contrary. Dr. Milos believed that Petitioner would likely require permanent restrictions of frequent 5-pound lifting and occasional 10-pound lifting. At the time that Respondent terminated Petitioner's benefits it had no basis on which to deny benefits, and it failed to provide the basis for its denial to Petitioner. Once Respondent obtained a medical opinion from Dr. Verma in early 2019 that Petitioner's bilateral shoulder condition was not causally connected to her accident, it could be said that Respondent has a reasonable basis on which to terminate benefits. However, Dr. Verma's report was not disclosed to Petitioner, and possibly not received by Respondent to do so, until February 1, 2019.

Based on these facts, the Commission does not find that a reasonable person in Respondent's position would believe a delay in payment of temporary total disability benefits pursuant to Section 8(b) of the Act was justified. Accordingly, the Commission finds that Petitioner is entitled to 19(l) penalties of $30.00 per day for the 129 days from September 26, 2018 through February 1, 2019 = $3,870.00 in 19(l) penalties. Regarding Section 19(k) penalties, the Commission finds that the Respondent's termination of temporary total disability payments was objectively unreasonable and entirely without justification. See *Southwest Airlines*, 2016 IL App (1st) 153126WC-U, ¶ 77; see *McMahan*, 183 Ill. 2d at 515. Thus, Petitioner is entitled to Section 19(k) penalties equal to 50% of the amount of medical expenses and temporary total disability and benefits payable through February 1, 2019. Finally, regarding Section 16 attorney fees, the Commission finds that Respondent deliberately terminated benefits as a result of bad faith or improper purpose. See *McMahan*, 183 Ill. 2d at 515. Under these circumstances the Commission awards Section 16 attorney fees in the amount of 20% of medical expenses and temporary total disability and benefits payable through February 1, 2019.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's denial of Petitioner's penalties and fees motion is hereby reversed. Respondent shall pay to the Petitioner the sum of $3,870.00 for Section 19(l) penalties, Section 19(k) penalties in the amount of 50% of all outstanding medical expenses and temporary total disability benefits payable through February 1, 2019, and Section 16 attorney fees in the amount of 20% of all outstanding medical expenses and temporary total disability benefits payable through February 1, 2019.

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

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without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

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

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

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

DATED: JUN 12 2020
O: 4/16/20
BNF/wde
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Barbara N. Flores

Marc Parker

Dissent

I respectfully dissent from the Decision of the Majority. The Majority modified the Decision of the Arbitrator to award penalties and fees which the Arbitrator denied. I would have affirmed and adopted the Decision of the Arbitrator. Therefore, I dissent from the Decision of the Majority to reverse the Decision of the Arbitrator to award penalties and fees.

The Arbitrator denied Petitioner's petition for penalties and fees because he did not find Respondent's behavior sufficiently unreasonable or vexatious to warrant the imposition of penalties and fees. I concur with the conclusion of the Arbitrator. In my opinion, Respondent had sufficient bases to terminate temporary total disability benefits. First, Petitioner's treating doctor, Dr. Salgado, noted that Petitioner exhibited malingering behavior because her subjective complaints were in excess of his objective findings. He released Petitioner to work without restrictions as of February 1, 2016. However, rather than attempting to return to work after that release, Petitioner responded by finding another doctor. In addition, I believe the decision to terminate TTD was reasonable based on the opinions rendered by its Section 12 medical examiners, Dr. Zelby and Dr. Verma. Finally, in my opinion, Respondent had shown good faith by reinstating temporary total disability benefits when another of its Section 12 medical examiners previously found that she was unable to return to her prior employment. Therefore, I believe Respondent had good faith bases to terminate TTD and accordingly that the imposition of penalties and fees is inappropriate in this case.

For the reasons stated above, I would have affirmed and adopted the Decision of the Arbitrator. Therefore, I respectfully dissent from the Decision of the Majority to reverse the Decision of the Arbitrator to award penalties and fees.

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DLS/dw
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Deborah L. Simpson

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

WILLIAMS, JENNY
Employee/Petitioner

Case# **15WC035422**

HEALTHSOUTH
Employer/Respondent

20IWCC0325

On 6/21/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.13% 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:

1131 GESMER & REYNOLDS PC
BRAD A REYNOLDS
526 E JEFFERSON ST SUITE 118
ROCKFORD, IL 61107

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

ESBOOMIOS

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
# CORRECTED ARBITRATION DECISION
19(b)

JENNY WILLIAMS
Employee/Petitioner

v.

HEALTHSOUTH
Employer/Respondent

Case # **15** WC **35422**

Consolidated cases: _____

20IWCC0325

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael Glaub**, Arbitrator of the Commission, in the city of **Waukegan**, on **2-26-19**. 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. ☒ 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 **Vocational Services**

20 IWCC0325

FINDINGS

On the date of accident, **9-29-15**, 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 **$54,232.36**; the average weekly wage was **$1,042.93**.

On the date of accident, Petitioner was **32** 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 **$98,358.47** for TTD, $ for TPD, $ for maintenance, and **$0** for other benefits, for a total credit of **$98,358.47**.

Respondent is entitled to a credit of **$98,358.47** under Section 8(j) of the Act.

ORDER

RESPONDENT SHALL PAY TO PETITIONER TTD FOR THE PERIOD OF 9-30-15 THROUGH 2-25-19 AT THE RATE OF $695.22 PER WEEK LESS THEIR 8(J) CREDIT.

RESPONDENT IS ENTITLED TO AN 8(J) CREDIT OF $98,358.47.

RESPONDENT SHALL PAY TO PETITIONER MAINTENANCE BENEFITS COMMENCING ON 2-26-19 AT THE RATE OF $695.22 PER WEEK.

RESPONDENT SHALL PAY MEDICAL BILLS IN THE AMOUNT OF $1,090.00 PER THE FEE SCHEDULE.

RESPONDENT SHALL REIMBURSE PETITONER FOR OUT OF POCKET EXPENSES IN THE AMOUNT OF $1,327.22.

RESPONDENT SHALL COMMENCE VOCATIONAL SERVICES PER THE REHABILITATION PLAN SUBMITTED ON BEHALF OF PETITIONER.

PETITIONER'S MOTION FOR PENALTIES UNDER SECTIONS 16 AND 19 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

June 20, 2019
Date

JUN 21 2019

IN AND BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JENNY WILLIAMS	)	
	)	
Petitioner,	)	
	)	
v.	)	**Case No. 15 WC 35422**
	)	
HEALTHSOUTH	)	
	)	
Respondent.	)	**20 IWCC0325**

STATEMENT OF FACTS

Petitioner Jenny Williams, hereinafter "Petitioner", was hired by HealthSouth, hereinafter "Respondent", on July 29, 2015 as a registered nurse. Trial Tr. p. 12. Petitioner was hired by Respondent to work as a registered nurse full time. See Petitioner's Ex. 3. As a nurse, Petitioner performed direct patient care which included transferring patients, bathing and feeding patients, medication administration, and communication with the physicians on any updates for patient care. Trial Tr. p. 14. Lifting was a component of Petitioner's job. Petitioner testified she had to lift at least 50 pounds in performing her regular job duties as a nurse for the Respondent. Trial Tr. p. 16.

On September 29, 2015 around 10:00 a.m. Petitioner was requested by the Certified Nursing Assistant if she could assist the CNA with getting one of Petitioner's patients up to use the restroom. Another staff member was called to assist as well. Trial Tr. p. 16. At hearing Petitioner described the event as follows:

> We stood the patient up using a gate belt. I was on the far right side of the patient. The patient stood up, started to lean towards her left side and I helped pull her over to my side. The patient weighed about 250 pounds. When I pulled the patient towards myself, I felt a sharp pain in my right shoulder immediately. Trial Tr. pp. 16-17.

Petitioner completed an Incident Report on the date of injury. See Petitioner's Ex. 22. Petitioner was instructed by the Respondent to go to Swedish American Immediate Care Clinic and she went directly to that facility from work following her work injury. Trial Tr. pp. 17-18. See also PX 19.

Respondent neither disputes accident nor timely notice of injury. See Arbitrator's Ex. 1.

Petitioner was first seen on September 29, 2015 at SwedishAmerican Immediate Care for an injury to her right shoulder, neck and upper back. The history indicates that the patient was working as an RN at Healthsouth today, lifting a patient with assist from two other co-workers while transitioning patient from sitting to standing she felt a sharp pain – first in her right shoulder and right upper back. She continued her shift but progressively through the day, the pain worsened and began to cause sharp intermittent pains down the right arm – at that time patient was sent here for evaluation. PX 19. A physical exam revealed tenderness over the paraspinal muscles on the right side of patient's neck, tenderness over trapezoidal muscles bilaterally and pain with range of motion. There was also noted paraspinal muscle tenderness and thoracic tenderness on the right. Examination of the right shoulder revealed reduced range of motion. PX 19. X-rays of the neck, mid-back, and right shoulder were obtained on initial evaluation. Diagnosis was back injury. Petitioner was placed on an anti-inflammatory and instructed to apply ice. She was placed on a work restriction of no heavy lifting, pushing or pulling until recheck. PX 19.

When re-seen on October 1, 2015 Petitioner presented with worsening pain from injury two days ago. PX 19. The patient reported her symptoms worsened and now she had pain in the left shoulder with continuing neck, mid-back and right shoulder pain. PX. 19. Physical exam revealed reduced range of motion of the right shoulder. Examination of the left shoulder revealed

painful range of motion, for flexion, extension, abduction, and adduction. PX. 19. X-ray of the left shoulder was obtained and was negative. Working diagnosis on October 1, 2015 included bilateral shoulder pain. Work restrictions were modified to include no lifting greater than 5 pounds. PX. 19. On October 6, 2015 Petitioner was seen by Dr. Salgado. The working diagnosis was bilateral shoulder and upper back pain. Physical therapy was prescribed. The patient remained on work restrictions. PX 19. Patient was next seen by Dr. Salgado on October 13, 2015 denying any improvement in her pain since her prior visit. Patient continued to rate pain 8 out of 10 in her bilateral shoulders, neck and upper back. It was recommended that the patient continue with physical therapy and she was referred to physiatry. The patient remained on work restrictions. Dr. Salgado noted given the patient's history (which included fibromyalgia) and current symptoms her progress will most likely be slow. PX. 19.

On November 3, 2015 the patient reported some improvement with range of motion in her bilateral shoulders. However, the patient reported decreased range of motion in her neck and tingling sensation from the neck down to her bilateral hands that was intermittent. PX 19. It was noted that her employer was not able to accommodate work restrictions and she continued to take anti-inflammatories and Norco. A formal referral to Rockford Spine Center was placed at that time. PX 19.

Petitioner was seen by Dr. Marie Walker at Rockford Spine Center on referral from Dr. Salgado on December 9, 2015. On December 8, 2015 Petitioner completed a questionnaire indicating her primary complaints were neck and upper back pain along with shoulder pain, numbness and weakness since September 29, 2015 when she sustained an injury while transferring a patient. Petitioner described her pain as 7 to 8 out of 10 in the area of her neck and bilateral arms with some intermittent tingling and numbness in her hands. PX 16. Dr. Walker noted the history

of work injury and that the patient had tried to prevent a stroke patient from falling and developed pain in her neck and bilateral shoulders. Physical exam revealed that Petitioner was tender to touch along the bilateral upper trapezius muscles and bilateral scalene muscles. PX. 16. Diminished range of motion in the bilateral shoulders was noted and she was diffusely weak in her upper extremities. PX. 16. Spurlings maneuver reproduced neck pain, but no radicular pain. X-rays obtained on that date were reviewed. An MRI of the mid back dated February 20, 2015 was normal. PX 16. An MRI of cervical spine dated November 30, 2015 noted broad based disc bulge at C4-5 and also at C5-6. It was noted there was mild deformation of the cervical cord at C4-5 and mild right sided foraminal stenosis. At C5-6 there was a disc herniation that abuts the cord at that level but does not significantly compress it. Dr. Walker diagnosed the Petitioner with cervical strain and persistent cervical myofascial pain with thoracic outlet symptoms and C4-5 disc bulge without symptoms of myelopathy. PX 16. Dr. Walker prescribed Meloxicam and Cyclobenzaprine and returned the patient to physical therapy. Petitioner was excused off work at that time and she was to follow up in six weeks. Dr. Walker indicated that they may need to consider trigger point injections. PX. 16. When re-evaluated on January 20, 2016 Petitioner reported she was no better with physical therapy. It was further noted that the physical therapist was very concerned that the Petitioner had reduced grip strength and was not progressing. The vast majority of the pain reported on January 20, 2016 was on the right side of the cervical spine and in the right shoulder. According to Dr. Walker, her own physical exam showed painful range of motion to mid abduction of the right shoulder and she was tender to palpation on the infraspinatus muscle and along the anterior deltoid of the right shoulder. Diagnosis continued to be cervical strain with persistent cervical myofascial pain and mild thoracic outlet symptoms. PX 16. Regarding the right shoulder Dr. Walker felt it was primarily soft tissue rather than internal

derangement. Dr. Walker felt all of Petitioner's symptoms were myofascial. PX 16. After having one of the spine surgeons review her cervical MRI, Dr. Walker referred Petitioner to Dr. Whitehurst concerning her right shoulder and she also referred her for a consultation with pain management to go over pain management options. PX. 16.

Petitioner was seen by Dr. Jon Whitehurst at Ortho Illinois in February 1, 2016 on referral from Dr. Walker for bilateral shoulder pain. PX. 17. Dr. Whitehurst noted her history of a work accident on September 29, 2015 with bilateral shoulder pain. Physical examination revealed diminished range of motion in the bilateral shoulders as well as positive impingement tests bilaterally. X-rays were obtained and reviewed. The preliminary assessment was bilateral shoulder pain. PX 17. Dr. Whitehurst ordered MRIs of the bilateral shoulders to rule out rotator cuff tears. Dr. Whitehurst noted that Petitioner had a history of prior right shoulder surgery several years before the September 29, 2015 work accident (November 23, 2010). PX. 17. Dr. Whitehurst noted that Petitioner developed onset of bilateral shoulder and neck pain when a patient began to fall and she attempted to counter the force and protect the patient from falling. The patient was placed on a work restriction of no vigorous activity with the bilateral shoulders. PX 17. Petitioner was re-evaluated by Dr. Whitehurst on April 20, 2016 with ongoing bilateral shoulder pain 8 out of 10 with some intermittent numbness and tingling in her fingers as well as neck pain and limited range of motion in her neck. Physical exam continued to show positive Neer and Hawkins tests bilaterally on impingement testing. PX 17. At the time of the April 20, 2016 evaluation an MRI of the right shoulder dated April 13, 2016 was reviewed which did not reveal any significant rotator cuff pathology. The MRI did reveal impingement anatomy of the acromion process. PX. 17. Dr. Whitehurst opined that some of the patient's symptoms were consistent with subacromial impingement syndrome; however in his opinion the majority of her symptoms were not consistent

with a specific shoulder pathology per se. Dr. Whitehurst did not feel she was a surgical candidate. He directed her to return for physical therapy. Due to ongoing symptoms including petitioner's cervical spine, Dr. Whitehurst recommended referral to an occupational medicine specialist. PX. 17.

Petitioner was seen by Dr. Thomas Dahlberg of Rockford Pain Center on referral from Dr. Walker on February 5, 2016. Dr. Dahlberg noted her history of a work accident. Dr. Dahlberg reviewed her thoracic MRI which was normal. Dr. Dahlberg reviewed her cervical MRI as well. PX 18. Physical exam of the neck and upper back revealed significant tenderness to palpation throughout her paracervical and upper parathoracic musculature. She had some tenderness in her shoulders as well. PX. 18. Dr. Dahlberg diagnosed the Petitioner with myofascial paracervical, parathoracic, and bilateral shoulder pain. Petitioner was placed on a Lidoderm patch. PX. 18.

Petitioner's Ex. 10 is a copy of the Respondent's Notice of IME exam which Respondent arranged for Petitioner to be examined by orthopedic surgeon Dr. Steven Milos on June 22, 2016. Dr. Milos examined Petitioner on that date and his opinions are reflected in his initial report dated June 22, 2016. See Petitioner's Ex. 8. Dr. Milos noted the patient's history that she developed an acute onset of right shoulder and neck pain while lifting a patient with assistance from two other coworkers, transitioning the patient from a sitting to standing position when she felt immediate sharp pain in her right shoulder and right upper back. The patient noted she began to have left shoulder pain shortly following the date of injury. PX. 8. Subjective complaints at the time of Dr. Milos's initial IME included significant spasms throughout the neck with very limited neck motion. There was also shooting pain down the arms with occasional paresthesias in all of the fingers in both hands. The Petitioner also described anterior shoulder pain on the right side with pain radiating down in the biceps muscle. She had very limited range of motion of her shoulder

secondary to pain. PX 8. Dr. Milos noted prior treatment included physical therapy and medications, none of which resolved her symptoms. Dr. Milos noted her recent MRI scan of her right shoulder with additional physical therapy per Dr. Whitehurst and that she had also been seen by Dr. Walker for her neck symptoms. Regarding past medical history, Dr. Milos noted a history of right shoulder and neck injuries that occurred on October 13, 2008 with treatment by Dr. Whitehurst. The patient reported those symptoms had completely resolved at the end of her treatment in 2011 and that the patient had not had any right shoulder or neck symptoms until the most recent injury of September 29, 2015. PX. 8. Dr. Milos had multiple diagnostic studies to review including X-rays of the right shoulder and neck which were obtained shortly after the accident. Dr. Milos reviewed an MRI of the cervical spine dated November 30, 2015 noting some central and foraminal stenosis with most significant changes at the C4-5 level. Dr. Milos also reviewed an MRI of the right shoulder dated April 13, 2016 showing no evidence of significant rotator cuff pathology. Regarding the right shoulder MRI, Dr. Milos noted there was impingement anatomy of the acromion process in correlation with clinical findings for impingement were recommended by the radiologist. PX. 8. Dr. Milos summarized his review of the medical records which included treatment for Petitioner's previous right shoulder and neck injury that happened on October 13, 2008. Dr. Milos also summarized recent medical records from the September 29, 2015 injury. Regarding past medical history Dr. Milos noted her history of fibromyalgia as well as her right shoulder manipulation under anesthesia and capsular plication which had been performed by Dr. Whitehurst on November 23, 2010. PX 8.

Next Dr. Milos performed a physical exam. He reported that the patient was in mild discomfort but an excellent historian. Pain level was 7 out of 10 at the time of the IME. PX. 8. Dr. Milos noted the patient had significant tenderness to palpation throughout the para spinal

muscles of her neck. She had extremely limited active range of motion of the neck approximately 25% of normal range of motion. PX 8. She had significant pain with any movement of her neck which radiated into the trapezium muscles bilaterally. She also had tenderness with significant trigger points throughout the trapezius and scalene musculature PX. 8. Regarding her right shoulder she demonstrated tenderness along the biceps tendon with incomplete range of motion. Forward flection and abduction were 160 degrees, normal being 180 degrees. PX 8. Active internal range of motion was very limited. She had subjective paresthesia in both upper extremities although she had intact sensation in the axillary, median, radial and ulnar nerves bilaterally. She had generalized tenderness in the arm and forearm of both upper extremities. Dr. Milos reported it was difficult to adequately assess for impingement signs due to pain with any motion of both shoulders. There was no atrophy noted. There was significant scapular dyskinesia with right and left shoulder range of motion. PX. 8.

Based on his review of all of the information, Dr. Milos formed the following impression to a reasonable degree of medical and surgical certainty:

1. Cervicalgia.
2. Myofascial pain.
3. Right biceps tendonitis.

PX. 8. Dr. Milos proceeded to answer 11 questions which were submitted by the Respondent in order to complete his initial IME report. Dr. Milos was asked to render a diagnosis regarding the work accident of September 29, 2015. Dr. Milos opined that the patient sustained a right shoulder strain with biceps tendinitis as well as aggravation of cervicalgia and myofascial pain. PX. 8. Next Dr. Milos was asked to address whether Petitioner's left shoulder complaints were related to the work injury of September 29, 2015. In regards to the left shoulder, Dr. Milos opined to a

reasonable degree of medical certainty that Petitioner's left shoulder complaints were secondary to the myofascial complaints and the neck pain. PX 8. Dr. Milos acknowledged that the left shoulder complaint did not occur at the time of injury, but rather became present later which lends itself more to being secondary to the cervical and myofascial issues. PX. 8. Dr. Milos was specifically asked whether the Petitioner's subjective complaints were consistent with the objective findings and diagnostic test results. Dr. Milos observed that diagnostic testing in and of itself failed to demonstrate any significant pathology which would explain the Petitioner's degree of pain. PX 8. Dr. Milos was asked if there was evidence of symptom magnification. Dr. Milos opined that the patient's complaints were significantly greater than what would be expected. However, Dr. Milos opined that the patient's complaints were consistent with myofascial pain, which he observed can be greater in proportion than objective findings. PX. 8.

Dr. Milos was asked to address whether there were any pre-existing or comorbid factors contributing to the patient's condition and/or impacting her recovery. Dr. Milos opined that the previous right shoulder injury from 2008 did not impact her current right shoulder symptoms. PX 8. In regards to her current cervical pain, Dr. Milos noted she had some baseline underlying cervical pain which was likely aggravated by the September 29, 2015 work injury. PX 8. Dr. Milos noted regarding comorbid factors that although there was no specific diagnosis of fibromyalgia that medical notes indicated the patient was taking Norco for fibromyalgia and that it was likely that the underlying fibromyalgia was impacting her recovery and her response to medical treatments which had been rendered since September 29, 2015. PX. 8.

Next, Dr. Milos was asked if the Petitioner required additional medical treatment. Dr. Milos noted that the patient had already exhausted treatments with physical therapy, injections, and various medications without objective or subjective improvements in her pain. Dr. Milos

noted her past history of previous cervical injections which did not provide relief, and were therefore unlikely to improve her symptoms. The only medical treatment recommendations made by Dr. Milos would be to consider a biceps tendon sheath injection with steroid since the patient had specific point tenderness to the right biceps tendon. PX 8. However, Dr. Milos did not recommend any further formal therapy. Instead he opined the patient could continue in a home exercise program. Dr. Milos also recommended that the patient's pain medications and muscle relaxants be consolidated and managed by a primary care physician so as to not overlap her medications and cause any undue interactions. PX. 8. Next, Dr. Milos was asked to opine whether restrictions were necessary at the time of his IME and whether those restrictions were temporary or permanent? Dr. Milos opined to a reasonable degree of medical certainty that the patient will likely require permanent restrictions. He testified that the patient was unlikely to be able to return to full unrestricted activity. Dr. Milos opined that the patient could perform frequent lifting of 5 pounds and occasional lifting up to 10 pounds. Dr. Milos opined that the patient would not be able to return to full and unrestricted duties and that these restrictions were most likely permanent. PX. 8. Dr. Milos further opined that there were no restrictions that he placed that were unrelated to the Petitioner's injury. Dr. Milos opined that the patient appeared to be at maximum medical improvement and that she was unlikely to make any significant progress with any further treatments. PX 8. Petitioner testified time spent with Dr. Milos during her initial IME exam was 60 minutes. Trial Tr. p. 30.

Following completion of the IME, Respondent offered Petitioner a modified light duty job on October 14, 2016. See Px. 9. Petitioner then returned to work for the Respondent in a part-time job as a PASC Coordinator. Petitioner testified the modified job was within her work restrictions set by Dr. Milos. Petitioner further testified that she received a combination of

part-time pay and temporary partial disability from the Respondent during the duration of time she worked the part-time light duty job. Petitioner testified that she worked four hours a day, five days a week for the duration of the light duty job. Trial Tr. pp. 32-33. As an auditor, Petitioner completed chart audits. To do that, she sat at a computer and reviewed patient charts to make sure they had all the information needed and also to come up with different values and different categories for rehabilitation improvement during patient stay. Trial Tr. pp. 31-32. Petitioner testified during the time that she worked part-time as an auditor she requested an ergonomic chair that would allow her feet to be on the floor and use of ice pack as needed. Petitioner testified that the Respondent did allow her to use an ice pack at work for her bilateral shoulders and neck. Trial Tr. p. 34. Petitioner testified at the hearing that during times that she worked part-time light duty that her duties as an auditor did aggravate her cervical and bilateral shoulder pain. Petitioner testified that during this time she was seen and treated by her primary care physician for these increased shoulder and neck symptoms by Dr. Doronila-Hughes. Trial Tr. p. 36. See also PX 4, 20, and 24. Petitioner testified that in the middle of January 2017 she was informed by Respondent that they could no longer accommodate her permanent work restrictions and she was instructed to stay home. Trial Tr. p. 37. Petitioner was then directed by the Respondent to return to Dr. Steven Milos for repeat IME exam on March 22, 2017. Trial Tr. p. 37.

Petitioner was seen for repeat IME exam by Dr. Milos on March 22, 2017. Dr. Milos noted he was asked by Respondent to reassess Petitioner since her initial IME exam on June 22, 2016. PX 7. Regarding the patient's interim history Dr. Milos noted following his initial exam that the patient had returned to work in an accommodating position until she was instructed to return home when the employer no longer was able to accommodate her work restrictions. Dr. Milos noted that the patient had continued to perform home therapy exercises although no formal additional

therapy had been performed since the time of his initial IME. PX 7. Dr. Milos noted that since the initial IME exam the patient had had repeat MRI scans of her cervical spine, her right shoulder and her left shoulder and that she had brought the MRI reports of her right shoulder and cervical spine but not the MRI report of her left shoulder. PX. 7.

Dr. Milos noted regarding subjective symptoms that Petitioner continued to complain of neck and bilateral shoulder pain and that she continued to have significant pain in the performance of daily activities. Dr. Milos noted since the last examination that he performed that she had been diagnosed by Dr. Hovis with fibromyalgia and had been placed on Gabapentin which had provided some improvement in her symptoms. PX 7. The Petitioner continued to complain of pain throughout her shoulders bilaterally and throughout her cervical spine. She reported paresthesia in her fingers which comes and goes throughout the day. She reported she had limited herself to 5 pounds of lifting and that she had been seeing her primary care physician Dr. Doronila-Hughes and was now back off work because the employer was unable to accommodate work restrictions. The patient denied any new injuries. PX. 7.

Dr. Milos reviewed an MRI of the cervical spine dated January 26, 2017. Dr. Milos noted some progression of superimposed degenerative changes that had resulted in severe central canal stenosis without cord compression at C4-5 and C5-6 as well as foraminal narrowing most significant on the right at the C4-5 level. Updated MRI of the right shoulder dated January 30, 2017 demonstrated supraspinatus tendinosis without a visible tear. The patient reported that the MRI of the left shoulder also demonstrated rotator cuff tendinosis but no tears. PX 7.

Next a comprehensive physical examination was carried out by Dr. Milos. Dr. Milos noted she was in moderate discomfort. Examination of the neck revealed significant tenderness to palpation more significantly at the C4-C6 levels of the spinous processes as well as the right

paraspinal muscles. Petitioner had significant limitations to neck motion with forward flexion 25% of normal, extension 50% of normal, and rotation 75% of normal. She had positive Spurlings maneuver that radiated into her bilateral shoulders. PX 7. Examination of her right shoulder revealed tenderness to palpitation throughout the right shoulder. She had limited forward flexion to 140 degrees. Examination to left shoulder demonstrated generalized tenderness to palpation throughout the left shoulder. She had forward flexion of 160 degrees on the left. She did have some AC joint clicking on the left. She did have tenderness to palpation at the AC joint. PX 7.

Following a review of the updated information and considering the history and physical exam, Dr. Milos opined the following diagnoses to a reasonable degree of medical and surgical certainty:

1. Cervicalgia with cervical stenosis;
2. Fibromyalgia;
3. Right shoulder mild adhesive capsulitis; and
4. Right shoulder AC joint arthritis.

PX. 7. Dr. Milos was asked a series of six questions by the Respondent which he answered to a reasonable degree of medical and surgical certainty. Dr. Milos was initially asked whether he found evidence of symptom magnification? Dr. Milos answered as follows:

ANSWER: I believe that the patient's complaints are consistent with the above diagnoses. I believe that the fibromyalgia is worsening her usual pain complaints. However, her pain complaints are consistent with the above diagnoses with the superimposed fibromyalgia. Therefore, I do not feel that she has significant symptom magnification. PX 7.

Dr. Milos was next asked if any additional diagnostic testing was necessary. Dr. Milos opined no additional diagnostic testing was necessary. In terms of the Petitioner's cervical spine, although he noted there were no obvious disc herniations, Dr. Milos indicated that the patient had severe central canal stenosis as well as foraminal stenosis in the neck which were consistent with

her clinical findings. Concerning additional treatment Dr. Milos recommended some additional formal therapy for the right shoulder due to evidence of stiffness which has regressed since she had stopped formal therapy. Dr. Milos did not think she required a significant amount of therapy. However, twice weekly therapy for four weeks with a transition to home stretching program would be appropriate. PX 7. In addition, Dr. Milos opined that there it was necessary to have formal physical therapy for the left shoulder AC joint as well. Dr. Milos also opined that the Petitioner might benefit from a cortisone injection in the left AC joint to determine if that would provide her any relief as she has crepitus on exams that was finding consistent with AC joint arthritis. Regarding the cervical spine Dr. Milos felt this was a major issue that she continue to experience and he thought it was appropriate for her to be seen by a cervical specialist to determine whether injections versus surgical treatment were indicated. PX. 7. Concerning work restrictions Dr. Milos opined that the patient still requires work restrictions which should include lifting up to 5 pounds frequently and 10 pounds occasionally. Dr. Milos opined further that she should be limited with no overhead reaching with the right arm due to limited motion. Dr. Milos also agreed with her primary care physician that warm and cool compresses as well as a high back chair for support of her upper back, shoulder and neck were appropriate. Dr. Milos further agreed that a foot stool, and cushioning such as pillows would be beneficial while working. Dr. Milos felt that the patient could use a TENS unit at home but did not need to use such a unit while working. PX. 7. Petitioner testified time spent with Dr. Milos during her repeat IME exam was 60 minutes. Trial Tr. p. 38.

Following the second IME with Dr. Milos on March 22, 2017 Petitioner testified that her workers' compensation weekly benefits continued. Trial Tr. p. 39. Petitioner further testified that after she was seen by Dr. Milos on March 22, 2017 that Respondent never called her back to any

type of light duty work through the date of the parties' hearing. Trial Tr. p. 40. Petitioner testified at the time of the parties' hearing that she continues to experience significant ongoing neck and bilateral shoulder pain. Trial Tr. pp. 49-54. Petitioner testified that she had most recently been treated by a medical pain management physician – Dr. Evelyn Oteng. Medical records from Rockford Memorial Hospital revealed that the Petitioner was seen by Dr. Oteng on May 22, 2018 with chief complaint of neck pain. PX 23. It was noted by Dr. Oteng that the neck pain started in 2015 with a work-related injury. Neck pain was described as 5 out of 10 at rest and 8 out of 10 with activity. PX 23. Symptoms included neck pain as well as radiation to the upper extremities associated with numbness and tingling. PX. 23.

A physical exam was carried out on that date by Dr. Oteng. Petitioner exhibited decreased range of motion and flexion rotation and extension of her neck as well as tenderness to the cervical paraspinals and trapezius, pain and spasm. Her neurological exam was normal. An old cervical MRI was reviewed. PX 23. Dr. Oteng diagnosed cervicalgia, chronic radicular cervical pain, degenerative disc disease of the cervical spine, and cervical facet syndrome. Dr. Oteng recommended physical therapy as well as a consult to neurosurgery for cervical stenosis. Risks and benefits of epidural and facet injections were discussed with the patient at the visit. PX. 23. See also Trial Tr. pp. 40-41. An updated cervical MRI obtained at RMH dated July 23, 2018 showed multi-level cervical spondylosis, most severe at C4-5 and C5-6. There was questionable cord signal changes at C4-5. There was a noted left paracentral disc protrusion at C5-6 that appeared to impinge upon the traversing nerve roots. PX. 23.

Petitioner testified that her weekly TTD benefit discontinued on September 29, 2018. See also RX 13. Petitioner testified that she received no explanation in writing why her TTD benefits were terminated. Trial Tr. p. 42. Petitioner testified she was directed by the Respondent to attend

an IME exam with Dr. Andrew Zelby which took place on September 26, 2018. Trial Tr. p. 42. See also RX 9. Dr. Zelby performed an IME on September 26, 2018. Dr. Zelby noted the history of work accident on September 29, 2015 when Petitioner and co-workers were transferring a patient she estimated weighed 250 pounds from her bed to a bedside commode. See RX. 9. At the time of the IME Petitioner reported constant pain in the right more than the left side of her neck and intermittent but daily pain going down the right more than the left upper extremity. She reported numbness and tingling in her hands every day or every other day that last for less than 30 minutes when this occurs. Petitioner reported her symptoms were exacerbated by sitting in a chair with poor support, lifting and overhead activities. She reported relief with ice, heat, rest and a Tens unit. Petitioner reported her prior cervical injury in 2008 with right shoulder and neck pain. She reported physical therapy and a cervical epidural steroid injection following the 2008 injury and reported those symptoms subsided until her injury on September 29, 2015. RX. 9. Dr. Zelby noted her history as an RN for the Respondent. He noted her work accident and that she was then off work until October 2016 where she did light duty clerical work until January 2017 and had been off work since that time. RX 9.

Dr. Zelby carried out a physical exam, noting mild tenderness along the medial scapular borders of her neck. Spurlings maneuver was negative. Dr. Zelby noted inconsistent behavioral responses were absent. RX. 9. Dr. Zelby reviewed two cervical MRIs dated January 26, 2017 and July 23, 2018 respectively. According to Dr. Zelby, there was no interval changes noted between the two cervical MRIs. Dr. Zelby also reviewed cervical spine X-rays taken on the date of injury. Next Dr. Zelby summarized medical records that included both of Dr. Milos's IME reports. Dr. Zelby also reviewed the physical therapy notes. RX. 9.

Dr. Zelby diagnosed cervical spondylosis without myelopathy or radiculopathy and cervical strain. According to Dr. Zelby objectively the Petitioner had a normal neurological exam and spine exam. Dr. Zelby opined her MRI shows degenerative changes dating back to her initial cervical MRI obtained in November 2015. Dr. Zelby opined Petitioner has no symptoms or findings of radiculopathy. Dr. Zelby opined based on the objective medical findings as it relates to the cervical spine Petitioner sustained a soft tissue cervical strain as the result of her reported September 29, 2015 injury at work. RX 9. This cervical strain occurred in the context of pre-existing degenerative condition in her cervical spine. According to Dr. Zelby her work accident did not exacerbate, aggravate, accelerate or make symptomatic degenerative conditions in her cervical spine. RX 9. Dr. Zelby opined that Petitioner required no more than three to four weeks of directed physical therapy to treat any infirmity that arose out of her work accident. Within four to six weeks of the work accident Dr. Zelby opined Petitioner was safe to return to work relative to her neck without restrictions. Dr. Zelby opined that she could return to her job full duty and that she was easily at maximum medical improvement by mid to late January 2016 from her September 29, 2015 work accident. RX. 9. Petitioner testified her IME with Dr. Zelby lasted 15-20 minutes. Trial Tr. pp. 41-42.

Next Respondent obtained a records review report from Dr. Nik Verma dated November 7, 2018. See RX. 11 and RX 1. Dr. Verma's report did not involve an actual evaluation nor a physical exam of the Petitioner. RX 11. Dr. Verma summarized the Petitioner's medical records and noted she had been examined by Dr. Milos two times at the request of the Respondent. See Rx. 11. Dr. Verma was provided with surveillance reports which were reviewed. Dr. Verma diagnosed Petitioner with myofascial pain. RX. 11. Dr. Verma also diagnosed sprain or strain of the right shoulder at the time of the work injury which according to him would have resolved

within four weeks. RX 11. Dr. Verma opined that the MRI scan of the right shoulder was non-focal. Dr. Verma opined that oral anti-inflammatories, activity modifications, and therapy for four to six weeks would be the only treatment that was necessary for the right shoulder injury sustained by the Petitioner on 9-29-15. Dr. Verma opined that the Petitioner did not sustain an acute injury to her left shoulder. RX 11. Dr. Verma opined that the Petitioner had reached MMI status four to six weeks following the accident and that any ongoing restrictions were due to subjective complaints of pain that were out of proportion to objective findings in comparison to her normal right shoulder MRI. RX. 11.

Respondent then notified the Petitioner that she was to be seen for an IME by Dr. Verma scheduled for November 28, 2018. Dr. Verma performed his IME on January 18, 2019. RX 12. Physical exam revealed tenderness to palpation over the para trapezoidal, region, axial neck region, and posterior and superior shoulders bilaterally. MRI of the right shoulder dated April 13, 2016 was reviewed noting no rotator cuff tear was noted. X-rays obtained that day of the right shoulder showed Type 1 acromion bilaterally. Following completion of his IME exam Dr. Verma diagnosed subjective pain in the bilateral shoulders. RX. 12. Dr. Verma opined that the Petitioner's symptoms were out of proportion to objective findings. Dr. Verma opined appropriate treatment regarding a sprain/strain would be physical therapy as outlined in his medical record review report for a period of six to twelve weeks and that no further ongoing treatment was necessary. RX 12. Regarding the bilateral shoulders because the imaging studies were normal, Dr. Verma opined that the patient had reached MMI (within four weeks of the initial work accident) and that she could return to work full duty at this time regarding her bilateral shoulders RX. 12. Petitioner testified time spent with Dr. Verma during her IME exam was 10 minutes. Trial Tr. p. 44.

Respondent offered surveillance video and report(s) of the Petitioner which is contained at Respondent' Exhibits 17-19. The Arbitrator has now reviewed RX 18 which is the surveillance video that was edited down to live action of the Petitioner who was observed on the following dates: December 27, 2017 through January 3, 2018, February 6, 2018, May 25, 2018 through May 28, 2018 and August 30, 2018 through September 3, 2018. RX 18 was obtained through traditional surveillance methods as well as a remote surveillance camera according to Respondent's witness private investigator Andy Edwards. Trial Tr. p. 129. RX 18 is the DVD that was edited that contains only those portions of surveillance on days that showed activity. Trial Tr. p. 132.

On December 27, 2017 Petitioner is seen on surveillance at her residence taking out the garbage and putting the garbage in a trash can. RX 18, Trial Tr. p. 139. On December 29, 2017, Petitioner is observed exiting her car with papers in her hand. She is also observed outside walking a small dog on a leash at her residence. Rx. 18. On various dates in February 2018 Petitioner is observed leaving her house and driving away in various vehicles. Rx. 18, Trial Tr. p. 140. On May 27, 2018, Petitioner is observed along with another female, (her mother) a male, (her boyfriend) a baby, and a baby stroller next to the vehicle. RX 18, Trial Tr. pp. 141-142. Petitioner is observed coming outside from her house, crouching down and looking underneath her car on May 25, 2018. Rx. 18. On May 27, 2018, Petitioner's boyfriend was observed pushing the stroller with the baby in the stroller into the house. Rx. 18. On September 1, 2018, Petitioner is observed exiting her car with papers in her hand. She is also observed outside walking a small dog on a leash at her residence. Rx. 18. On September 24, 2018, Petitioner is observed putting her baby in the car while carrying the baby in a car seat driving away and then removing the baby from the vehicle in the car seat upon returning to the residence. This activity is observed two times on that date. RX 18.

On cross-examination Andy Edwards admitted that he did not weigh the garbage bag that was lifted by the Petitioner to put into the trash can on December 27, 2017. Trial Tr. pp. 147-148. Mr. Edwards admitted that he also did not weigh the contents of the purse that Petitioner was wearing across her body seen on surveillance dated December 30, 2017. Trial Tr. p. 148. Mr. Edwards conceded that it was the mother of Petitioner who pulled the stroller out of the car on May 27, 2018 and it was the male in the scene (boyfriend) who placed the infant and infant car seat on top of the stroller. Trial Tr. p. 148.

CONCLUSIONS OF LAW

F. IS PETITIONER'S CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY

The Arbitrator finds Petitioner sustained her burden of proving that her current condition of ill-being regarding her neck and bilateral shoulders is causally related to the 9-29-15 work injury. In making this finding the Arbitrator considered all of the evidence in the record. The Arbitrator does not find the opinions of Dr. Zelby and Dr. Verma that Petitioner sustained merely a resolved neck strain and right shoulder strain and reached MMI within 4- 6 weeks of September 29, 2015 to be credible. Instead, the Arbitrator is persuaded by the opinions of Dr. Milos and the multiple treating doctors who diagnosed Petitioner with work related (1) refractory chronic myofascial pain of the neck and bilateral shoulders, (2) bilateral shoulder impingement (which explains some but not all of her bilateral shoulder symptoms), and (3) cervical stenosis aggravated and accelerated by the work injury.

Regarding Petitioner's neck, the Arbitrator is not persuaded as Dr. Zelby suggests that Petitioner had a normal cervical spine exam and sustained a neck sprain in the setting of a pre-

existing degenerative cervical condition that was not exacerbated, aggravated, accelerated or made symptomatic by her work injury. Considering Petitioner's neck the Arbitrator finds that the correct diagnosis of her neck is both chronic cervical myofascial pain refractory to all conservative treatment rendered to date of the parties hearing and cervical stenosis which is symptom producing. This finding is supported by a plethora of evidence contained in the record.

Petitioner complained as soon as the office visit of 11-3-15 at Immediate Care as well as in the Pain Questionnaire completed at Rockford Spine Center on 12-8-15 of an intermittent numbness and tingling sensation from her neck down to her hands. Multiple cervical MRI findings demonstrate cervical stenosis (symptom producing), an actual worsening of the cervical findings over time since the injury, cervical cord contact, and cervical nerve root irritation all of which objectively explain some (but not all) of Petitioner's symptoms. For example, the first MRI obtained after the 9-29-15 injury dated 11-30-15 revealed moderate bilateral stenosis at C4-5. PX 13. Dr. Marie Walker personally reviewed the 11-30-15 cervical MRI and she found broad based disc bulge at C4-5 and also at C5-6. Dr. Walker noted there was mild deformation of the cervical cord at C4-5 and mild right sided foraminal stenosis. At C5-6 there was a disc herniation that abuts the cord at that level but does not significantly compress it. Subsequent cervical MRI dated 1-26-17 reports at C4-5 a slight progression of the disc degeneration (compared to previous cervical MRI) along with severe right sided (worse) and moderate left sided cervical stenosis. PX 14. Cervical MRI obtained at RMH dated July 23, 2018 showed cervical cord signal changes at C4-5 as well as a disc protrusion at C5-6 that appeared to impinge upon the traversing nerve roots. PX 23.

Second and regarding the neck, Petitioner testified she was asymptomatic for 2 years or longer prior to 9-29-15 after an injury to her neck in 2008. Petitioner was not missing work nor

was she under any formal work restriction that would limit her ability to work as a nurse at the time she was injured on 9-29-15. See Trial Tr. pp. 45-49. The Arbitrator is persuaded by the opinion of Dr. Milos who thoroughly examined Petitioner on two occasions that the 9-29-15 work injury aggravated pre-existing cervical stenosis and serves as an objective basis for some of petitioner's neck symptoms and as a basis in part for the need for permanent work restrictions.

Petitioner's remaining neck symptoms are consistent with chronic refractory myofascial pain of the neck and bilateral shoulders. The work related diagnosis of chronic neck and bilateral shoulder myofascial pain was made by all of the following physicians: Dr. Salgado (petitioner was directed to this medical facility by Respondent), Dr. Marie Walker (petitioner was referred to this doctor by the company clinic), Dr. Whitehurst (referred by Dr. Walker), Dr. Dahlberg (referred by Dr. Walker), Dr. Milos (Respondent's twice over IME doctor) and Dr. Verma (in his records review report). The Arbitrator is persuaded and adopts the opinion of Dr. Milos that Petitioner's chronic myofascial pain in her neck and shoulders did not improve or resolve in part due to underlying fibromyalgia that was well controlled prior to the date of injury. See Trial Tr. pp. 46-49. This observation that Petitioner's recovery would be long or slow was made not only by Dr. Milos but also by the company physician Dr. Salgado who made the same findings due to Petitioner's underlying fibromyalgia.

Regarding Petitioner's bilateral shoulders, the Arbitrator is not persuaded by Dr. Verma's opinion that Petitioner merely sustained a right shoulder sprain on account of the 9-29-15 work injury. While it is true that Petitioner's bilateral shoulder MRI's do not reveal any rotator cuff tears, both MRI's do reveal impingement pathology and tendinosis- both which are or can be symptom producing and both of which explain some but not all of Petitioner's bilateral shoulder symptoms. See PX 13, PX 25. The Arbitrator finds persuasive Dr. Milos' (shoulder surgeon)

opinions that Petitioner initially injured acutely her right shoulder on 9-29-15. The Arbitrator finds persuasive and adopts Dr. Milos' opinion that Petitioner's left shoulder complaints (noted on her second doctor visit after the injury) are related to chronic myofascial pain due to the work injury. As with Petitioner's neck, her underlying fibromyalgia (well controlled prior to 9-29-15) has played a major role in the nature of Petitioner's ongoing bilateral neck and shoulder symptoms through the parties' hearing date. The Arbitrator adopts Dr. Milos' opinion that the 2008 injury to Petitioner's right shoulder is not the cause of Petitioner's current right shoulder symptoms.

The Arbitrator further finds Petitioner credible regarding Petitioner's testimony that her neck and bilateral shoulders symptoms have essentially remained unchanged since the date of injury through the time of the hearing and on her testimony at hearing that she is not capable of performing the lifting demand of 50 pounds or more to do her job as a nurse. Trial Tr. pp. 49-54. In support of these credibility findings the Arbitrator relies in part on the treating records which never once document that Petitioner's neck and bilateral shoulder symptoms resolved following the 9-29-15 injury through the date of the parties' hearing. The opinions of Dr. Milos support this finding as well.

The Arbitrator is not persuaded that surveillance footage demonstrates that Petitioner's current neck and shoulder symptoms are resolved and/or no longer work related. After watching the entire surveillance footage contained in RX 18 which covered a period of nearly one year, the Arbitrator finds there is no probative evidence to suggest that at the time of the hearing Petitioner is capable of lifting more than 15-20 pounds. Furthermore, there is no live action footage of Petitioner over nearly a one year time frame which proves that she is capable of performing her job as a registered nurse which is designated as a medium job according to the Dictionary of Occupational Titles and requires lifting up to 50 pounds as an essential function of the job. When

Petitioner is observed placing the garbage sack into the garbage can on December 27, 2017 it is clear that the Petitioner struggled to open the garbage can and place the garbage sack into the garbage can as this involved some amount of lifting of her bilateral shoulder shoulders slightly above shoulder level. Not only did she struggle to do this one time, but the weight of the residential garbage sack is unknown.

Second, the only other observed lifting which was relevant appeared on September 24, 2018 when Petitioner was observed taking her baby in and out of a car seat and exiting her house and entering her house two times. Petitioner was asked on cross-examination since the incident of September 29, 2015 whether she had attempted to lift more than 10 pounds. Petitioner answered in the affirmative testifying that there have been times since the accident where she has attempted to lift more than 10 pounds. Trial Tr. p. 76. Petitioner testified that this happens when she lifts her son. At this time of the hearing, Petitioner testified her son weighed 16 pounds. Trial Tr. p. 77. Petitioner testified that her son weighed 6 pounds at birth and that between birth and the date of the hearing he had gained 10 pounds. Trial Tr. p. 77. Petitioner testified that the car seat she used for her son was weighed and weighs 7-1/2 pounds. Trial Tr. p. p. 80. Petitioner testified that she recalled lifting her son and the car seat two or three times in September of 2018. Petitioner testified at that time (September 2018) her son weighed 12 pounds and she agreed that between the weight of the car seat and her son that the two weighed approximately 19 pounds when she performed this act. Trial Tr. pp. 80-81. Petitioner went on to testify that her parents are actively involved in her son's care and more often than not are the ones who lift her son or carry him in and out of his car seat. Trial Tr. p. 82, 85, 91-93. Petitioner further testified that her brother is also involved in her son's care and he does more of the transferring of the baby in and out of the car and lifting of her son than she does. Trial Tr. p. 94. Regarding the small dog seen on

surveillance footage Petitioner testified that she has one pet-a silky Maltese that weighs less than 10 pounds. Trial Tr. p. 85.

Third, besides the fact that Petitioner is not observed for nearly one year of surveillance footage performing any physical activities suggesting that her symptoms have resolved and/or that she can return to full work as a nurse, the Arbitrator also notes the absence of any medical testimony provided by the Respondent to support a conclusion that Petitioner is now able to return to work full duty as a nurse based solely on observations made of the Petitioner from the surveillance footage. Respondent sent Petitioner to Dr. Andrew Zelby for an IME regarding her neck on September 26, 2018. See Rx. 9. Dr. Zelby was not provided with any surveillance video nor does he comment on the content of the surveillance video in his report. Dr. Zelby did not rely on surveillance to opine that Petitioner could return to work full duty without restrictions. Initially Dr. Verma performed a medical records review at the request of the Respondent on November 7, 2018. See Rx. 11. Dr. Verma was provided with the surveillance report for which he comments on Page 4 of his report. Dr. Verma made the following observation:

> She was noted to be opening and closing doors, carrying a purse and carrying bags over the shoulder, raising both arms overhead and it was noted that no orthopedic devices were utilized. She was able to carry small items in both hands. It was noted that she was able to install a car seat, carry a backpack over the shoulder, and carry a purse over the shoulders.

Dr. Verma who reviewed the surveillance did not use any of the surveillance as a basis for concluding that the Petitioner could return to work without restrictions. Instead Dr. Verma's opinion was based solely on the lack of surgical abnormalities in either of the bilateral shoulder MRIs. When Dr. Verma performed the actual IME of Petitioner on January 18, 2019 his report does not even mention surveillance and any observed activity of the Petitioner on surveillance was

not identified by Dr. Verma as a basis for concluding the Petitioner could return to work without restrictions as a nurse.

Fourth, the Petitioner testified on cross-examination before she had the opportunity to review the surveillance with her counsel during the time of the hearing. The Arbitrator finds that Petitioner's testimony at the time of the hearing and prior to review of the surveillance was truthful and entirely consistent with the observations of Petitioner seen on surveillance.

Based on all of the above, the Arbitrator finds the petitioner's condition of ill-being is causally related to her injuries September 29, 2015.

G. WHAT WERE PETITIONER'S EARNINGS?

The parties do not agree regarding the calculation of Petitioner's average weekly wage. Petitioner contends the AWW is $1042.93. Respondent contends Petitioner's AWW is $640.69. See Arbitrator's Exhibit 1. Section 10 of the Act defines average weekly wage as the 52 weeks of earnings by the injured employee in the one year prior to the accident date. Respondent's Exhibit 16 contains Petitioner's pay stubs for work she performed for the Respondent. Petitioner's regular work hours were based on 72 hours per two week pay period (6 12-hour shifts) with rotating weekends and holidays at an hourly rate of $27.53. See PX. 3. Petitioner's start date for Respondent was on August 17, 2015 and she accepted the terms of this employment offer on July 29, 2015. PX 3. Before accepting employment with HealthSouth, Petitioner testified that she notified the Respondent of a pre-planned vacation which was to begin shortly after she commenced employment with Respondent. Trial Tr. p. 13. Petitioner testified that the pre-planned vacation was for approximately two weeks and HealthSouth agreed at the time she accepted employment to allow her to go on vacation shortly after she commenced her employment there as a nurse. Trial

Tr. pp. 13-14. A review of Petitioner's pay stubs contained within RX 16 confirms that Petitioner began work on August 17, 2015. In the two week period covering August 16, 2015 through August 29, 2015 Petitioner worked 77.10 hours at an hourly rate of $27.53 with gross earnings of $2,122.56. For the next two week period from August 30, 2015 through September 12, 2015 Petitioner was on vacation for nearly all of the pay period. Pay stub shows Petitioner worked two days (two 12 hour shifts) of the 14 day period or 24.57 hours with gross earnings of $676.41. Petitioner then worked the last week of the next two week period beginning September 13, 2015 through September 26, 2015 or 36.55 hours with gross earnings of $1,006.22. No other work was performed before the date of injury on September 29, 2015.

Under Sylvester it is appropriate to calculate the wage under a weeks and parts thereof analysis. Petitioner worked the full two-week period covered by August 16, 2015 to August 29, 2015. Petitioner was on vacation other than two days for the entire pay period of August 30, 2015 to September 12, 2015 so this two-week period is excluded from the AWW calculation.

Based on all of the above the Arbitrator finds that gross earnings for the three weeks where petitioner performed full work total $3,128.78 which yields an average weekly wage of $1,042.93 with a corresponding TTD rate of $695.22.

J. WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE & NECESSARY? HAS RESPONDENT PAID FOR ALL APPROPRIATE CHARGES FOR ALL REASONABLE & NECESSARY MEDICAL SERVICES?

Respondent is ORDERED to pay the medical bill contained within PX 6 – Rockford Neuroscience Center in the amount of $1,090.00 for EMG dated January 23, 2017 per the Fee Schedule. This EMG was ordered by Dr. Doronilla-Hughes on 1/13/17 due to ongoing complaints

of intermittent numbness and tingling in the arms down to Petitioner's fingers. PX 15. The treatment was reasonable and not outside the two doctor rule.

Respondent is also ORDERED to reimburse Petitioner for work-related medications that petitioner paid out of her pocket as contained within Petitioner's Exhibit 11. Petitioner's Exhibit 11. Petitioner's Exhibit 11 are pharmacy logs for medications that were ordered by her treating physicians as documented in the treating records and are the direct result of her injury to her neck and bilateral shoulders. Those pharmacy logs demonstrate that the Petitioner paid $1,327.22 for these medications that were causally related to her injury of September 29, 2015.

L. WHAT TEMPORARY BENEFITS ARE IN DISPUTE?

TPD **Maintenance** **TTD**

For the reasons stated in Section F above, the Arbitrator finds Petitioner is entitled to an award of TTD benefits from 9-30-15 through 2-25-19 subject to any credit due Respondent pursuant to 8(j) of the Act. Respondent disputes their obligation to pay TTD benefits for an additional reason not previously addressed and beyond those opinions expressed by Dr. Zelby and Dr. Verma. At the time of hearing Respondent contends that no TTD benefits are owed after September 28, 2018 because the Petitioner failed to conduct a self-directed job search. See Respondent's Exhibit 14. At hearing Petitioner testified that after she was sent home by Respondent from her part time job in mid-January of 2017 and from that time on and up to the date of hearing she was never asked by the Respondent to begin a formal job search. Trial Tr. p. 40. Furthermore, it is clear from other evidence in the record that Respondent through their then existing counsel instructed the Petitioner not to commence job search efforts on her own or through Vocamotive.

Petitioner's Exhibit 2 are a group of letters that were admitted between Respondent' s then legal counsel and Petitioner's counsel. Those letters were drafted in a capacity by respondent's counsel while they were acting as an agent for the respondent. The Arbitrator finds those letters to be an admission against interest on this particular issue. Communications between Respondent's then counsel and Petitioner's counsel which are admitted into the record as PX. 2 confirm that Respondent had not yet decided whether they were to place Petitioner into a vocational plan or not as of July 6, 2017. Then on August 21, 2017 counsel for the Respondent acknowledged that Petitioner had reported that she was more than willing to participate at their direction in a vocational assessment program and would participate in meaningful job placement should the Respondent not be in a position to resolve the claim at that time. See PX. 2.

Significantly the Arbitrator finds at no time did Respondent ever direct Petitioner to commence a self-direct job search. For her part, Petitioner provided Respondent with Vocamotive's vocational assessment along with a Rehabilitation Plan at that time those documents were completed and clearly stated her willingness to work with Vocamotive once Respondent authorized those services as confirmed by multiple letters contained within PX 2. Respondent cannot cite Petitioner's failure to do self-directed job searching as a basis for refusing to pay TTD when the Respondent agreed that Petitioner need not perform vocational activities either while the parties discussed resolution of the claim or while Respondent decided whether it was going to authorize the requested rehabilitation services.

Regarding the award of TTD from 9-30-15 through 2-25-19 TTD, the Arbitrator finds that there is an underpayment of TTD benefits that were previously paid by Respondent to Petitioner between September 30, 2015 through September 28, 2018. Respondent paid $686.08 per week through 9-28-18. See RX 13. As explained in Section G, the correct weekly TTD amount is

$695.22. This results in a weekly shortage of $9.14 per week or 156 and 2/7th's weeks or $1,425.84. In addition, 8 TTD checks that were not cashed as void (see Section N below) are owed at $695.22 or $5561.76 for a total of $6,987.60 for the period between 9-30-15 through 9-28-18 when TTD was improperly terminated. Respondent is further ordered to pay TTD from 9-29-18 through 2-25-19 or 21 and 3/7th's weeks at $695.22 per week or $14,897.58. Total TTD due and owing to Petitioner through 2-26-19 is $23,311.02.

The Arbitrator further finds Petitioner is entitled to an award of maintenance benefits commencing on February 26, 2019 at the rate of $695.22 per week and continuing until vocational rehabilitation services are provided by Respondent to the Petitioner as more fully explained in Section O below.

M. SHOULD PENALTIES BE IMPOSED ON THE RESPONDENT?

Petitioner filed a pre-hearing Petition for Penalties. See PX. 5. Prior to the hearing Respondent filed its Response to Petitioner's Request for penalties. See RX. 14. The Arbitrator has considered both the request for penalties by the Petitioner and the Respondent's response. After considering the entire record, the Arbitrator denies petitioner's motion for penalties as he does not find the respondent's behavior in this case to be unreasonable **and** vexatious. The Arbitrator notes that the respondent based its denial of benefits on the medical opinions of Dr. Zelby and Dr. Verma. Therefore, the Arbitrator believes that respondent's conduct was 'not merely frivolous or for delay" but instead did present "a real controversy".

N. IS THE RESPONDENT DUE ANY CREDIT?

Respondent seeks a credit for TTD paid in the amount of $103,846.95. On the parties' Request for Hearing contained in Arbitrator's Exhibit 1 the Respondent stipulated that it paid

$103,846.95 in TTD benefits. Petitioner contends that the correct amount of the 8(j) credit is $98,358.47. See Arbitrator's Exhibit 1. Petitioner testified that there were eight TTD checks that she received from Respondent which she deposited with her credit union that were subsequently declined and not deposited/processed by her financial institution so that she did not receive the money represented by those 8 checks. Those eight TTD checks were for September 22, 2016 through August 28, 2016 and then in sequence April 29, 2017 through May 5, 2017 and June 10, 2017 through June 16, 2017. See PX. 12 and Trial Tr. pp. 55-60. Petitioner testified her credit union declined to deposit those 8 checks into her account and that at no time between when these checks were declined and the date of the hearing were the checks cancelled and reissued by Respondent and received by Petitioner and then cashed. Trial Tr. pp. 59-60.

A review of the check dated August 22, 2016 to August 28, 2016 shows that it was stamped by Members Alliance Credit Union on November 15, 2016. PX 12. The front of the check dated August 26, 2016 indicates VOID after 60 days. This provides the probable explanation for why the check was not cashed or honored by the credit union- namely it was presented by petitioner to the credit union after the check was void. The seven remaining checks covering April 29, 2017 to May 5, 2017 through June 10, 2017 through June 16, 2017, although received by Petitioner were also declined to be deposited by Petitioner's credit union. A review of a letter sent to opposing counsel dated 8-29-17 indicates Petitioner just learned that a series of 2017 checks were declined to be deposited by her credit union. The date Petitioner was informed that the credit union would not deposit the checks was more than 60 days after the date the last of the 7 checks had been issued by Respondent. It is clear these 7 checks were declined as void like the TTD check from August 2016.

Respondent was paying Petitioner $686.06 per week in TTD. There are eight TTD checks that were declined by the Petitioner's bank and not re-issued to the Petitioner as confirmed by PX 12 and RX. 13. The total amount of those 8 checks is $5,488.48. Therefore the Respondent's actual credit is $103,846.95 less $5,488.48 or $98,358.47 under 8(j). The petitioner should return the uncashed checks to the respondent if she is still in possession of same. If petitioner longer has possession of the checks, respondent should be given a credit for the disputed $5,488.48 if the respondent can prove those checks were in fact cashed by the petitioner.

O. IS PETITIONER ENTITLED TO VOCATIONAL REHABILITATION SERVICES?

At the request of Petitioner's attorney, Petitioner was evaluated for a vocational assessment done by Vocamotive on August 12, 2016. An initial evaluation report was completed by Certified Rehabilitation Counselor Kari Stafseth, CRC on November 8, 2016 which appears at PX. 21. Kari Stafseth also testified in Petitioner's Case in Chief. Trial Tr. p. 96. Ms. Stafseth is a Certified Vocational Rehabilitation Counselor and has been so since March 2009. Trial Tr. pp. 96-97. Ms. Stafseth has a Master's degree in rehabilitation counseling from the University of Illinois at Urban, Champaign. Most recently she renewed her certification as a rehabilitation counselor in March 2019. Trial Tr. pp. 97-98. Ms. Stafseth works as a rehabilitation counselor for Vocamotive where she completes vocational assessments, the majority of which are for individuals who have been injured at work. Mr. Stafseth also prepares rehabilitation plans that focus on providing injured workers with training and/or education and job placement assistance to get them back to work. Last Ms. Stafseth oversees the vocational rehabilitation process for a list of clients to make sure they are following through on all aspects of the vocational rehabilitation plan. Ms. Stafseth also

performs career counseling, complete labor market surveys, and does some vocational testing as well as testifying as an expert. Trial Tr. p. 99.

Ms. Stafseth was asked by Petitioner's attorney to perform an initial vocational assessment which she completed following an interview of the Petitioner on November 18, 2016. Trial Tr. p. 100. See PX 21. In preparation for her initial evaluation report Ms. Stafseth testified that she reviewed the Independent Medical Evaluation of Dr. Steven Milos dated June 22, 2016. Trial Tr. p. 102. Ms. Stafseth also considered an office note from Dr. Doronilla-Hughes dated November 2, 2016. Trial Tr. p. 103. See also PX. 4. In addition to this information, Ms. Stafseth testified that she considered the Petitioner's age, her education, her past work history and the job she was performing at the time of the injury for the Respondent as a registered nurse. Trial Tr. p. 103. At the time of completion of the initial evaluation report Ms. Stafseth was aware that Petitioner was working in a part-time job for the Respondent.

Concerning Petitioner's vocational history, Ms. Stafseth noted that the Petitioner worked 36 hours per week for Respondent at the time of the injury and earned over $27.00 per hour. Petitioner reported that she pulled medication out of Pixsys which was the storage system. She reported she passed out medications and completed head to toe assessments of patients. She reported she took patient vitals. She reported she completed rounds. She reported she performed wound care which included changing of bandages. She reported she assisted with patient transfers. She reported she assisted patients with the completion of activities of daily living. She reported she oversaw approximately seven patients at any given time. She reported she would be given a report to the next shift regarding patient status. She reported entering the documentation on a daily basis. Petitioner further reported she was required to push a 200 pound computer, lift equipment, and maneuver patients. She reported she remained on her feet throughout the course of the day.

She reported she would bend and squat to the floor. She reported she would reposition patients every two hours which might require having to climb atop a bed. See PX 21.

Prior to her employment with the Respondent Petitioner worked at OSF as a nurse from January 2014 to July 2015. See PX 21 pp. 5-6. Prior to that Petitioner reported she worked for the Rockford Health System as a registered nurse from 2007 to 2014. PX 21 p. 6.

Ms. Stafseth testified concerning Petitioner that she held the following opinions to a reasonable degree of vocational certainty:

- Petitioner who was then 33 years old was considered to be a younger person according to Social Security Administration. Petitioner's age does not negatively impact her employability.
- Petitioner is a well-educated individual who completed a Bachelor of Science Degree in Nursing with certifications related to CPR and advanced cardiovascular life support. Petitioner had no certifications regarding case management or Utilization Review.
- Petitioner's work experience included DOT No. 075.364-010, nurse, general duty, a medium duty physical demand level occupation with a specific vocational preparation level of 7 (skilled, 2 to 4 years of training).
- Based on Dr. Milos's opinion Petitioner required a permanent restriction of lifting 5 pounds on a frequent basis and 10 pounds on an occasional basis. Furthermore, Petitioner is unable to drive more than 15 miles at a time due to significant neck pain, shoulder pain and neck stiffness according to Dr. Doronilla- Hughes.
- Regarding transferable skills, Petitioner had skills related to customer service, medical terminology, and use of computer software. Additionally she managed patients and performed some administrative functions.

• Ms. Stafseth's opinion was that Petitioner had lost access to her usual and customary job and line of occupation as a nurse. The basis of this opinion is that the position of nurse as outlined by the Dictionary of Occupational Titles required physical capabilities at the medium level of physical demands which exceeds the restrictions outlined by Dr. Milos.

• Regarding the issue of employability, Ms. Stafseth opined that Petitioner is employable. Review of on line job postings indicated that there were few opportunities as a PPS Coordinator full time within Petitioner's geographical area. It was noted that Respondent was only able to accommodate part-time work. Petitioner further opined that given the 10 pound restriction identified by Dr. Milos that Petitioner would most quality for sedentary work. Prospective job targets would include triage coordinator, admissions coordinator, registrar, medical secretary, office clerk, dispatcher, ER case manager, and similar positions. See PX 21, p. 10. With regard to wage earning potential, Ms. Stafseth opined that Petitioner would have a most probable wage earning potential of $13.00 to $16.00 per hour in the above mentioned job targets.

• Ms. Stafseth opined that the actual implementation of meaningful vocational interventions would of benefit to Petitioner. PX 21, p. 10. Vocational rehabilitation interventions would include an assessment of Petitioner's computer software and keyboarding proficiency, comprehensive job seeking skills instruction to include management of disability-related inquiry, and effective supervised job search to assure that Petitioner is able to effectively access any available labor market which may be targeted.

On cross-examination Ms. Stafseth reiterated her opinion that meaningful vocational interventions would be of benefit to the Petitioner. Ms. Stafseth explained that there are aspects of vocational rehabilitation that would assist in applying for the positions that she identified that the Petitioner was physically qualified to perform including such things as how to properly fill out applications. Trial Tr. pp. 116-117. Ms. Stafseth explained that in her experience many clients when they are returning to work they do not fill out applications appropriately and that the individuals also require assistance with disability-related questions due to injury in particular where one may have to address the need for a reasonable accommodation and many clients do not know how to go about doing that. Trial Tr. p. 117. When asked on cross-examination whether it was appropriate for the Petitioner to do a self-directed job search prior to engaging in vocational services, Ms. Stafseth disagreed. Ms. Stafseth opined in her experience the majority of injured workers do not know how to engage in an aggressive independent job search in her experience injured workers who had lost access to what they have done throughout their entire vocational history are usually unsure at what point to start at. Where do they go? They need some additional counseling to go through potential plans to search for work. Trial Tr. pp. 121-122.

Ms. Stafseth testified that after her initial vocational report contained in PX 21 and through the date of hearing at no time had she been contacted by HealthSouth or their workers' compensation carrier to begin vocational rehabilitation services that she recommended for Petitioner. Trial Tr. pp. 122-123. Ms. Stafseth testified that shortly prior to the parties' hearing she was provided with a copy if the IME report of Dr. Zelby as well as the IME report of Dr. Verma. Trial Tr. p. 105. Ms. Stafseth testified that the opinions of Dr. Zelby and Dr. Verma were not available at the time she performed her initial vocational evaluation in November 2016. Trial Tr. p. 105. Ms. Stafseth opined that if Petitioner was limited to lifting frequently to 5 pounds and

occasionally to 10 pounds and had a limitation of no driving more than 15 miles at a time that her opinions would remain the same and that she held those opinions to a reasonable degree of vocational certainty. Trial Tr. p. 106.

The Arbitrator finds witness Kari Stafseth's opinions credible and awards Petitioner vocational rehabilitation services as outlined in the Rehabilitation Plan completed by Vocamotive contained in PX 21. Ms. Stafseth offered multiple plausible reasons why Petitioner would benefit from rehabilitation services despite the fact she is college educated. The Arbitrator notes in so finding that Respondent offered no vocational opinion evidence whatsoever. Maintenance benefits are to be paid to Petitioner commencing on 2-26-19 and continuing for the duration that vocational services are made available to Petitioner and until such services are no longer needed under the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

SCOTT QUINN,

Petitioner,

vs. NO: 16 WC 31096

THE AMERICAN COAL COMPANY,

Respondent.

20IWCC0326

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, causation, disablement, and nature and extent, and being advised of the facts and law, reverses the Decision of the Arbitrator and denies Petitioner's claim for compensation, for the reasons stated below.

I. FINDINGS OF FACT

A. Background

Petitioner testified that he was a high school graduate with an associate's degree in Forestry. He stated that he worked 37 years in coal mines, approximately half of those years underground. According to Petitioner, he was regularly exposed to and breathed coal dust, silica dust, roof bolting glue fumes, diesel fumes and smoke from coal fires. On his last date of exposure, Petitioner was 59 years old and held the position of belt manager.

Petitioner testified that he first worked for the Ziegler Coal Company in Murdock, Illinois, in 1977. He stated that he worked as a general inside laborer, with duties including belt shoveling and cleaning. He explained that there were long belt lines underground and accumulations of coal dust he was required to clean.

Petitioner also testified that he later went to the face (the production area of the mine) where the coal was being loosened and evacuated. According to Petitioner, they would drill holes into the face, insert a shell and run 10,000 pounds of air pressure to it, causing an explosion that would break up the coal into a size where it could be removed. He compared the mechanism to a jackhammer. Petitioner added that the process blew out a lot of dust, which the workers "ate" because there was less concern about using water and ventilation in the 1970s.

Petitioner stated that after a few years, he went into maintenance and spent most of his career there. He explained that the machines were serviced and repaired at the face or nearby underground. Petitioner agreed that he had the sort of exposures that the miners had while he was working on the machines.

Petitioner further testified that he began working for the Kerr-McGee Coal Corporation in 1983, until a Mr. Murray bought the mine in 1998. According to Petitioner, the name changed but he continued working at the mine for the rest of his career. He testified that he took on additional duties while working for Kerr-McGee, which was a non-union operation. He stated that he worked in the shaft and in the slope, which were the two entrances to the mine. He explained that he did belt work where the coal was bellied out of the mine, and maintained the shaft, guides, and the upcast where air entered and left the mine. He added that he did a lot of roof bolting, which maintained the roofs by drilling holes, inserting glue or resin, and running in a bolt. According to Petitioner, the glue was "wicked stuff" with an odor that could be smelled outside the mine near the upcast. Petitioner also explained that he was exposed to diesel fumes because Kerr-McGee was one of the first to take diesel equipment underground; the equipment had "scrubbers" but they were not maintained as well as they should have been. Petitioner additionally testified that much of his exposure to dust during his later years was as a belt manager.

B. NIOSH X-Ray Records

Respondent introduced records from NIOSH into evidence. Chest X-rays dated July 10, 1983, April 6, 1987, and June 12, 1989, were interpreted by an A-reader and a B-reader as completely negative. A chest X-ray dated July 29, 1991, was interpreted by an A-reader as completely negative (there is no accompanying B reader). A chest X-ray dated August 5, 1992, was interpreted by an A-reader as completely negative while the B-reader found no abnormalities consistent with pneumoconiosis. A chest X-ray dated May 9, 1994, was interpreted by an A-reader and a B-reader as completely negative. Chest X-rays dated September 28, 2006, May 6, 2011, April 3, 2013, and September 29, 2015, were interpreted by an A-reader and a B-reader as finding no abnormalities consistent with pneumoconiosis.[1]

[1] The form changed to eliminate Box 1C's "completely negative" rating.

C. Prior Medical Treatment

On April 12, 2003, Petitioner saw Dr. James Alexander for a sore throat and possible fever. Petitioner reported no cough or sinus drainage. An examination noted the chest was clear. Petitioner was prescribed an antibiotic and Tylenol 3, with directions to take fluids and rest.

On March 10, 2005, Petitioner underwent a PA and lateral chest X-ray. Dr. Alexander noted that no prior films were available for comparison. The doctor found the lungs were expanded but no evidence of active infiltrate was identified in either lung field. His impression was of no active pulmonary disease.

On March 17, 2005, Petitioner underwent a treadmill cardiolyte rest/stress myocardial perfusion study. Dr. Hisham Youssef, the interpreting radiologist, found a normal study with a normal measured left ventricular ejection fraction of 56 percent.

On February 6, 2006, Petitioner underwent a spirometry examination in which Petitioner reported being a five-pack smoker for five years, quitting in 1981. Petitioner's FVC was 105% of predicted, while his FEV1 was 100% of predicted.

On February 13, 2006, Petitioner underwent a PA and lateral chest X-ray. Dr. Alexander noted the cardiac silhouette appeared to be within normal limits and unchanged from the prior study. He again noted the lungs were expanded but no evidence of active infiltrate was identified in either lung field. His impression was of no active pulmonary disease.

On February 16, 2007, Petitioner saw Dr. Alexander complaining of a sore throat. An examination indicated Petitioner's lungs were clear; his throat had erythema, no exudate. Dr. Alexander diagnosed Petitioner with strep and prescribed Z-PAK.

On April 18, 2007, Petitioner returned, complaining of a cough and congestion, but no sore throat. The chest examination indicated some distant bronchial sounds, with few rhonchi but no wheezes. Dr. Alexander diagnosed Petitioner with an upper respiratory infection and bronchitis, prescribing Z-PAK and Histussin-HC.

On November 18, 2008, Petitioner complained of a cough, congestion, and sore throat lasting 10 days. An examination indicated Petitioner's lungs were clear; his throat had erythema, no exudate. Petitioner was diagnosed with an upper respiratory infection and sinusitis, prescribing Cefzil and Tussionex.

On November 12, 2010, Petitioner complained of a four-day cold to a nurse practitioner. Petitioner reported feeling tired or poorly, with a cough, headache, sinus pain, and mucinous nasal discharge, but no fever, sneezing or dyspnea. A lung examination disclosed normal breath or voice sounds. Petitioner was diagnosed with acute sinusitis and prescribed Zithromax and Promethazine-Codeine.

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On May 6, 2011, Petitioner underwent an X-ray of the PA view of the chest. Dr. Youssef, the interpreting radiologist, found bilateral pulmonary hyperinflation, but the examination was otherwise unremarkable.

On June 29, 2012, Petitioner returned to Dr. Alexander complaining of a three-day sore throat. Petitioner also reported sinus pain and nasal discharge, but no cough, wheezing, fever, chills, or earache. Dr. Alexander noted that Petitioner's history had no recurrent upper respiratory infections. A lung examination was clear to auscultation and no rales or crackles were heard. Petitioner was diagnosed with acute pharyngitis and prescribed Clarithromycin.

On April 29, 2013, Petitioner saw Dr. Alexander again. The office note's review of symptoms indicated "Pulmonary symptoms RECENT BLACK LUNG CXR. No dyspnea and no cough."

On June 2, 2014, Petitioner saw Dr. Alexander for annual lab tests and complaints regarding his left knee (an injection which had provided relief had worn off after four months). The review of pulmonary systems noted a recent black lung X-ray in 2013, but no dyspnea or cough. A lung examination revealed normal breath sounds, with no wheezing, rhonchi, rales or crackles. Dr. Alexander's assessment was: (1) Normal routine history and physical adult; (2) Benign prostatic hypertrophy without urinary obstruction; (3) Hyperlipidemia; (4) Localized osteoarthritis of the knee; (5) Abnormal skin lesion on chest; and (6) Actinic keratosis right ear and left cheek.

On January 29, 2015, Petitioner saw nurse practitioner Elizabeth Eversmann[2], complaining of a cough with congestion, wheezing, and coughing up purulent sputum. Petitioner reported that he had the flu a month prior and ever since, his cough and shortness of breath has gotten worse. A lung examination disclosed wheezing and a decrease in breath sounds. Petitioner was diagnosed with acute bronchitis. Kenalog and Celestone injections were ordered, as well as Cefprozil, Prednisone, Breo Ellipta and chest X-rays. The X-ray was interpreted as showing chronic changes, but Ms. Eversmann did not have anything for comparison.

On February 22, 2015, Petitioner underwent a CT scan of the abdomen and pelvis, with and without contrast. Dr. Yousef's primary impression was of acute sigmoid diverticulitis, negative for obstruction, abscess or free air. He also noted that the visualized lung bases were negative for mass, pleural fluid and active infiltrate. He further noted mild dependent atelectasis and/or fibrosis in both lung bases posteriorly. Petitioner saw Dr. Alexander on February 25, 2015 regarding diverticulitis but noted he still had head and chest congestion; the lung examination was clear.

On September 29, 2015, Petitioner underwent a single frontal view chest X-ray ordered by Dr. Alexander. The interpreting radiologist, Dr. Tranh Trieu, found the lungs hyperinflated

[2] Eversmann's title is not specified in this record, but "NP" is indicated On Aug. 4, 2016.

but the lung fields were unchanged compared to the prior study, with no evidence of pneumonia, pneumothorax or pleural effusion.

On October 9, 2015, Petitioner saw Dr. Alexander regarding the injury of his left knee at work. The doctor assessed Petitioner had internal derangement of the left knee.

D. Accident

Petitioner testified that he first began noticing breathing problems at work approximately a year or two before he retired. He stated that the mine had many incline belts and slope belts and he noticed a big difference when walking, climbing, and carrying items. He described being short of breath and fatigued.

Petitioner testified that he last worked in the coal mines on February 6, 2016. Petitioner stated that he had been working for Respondent at the Galatia mine. According to Petitioner, he retired for several reasons: the mine was in the process of shutting down; he had a knee problem; and he had shortness of breath. Petitioner also stated that he could have found other mining work if he had chosen to do so, but he felt physically incapable.

E. Medical Treatment

On August 4, 2016, Petitioner saw Ms. Eversmann regarding his right lower eyelid, complaining of a spot on his right lower eye for three days. Petitioner reported no dyspnea, cough, or wheezing. The lung examination was clear to auscultation, with no wheezing, rhonchi, rales or crackles.

On September 8, 2016, Petitioner underwent chest PA and lateral X-rays. Dr. Henry K. Smith, the interpreting radiologist, prepared a B-reader report on September 26, 2016. In an accompanying letter to Petitioner's counsel, Dr. Smith noted "interstitial fibrosis of classification p/s, bilateral mid to lower zones involved, of a profusion 1/0." Dr. Smith found no chest wall plaques, calcifications or large opacities. He noted minimal accentuated Kerley-B septal lines in the later left lung base, as well as "questionable bleb/bulla in the right upper to mid lung." Dr. Smith's impression was simple CWP "with small opacities, primary p, secondary s, mid to lower zones involved bilaterally, of a profusion 1/0."

On November 24, 2017, Petitioner was seen by Dr. Alexander for a refill of medication. The office note for this visit states: "Physical disability but able to perform usual physical activities for age. Severe visual impairment, severe hearing impairment, and severe breathing difficulty." The lung examination indicated normal breath sounds, with no wheezing, rhonchi, rales or crackles. The office note does not contain an assessment but the CWP is listed elsewhere as an active problem and the treatment plan indicates treatment for CWP, primary insomnia, and unspecified internal derangement of the left knee.

On April 4, 2018, Petitioner returned to Dr. Alexander for an annual wellness physical. Petitioner's history indicated no chest pain or discomfort. The history also indicated: "Chronic dyspnea – During exertion – No dyspnea – Not expressed as feeling short of breath – No chronic cough – No wheezing." Petitioner's active problems do not include CWP. Petitioner's past diagnoses are listed as Measles, Mumps, and Varicola; a left knee arthroscopy and arthroplasty are also noted. The lung examination indicated normal breath sounds, with no wheezing, rhonchi, rales or crackles. Dr. Alexander's assessments were: (1) Routine senior citizen history and physical without abnormal findings; (2) Benign prostatic hypertrophy without urinary obstruction; (3) Subacromial bursitis on the right and left; and (4) shingles.

On June 11, 2018, Petitioner saw Ms. Eversmann regarding a right shoulder and neck muscle strain. CWP is listed as an active problem. The pulmonary system review indicated no dyspnea. The lung examination was clear to auscultation, normal, with normal and symmetric respiratory excursion. The assessment was neck strain and rotator cuff tendonitis – right impingement syndrome.

On July 3, 2018, Ms. Eversmann authored a note stating that due to black lung, Petitioner should not be working in or around dusty conditions.

On October 4, 2018, Petitioner saw Ms. Eversmann regarding a lesion on his right ear. Petitioner reported no pulmonary symptoms during this visit. CWP is listed as an active problem. The lung examination indicated normal breath sounds, with no wheezing, rhonchi, rales or crackles.

On December 3, 2018, Petitioner saw Ms. Eversmann regarding a sinus complaint. CWP is listed as an active problem. Petitioner reported no cough, dyspnea, or wheezing. The pulmonary review indicated "nonprod cough." The lung auscultation revealed abnormalities. Wheezing and diffuse inspiratory wheezing was heard, but no rhonchi, rales or crackles. The treatment plan for CWP included Prednisone, Augmentin, Stiolto Respimat, and Levaquin.

On January 14, 2019, Petitioner returned to Ms. Eversmann, complaining of cough, headache, sore throat, drainage, congestion, and increased shortness of breath for a week. Petitioner reported he began coughing after taking a long truck ride with someone who hacked the entire time. CWP is listed as an active problem. The pulmonary system review indicated a nonproductive cough. The lung auscultation revealed abnormalities. Wheezing and diffuse inspiratory wheezing was heard, but no rhonchi, rales or crackles. Petitioner was assessed with CWP; the plan included an injection of Kenalog and Celestone, Prednisone, Cefuroxime Axetil, and Tussionex Pennkinetic ER. Ms. Eversmann also ordered X-rays, which were performed on the same day. Dr. Youssef found the lungs were clear of active infiltrate and that the cardiac silhouette and pulmonary vessels were within normal limits, with no pleural fluid or pneumothorax. Dr. Youssef's impression was of no active cardiopulmonary disease.

F. Examination and Deposition by Dr. Suhail Istanbouly

On April 26, 2017, Petitioner was seen by Dr. Suhail Istanbouly for a coal worker's pneumoconiosis (CWP) evaluation. Petitioner provided a work history consistent with his testimony at the arbitration hearing. Dr. Istanbouly further noted:

> "He is a nonsmoker. He used to chew tobacco, but he quit four years ago. He lives with his wife who is a nonsmoker. They do have two dogs at home. He does not recall being diagnosed with asthma or COPD in the past. He is on Albuterol HFA to be used as needed, and that was started recently by his primary care physician, Dr. Alexander. He has been coughing intermittently for the past several years. The cough is mild to moderate in intensity and it is around the clock. He could not specify any triggering factors for his cough. The cough is productive of slight white clear sputum, one teaspoonful in size per day. No hemoptysis. No fever or chills. No night sweat. No orthopnea, he sleeps on one pillow. He has had occasional episodes of nocturnal dyspnea, but usually less than once a week. No history of heavy snoring, witnessed apnea episodes, or excessive daytime sleepiness or fatigue. No significant exertional dyspnea, he is able to walk for one mile without any breathing problems and he hasn't noticed any declining of respiratory capacity over the past six months. No chest pain or tightness. He does wheeze occasionally. He does get heartburn around twice a week. No significant runny nose or post nasal drip. No leg edema. No dysphagia or odynophagia. He has gained 20 pounds since he left the coal mines and he attributes that to the knee replacement surgery he had last year. Spirometry test today in Harrisburg medical Center was within normal range with FEV1 3.73L, 103% predicted. FVC 4.92L, 103% predicted. FEV1/FVC 76%. I did review the chest x-ray he had in Harrisburg Medical Center on September 8, 2016 which revealed mild bilateral interstitial changes consistent with simple coal worker's pneumoconiosis, profusion 1/0 per the B reader, Dr. Henry Smith."

Dr. Istanbouly's assessment was "Simple Coal Worker's Pneumoconiosis (early stage) related to long term dust inhalation." The doctor noted that CWP seems to be a significant contributor to Petitioner's chronic respiratory symptoms (intermittent cough, sputum production, wheezing, and occasional episodes of nocturnal dyspnea). He advised that Petitioner avoid any further coal dust inhalation to prevent the progression of his lung disease and that he could not go back to work in the coal mines.

On September 17, 2017, Dr. Istanbouly, who is board-certified in internal medicine, pulmonary medicine, and critical care medicine, testified by deposition on behalf of Petitioner. He testified that he has treated numerous coal miners and former coal miners. He stated that he has treated lung diseases including emphysema, COPD, chronic bronchitis, asthma, and CWP.

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Dr. Istanbouly's testimony was generally consistent with his CWP evaluation. Regarding Petitioner's work history, the doctor added that Petitioner reported working as many as 72 hours weekly.

Dr. Istanbouly added that all of Petitioner's symptoms fell under the legal definition of CWP. He also testified that hypothetically, if there were three different chest X-rays taken of Petitioner and all three indicated hyperinflated lungs, it could be COPD, though with Petitioner's normal pulmonary function test (PFT) he would assume if he had COPD it would be early stage. He stated that it was not clear whether Petitioner's cough would meet the requirements for chronic bronchitis. He explained that most of the cases where someone has an intermittent cough, eventually the cough is daily and mild but the patient remembers it when it gets worse. Dr. Istanbouly then offered that overall, it made sense that Petitioner had chronic bronchitis.

The doctor testified that his PFT did not employ post-bronchodilator testing or give a methacholine challenge. He stated that he just performed a baseline spirometry test, which was normal. Acknowledging that he did not test for reactivity, based on Petitioner's history and examination, Dr. Istanbouly opined that Petitioner's COPD and chronic bronchitis could be a reactive airways disease related to coal dust inhalation. He later agreed that given the gradual progression of COPD, a person could have early COPD which does not manifest itself in a PFT.

Dr. Istanbouly further testified that CWP can manifest itself on a chest X-ray even two or three years after a miner leaves the mine. He noted that some of the coal dust remains in the lungs for the rest of the miner's life. He agreed that Petitioner had an active exposure to coal dust while working and residual exposure to dust trapped in his system. He also opined that sometimes CWP can be a progressive, latent disease.

Dr. Istanbouly stated that the gold standard for diagnosing a pulmonary disease initiated by a coal mine is a combination of radiographic study and pathologic tissue evaluation, though the latter is the most accurate. He agreed that if a patient has a chest X-ray positive for CWP and sufficient exposure to coal dust to cause CWP, it would be sufficient to make a diagnosis of CWP. However, the doctor also agreed that a negative chest X-ray by itself cannot rule out pneumoconiosis. He further agreed that based on the literature regarding autopsies of long-time coal miners, it was highly likely that a man with 37 years of coal mine work would be found to have pathologically significant CWP.

Dr. Istanbouly opined within a reasonable degree of medical certainty that Petitioner has clinical or medical CWP caused by long-term coal dust exposure. He also opined there was a "good possibility" that Petitioner had COPD. He further opined that Petitioner had chronic bronchitis, which is considered a subdivision of COPD, caused by long-term coal dust exposure. He additionally opined that it is a possibility that Petitioner has a reactive airways disease, noting that he would include it with chronic bronchitis and COPD as the same entity.[3] He agreed that Petitioner taking Albuterol could affect his PFT results from month to month and that it could

[3] He reiterated that this was a "possibility" during cross-examination.

have raised his baseline FEV1 and FVC due to physiologic improvement from the bronchodilator treatment.

On cross-examination, Dr. Istanbouly acknowledged that he saw Petitioner at opposing counsel's request. He testified that for the past three to five years, he has performed five to seven such examinations monthly, always at the request of a claimant's counsel.

Dr. Istanbouly also acknowledged that he examined Petitioner only once. He testified that he reviewed none of Petitioner's treatment records. The doctor considered Petitioner's oral history, the chest X-ray, and the PFT performed on the date of the evaluation.

Dr. Istanbouly agreed that Petitioner reported no significant exertional dyspnea while describing his job as physically demanding. He agreed that Petitioner could not specify any triggering factor for his cough, including smoke, dust, fumes or vapors. He also agreed that Petitioner's forced vital capacity and forced expiratory volume were both normal. He further agreed that the FEV1/FVC ratio of 76 percent was 100 percent of predicted normal for Petitioner. Dr. Istanbouly conceded that Petitioner had no abnormality in the PFT and no evidence of obstruction. While the doctor did not test lung volumes, he conceded the spirometry test is not suggestive of restrictive defect.

Dr. Istanbouly attempted to discuss the general percentage of long-time coal miners who still show pathologic evidence of CWP but ultimately testified he could not comment on the specifics because he did not have the study in front of him. The doctor was unaware of any study confined and specific to Illinois. The doctor was also unaware of the results of any NIOSH studies regarding the rate of CWP in Illinois.

Dr. Istanbouly acknowledged that he is not an A-reader or B-reader of films.[4] He testified that when he interprets a film, he determines whether it is positive or negative; if positive he classifies it as early, moderate, or severe. He added that he reviews a film first to get his own impression before reviewing a B reader report. He stated that he does not give profusion ratings on films and could not say whether Petitioner's film was a 0/1 profusion or a 1/0 profusion.

Dr. Istanbouly testified that his single diagnosis was pneumoconiosis. He opined that it was not fair to claim that Petitioner had nothing wrong with his lungs, after all these years of coal dust exposure, a positive X-ray and all of his symptoms. However, the doctor added that based on the normal PFT, Petitioner's condition had to be early stage. He later testified that absent his positive reading of the X-ray, he nevertheless would have diagnosed Petitioner with black lung, albeit early stage.

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[4] During cross-examination, the doctor conceded he did not know what various markings on the B reader's report meant.

G. X-Ray Readings and Deposition Testimony by Dr. Cristopher Meyer

On May 6, 2017, Dr. Cristopher Meyer reviewed Petitioner's September 29, 2015 and September 8, 2016 chest X-rays. Regarding the September 29, 2015 X-ray, Dr. Meyer found the lungs were well-expanded and clear, with no small rounded, small irregular or large opacities. He found the mediastinum, cardiac silhouette, bones and soft tissue were all normal. His impression was of a normal PA chest X-ray, with no radiographic findings of CWP. His findings and impression regarding the September 8, 2016 chest X-ray were unchanged. Dr. Meyer wrote that he disagreed with the B-reading form provided by Henry K. Smith, D.O. regarding the reported findings of small opacities of size "p/s" with profusion of 1/0. He declared that the lungs are clear, a normal examination with no findings of CWP.

On November 3, 2017, Dr. Meyer, a board-certified radiologist since 1992 and a B-reader since 1999, testified by deposition on behalf of Respondent. He stated that one becomes a B-reader by taking a weekend course which includes a series of lectures, typically by experienced, senior B-readers, followed by a series of practice examples overseen by mentors, followed by an examination. He also stated that he was invited to take the B-reader examination by a member of the committee that designed the training and testing program for B-readers. He further stated that he is currently on the ACR Pneumoconiosis Task Force, which is engaged in redesigning the course and the examination, as well as submitting cases for the training module and examination.

According to Dr. Meyer, a B-reading is an epidemiologic evaluation of chest X-rays, in which the reader evaluates the quality of the film, describes any limitations of the X-ray, and examines the film to decide both whether there are any small nodular (round) opacities or linear opacities and to describe the distribution of these findings. He noted that CWP is typically an upper-zone predominant process, while idiopathic pulmonary fibrosis or asbestosis is a basilar or linear process.

Dr. Meyer added that the last component is to interpret profusion of small opacities, the most difficult component of the classification system for most radiologists. Dr. Meyer testified that profusion varies from a normal reading of 0/0 to 3/+, which is the most abnormal. He explained that the numerator represents what the reader thinks the profusion value is, while the denominator implies the other closest possible value. According to the doctor, a 1/0 is a film that is right on the borderline between abnormal and normal. He later testified that the B-reader training syllabus emphasizes that training to distinguish between 0/1 and 1/0 is one of the most challenging distinctions to be made in the field of radiology. He further stated that B-readers also evaluate the chest X-ray for large opacities, pleural disease and other miscellaneous findings.

Consistent with his prior letters, Dr. Meyer testified that Petitioner's chest X-rays, which were Quality 1 films, showed no radiographic findings of CWP. He thought these films were as clear as a teenager's lungs in that it was very uncommon for him to call a chest radiograph normal and he described both of Petitioner's films as normal.

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On cross-examination, Dr. Meyer testified that it would be extremely unlikely for CWP to manifest between Petitioner's 2015 X-ray and the end of the statutory period for making a claim. When asked whether CWP could have manifested within 2 ½ years after the September 29, 2015 X-ray,[5] Dr. Meyer replied that he had never seen it happen from a normal chest radiograph. He conceded it was possible if another six months of work in the mines was added.

Dr. Meyer also agreed that the gold standard for determining the existence of lung disease is pathologic review of the tissue itself rather than radiology. He further stated that most B-readers prefer not to know anything about the patient in order to interpret the film as objectively as possible, but he assumes that any worker warranting the chest X-ray has an appropriate exposure history. He testified that PFT results would not change what he saw in the X-ray. He acknowledged that B-readers can disagree as to whether they are seeing small opacities.

Dr. Meyer agreed that while all long-time coal miners will come out with some dust deposit trapped in their lungs, the majority will not have the changes in their lungs that qualify as CWP. He also indicated that it was not possible to have CWP without having a tissue reaction to the coal dust. He further agreed that CWP can be considered a chronic progressive disease in some coal miners. He additionally agreed that hyperinflation was a finding consistent with emphysema and COPD. He acknowledged that he was generally retained by a coal company rather than a miner.

Dr. Meyer would not rule out the possibility that at autopsy or pathology Petitioner might have coal macules with a negative chest X-ray. He agreed that CWP could be found in the mid and lower lung zones, but very rarely would it be found there and not in the upper lung zones. He conceded there was no NIOSH or B-reader document stating that CWP must begin in the upper lung zones. He acknowledged that there are studies that show at autopsy that as much as 50 percent of coal miners are found to have abnormalities of CWP when it might not have been apparent radiographically during their lives.

On redirect examination, Dr. Meyer testified that it was very unlikely for simple pneumoconiosis to progress once the exposure ceased. He added that it was very, very unlikely for Petitioner to have developed CWP after September 29, 2015. He also testified that there was no evidence of bulla or hyperinflation on Petitioner's films.

Dr. Meyer further testified that if a physician who is not a radiologist, A-reader, or B-reader makes a diagnosis of pneumoconiosis, that physician absolutely does not know whether he or she is seeing a profusion of 0/1 or 1/0, or whether the diagnosis meets the ILO criteria for that diagnosis.

[5] This is not the same time period as the prior question.

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H. Records Review, X-Ray Review and Deposition Testimony by Dr. David Rosenberg

On August 9, 2017, Dr. David Rosenberg conducted a review of Petitioner's medical records and a radiographic review for Respondent's counsel. In his report, Dr. Rosenberg indicated he reviewed: (1) Dr. Smith's B-reading of the September 8, 2016 chest X-ray; (2) Dr. Meyer's B-readings of the September 29, 2015 and September 8, 2016 chest X-rays; (3) Dr. Istanbouly's records; Petitioner's NIOSH file; (4) Harris Medical Center's records; (5) Methodist Hospital's records; and (6) Petitioner's September 29, 2015 and September 8, 2016 chest X-rays.

After summarizing Petitioner's medical records, Dr. Rosenberg reviewed the September 29, 2015 and September 8, 2016 chest X-rays, concluding that the films were Quality 1 and both were 0/0. The doctor summarized that Petitioner: "is a 60 year old who formerly worked in the coal mines for over 30 years. He is a nonsmoker and had had minimal intermittent respiratory symptoms. The treatment records do not outline chronic respiratory problems. His pulmonary function tests are normal, without obstruction or restriction, and he has a normal diffusing capacity. His X-rays are negative for the presence of any micronodularity."

Dr. Rosenberg concluded that Petitioner has no respiratory impairment related to past coal mine dust exposure or any chronic respiratory disorder consequent to his coal mine employment. The doctor added that there was no evidence in the treatment records of Petitioner having received treatment for chronic respiratory problems. Dr. Rosenberg opined with a reasonable degree of medical certainty that Petitioner has not developed a respiratory disorder or any form of a pneumoconiosis related to his coal mine employment.

On September 29, 2017, Dr. Rosenberg, who is board-certified in internal medicine, pulmonary disease, and occupational disease, testified on behalf of Respondent. The doctor testified consistently with his report. He also testified that he found no hyperinflation or emphysema in the films he read. Similar to Dr. Meyer, Dr. Rosenberg testified that in general, when coal dust causes parenchymal changes, they begin in the upper lung zones, greater on the right. He added that as the disease progresses, it can involve all lung zones, but generally with an upper lung zone predominance. He also testified that profusion ratings were developed by the ILO to get away from characterizing films as early, moderate, or severe. He noted that an 0/1 rating would not be a significant finding for CWP, whereas a 1/0 rating would be.

Dr. Rosenberg was asked about Dr. Istanbouly's testimony regarding studies showing that as many as 50 percent of coal miners have pathologic evidence of pneumoconiosis. Dr. Rosenberg was not aware of any such studies from the Illinois Coal Basin. He was aware of the Vallyathan study of severely affected miners from Appalachia, within a 100-mile radius of Beckley, West Virginia. He agreed that in that study, almost 70 percent of miners had some X-ray evidence of parenchymal abnormalities. He also agreed that 41 percent of miners in the study had a profusion of 2/1 or greater. He added that in the Vallyathan study, approximately 30 percent of patients with negative X-rays had pathologic findings, generally of the macular variety. He further agreed with the Vallyathan study authors' statement that the miners'

exposures, which were prior to 1971, and associated level of disease should not be taken as typical of coal miners working today. He stated that the study was written and published in 1996.

Dr. Rosenberg opined that it was more probable than not that Petitioner does not have pathologic evidence of pneumoconiosis. He explained that if Petitioner had pathologic evidence of pneumoconiosis that was so limited as to not show up on film, it meant that there was no clinical relevance in the sense shown by the Vallyathan study of macules which are not associated with fibrosis or scarring. He noted that diffusion capacity testing is a very good, if imperfect, test to rule out clinical significance for pneumoconiosis. He also noted that Petitioner's diffusion capacity was entirely normal. He further found no objective evidence of bronchoreactivity.

Dr. Rosenberg also opined that based on Dr. Istanbouly's testing, applying Table 5-4 of the AMA guidelines on permanent impairment, Petitioner would fall into Class 0. He also opined that assuming Petitioner had reactive airways disease and had taken a bronchodilator before Dr. Istanbouly's testing, applying Table 5-5 of the AMA guidelines on permanent impairment, Petitioner would fall into Class 0. He further opined that Petitioner did not have any pulmonary function impairment under either Table, the interpretive strategies of the American Thoracic Society, or the standard of the Global Initiative on Obstructive Lung Disease (GOLD). He added that Petitioner does not meet the GOLD standard for COPD.

On cross-examination, Dr. Rosenberg acknowledged that he never met Petitioner and never took a patient history from Petitioner. He added that he had no reason to doubt the patient history taken by Dr. Istanbouly. He also acknowledged that in Petitioner's last year of work, Petitioner worked as many as 72 hours weekly. He agreed that excess exposure would increase the risk of pulmonary disease. He further agreed that hyperinflation seen on a chest X-ray can be consistent with COPD. He testified it was possible for early COPD to manifest pathologically or radiographically without being severe enough to show up in a PFT, but noted that it was more likely than not that if it was severe enough to appear on an X-ray, the PFT would be abnormal.

Dr. Rosenberg additionally agreed that coal mine-induced lung disease can be latent and progressive. He stated that it was possible for a miner to develop radiologically apparent CWP that manifested two years after leaving the mines. He conceded that a person could have CWP and a normal diffusing capacity. He also conceded that despite his X-ray readings, Petitioner could have CWP. He agreed that a negative chest X-ray would not rule out the possibility of pathologic pneumoconiosis. He also stated that CWP can progress after a miner leaves the coal mine, though the probability is much smaller.

Dr. Rosenberg acknowledged that there were studies other than the Vallyathan study which showed 50 percent or more of long-term miners were found to have CWP, but was not aware that the subjects actually had X-ray readings. He was also aware of studies that show at autopsy that as many as 80 to 90 percent of long-term miners will have pathologic changes of

simple CWP. He testified, however, that the Vallyathan study was the only one that looked at correlated negative X-rays and pathological findings of CWP and the rate was around 30 percent. On redirect examination, Dr. Rosenberg testified that the studies of which he was aware were all old and from Appalachia.

I. Additional Information

Petitioner testified that his shortness of breath and fatigue had worsened since he left the mine. He stated that he has a rescue inhaler and a maintenance inhaler which he uses at least daily. He also stated that his condition makes it difficult to spend more time with his grandchildren, hunt deer with his sons, or hike with his wife. Petitioner later added that he hunted four or five days during the past deer season. Petitioner further stated that he and his wife hiked a bicycle trial with their dogs for a couple of miles once or twice in the late winter or spring.

Petitioner added that it has become more difficult for him to monitor his horses, goats, chickens and rabbits. He later explained that he has a 10-acre farmstead south of Harrisburg with a pasture and pens. The pasture is used to grow hay for the animals, though someone with a share harvests the hay for Petitioner. Petitioner testified that he occasionally has to break the ice on the pond at the property in order for the animals to drink.

Petitioner testified that he has never been a smoker. He stated that he had no physical ailments other than his breathing difficulties. He acknowledged that he had a left knee replacement. On cross-examination, Petitioner explained that he injured his left knee at work on October 7, 2015 and had settled his claim. He agreed that his knee was scoped in February 2016 before undergoing total knee replacement surgery in May 2016. Petitioner also testified that he received TTD payments while he was off work for this injury but added that he and others were laid off during this period because the mine was in the process of closing.

II. CONCLUSIONS OF LAW

The Arbitrator concluded that Petitioner proved by a preponderance of the evidence that he suffers from CWP, COPD, and bronchitis, and that these diseases were all related to his coal mine exposures. The claimant in an occupational disease case has the burden of proving both that he suffers from an occupational disease and that a causal connection exists between the disease and his employment. *Anderson v. Industrial Comm'n*, 321 Ill. App. 3d 463, 467 (2001). CWP is a slowly progressing lung condition caused by long-term exposure to coal dust and must be proven by medical documentation and opinion testimony. See *Zeigler Coal Co. v. Industrial Comm'n*, 237 Ill. App. 3d 213, 219 (1992); *Monterey Coal Co. v. Industrial Comm'n*, 241 Ill. App. 3d 386, 392-93 (1992). The question of whether a claimant has CWP is a question of fact to be established by competent medical evidence. *Id.* Indeed, whether an employee suffers from an occupational disease and whether there is a causal connection between the disease and the employment are questions of fact. See *Bernardoni v. Industrial Comm'n*, 362 Ill. App. 3d 582,

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596 (2005. Where conflicting medical testimony is presented, it is for the Commission to determine which testimony is to be accepted. *E.g.*, *Martin v. Industrial Comm'n*, 91 Ill. 2d 288, 294 (1982).

In this case, the Arbitrator primarily relied on the examination and testimony of Dr. Istanbouly. However, Dr. Istanbouly testified that the gold standard for diagnosing a pulmonary disease initiated by a coal mine is a combination of radiographic study and pathologic tissue evaluation, though the latter is the most accurate. Given that there is no pathologic evidence submitted in this case, even Dr. Istanbouly's testimony establishes that the radiographic evidence is the most important. Yet Dr. Istanbouly acknowledged that he is not an A-reader or B-reader of films.

The B-reader radiographic examinations universally indicated that Petitioner did not have CWP, with one exception. Oddly, neither the Arbitrator nor Petitioner relied on Dr. Smith's impression of simple CWP. Petitioner did not take deposition testimony from Dr. Smith in this case. Given that this case turns on which expert opinions to prefer, it is notable that Dr. Smith recently testified that the panel which assembles the B-reading syllabus are the peers he aspired to be and acknowledged that Dr. Meyer was one of the authors of the syllabus. *Ferrell v. The American Coal Company*, 20 IWCC 0067. Dr. Meyer testified that the B-reader training syllabus emphasizes that training to distinguish between 0/1 and 1/0 is one of the most challenging distinctions to be made in the field of radiology. Dr. Smith found a 1/0 profusion; Dr. Meyer disagreed.

The Arbitrator's Decision also contains numerous critiques of the testimony from Dr. Meyer and Dr. Rosenberg but lacks any findings of fact regarding their testimony.

The Arbitrator accepted Dr. Istanbouly's opinions over Dr. Rosenberg's in large part because the latter conducted a records review instead of an examination. Dr. Istanbouly examined Petitioner once and did not review Petitioner's treatment records.

Petitioner reported to Dr. Istanbouly that he has been coughing intermittently for the past several years. Yet Dr. Istanbouly relied on his experience that most of his cases where someone has an intermittent cough, eventually the cough is daily and mild but the patient remembers it when it gets worse. The doctor first testified that it was not clear whether Petitioner's cough would meet the requirements for chronic bronchitis, but stated shortly thereafter without explanation that overall, it made sense that Petitioner had chronic bronchitis. Dr. Istanbouly's opinions seem contrary to Petitioner's treatment records, which mention bronchitis only a few times over the course of decades, with one of those diagnoses being an episode of acute bronchitis. Dr. Istanbouly inferred that Dr. Alexander had diagnosed Petitioner with chronic bronchitis because he prescribed Albuterol for Petitioner but there is no evidence that it was prescribed to treat chronic bronchitis.

The Arbitrator accepted Dr. Rosenberg's general testimony regarding COPD, but ignored his opinion that that Petitioner does not meet the GOLD standard for COPD. The Arbitrator also ignored Dr. Rosenberg's testimony that if COPD was severe enough to appear on an X-ray, the PFT would be abnormal. Respondent correctly notes that Dr. Istanbouly's initial testimony regarding COPD was stated as a hypothetical. Dr. Istanbouly later opined there was a "good possibility" that Petitioner had COPD, which is not the same as "more likely than not" to a reasonable degree of medical certainty. Dr. Istanbouly testified shortly thereafter that he considered Petitioner's purported chronic bronchitis to be a subdivision of COPD. Dr. Istanbouly's testimony on this point seems internally inconsistent, and inconsistent with Petitioner's assertion that Dr. Istanbouly rendered discrete diagnoses.

The Arbitrator also discounted Dr. Rosenberg's records review and testimony because it did not include records after Petitioner's retirement date. It is not clear that the appearance of the CWP diagnosis in Petitioner's treatment records from Dr. Alexander's office reflects an independent diagnosis or a reliance on Dr. Istanbouly's evaluation. In either case, the issue is the basis of the diagnosis. The Arbitrator faulted the records review for not running through the entire Section 1(f) period. Dr. Rosenberg testified that CWP can progress after a miner leaves the coal mine, though the probability is much smaller. Dr. Meyer testified that it would be extremely unlikely for CWP to manifest between Petitioner's 2015 X-ray and the end of the statutory period for making a claim. As there is no evidence of the basis for Dr. Alexander's notation of CWP, the Commission must decide whether to prefer the opinions of Drs. Istanbouly and Smith to Drs. Meyer and Rosenberg.

The Arbitrator's critique of the scope of Rosenberg's review frequently places the burden of proof on Respondent rather than Petitioner. The Decision notes that Drs. Meyer and Rosenberg agree that notwithstanding their readings, Petitioner could still have CWP, when the issue is whether Petitioner proved that he does. The Arbitrator observed that "[n]o expert in this record testified that Petitioner could not have CWP," though it was not Respondent's duty to produce such evidence. The Decision notes Dr. Meyer's testimony that he would not rule out pathology or autopsy showing Petitioner had CWP, when the issue is whether Petitioner proved that he does.

The Decision refers to Dr. Meyer's testimony that some studies showed 50 percent or more of long-time coal miners have CWP diagnosed at autopsy. However, the Decision ignores Dr. Rosenberg's testimony that such studies involved Appalachia decades ago, not the Illinois Coal Basin today. Furthermore, the Decision does not address Dr. Rosenberg's testimony that the Vallyathan study was the only one that looked at correlated negative X-rays and pathological findings of CWP and the rate was around 30 percent.

Indeed, the Arbitrator concluded that "[h]aving no medical evidence at all, it would still be more likely than not that Petitioner could have CWP." The Arbitrator's reliance on the 50 percent statistic seems consistent with Dr. Istanbouly's testimony that absent his positive reading of the X-ray, he nevertheless would have diagnosed Petitioner with black lung. The Arbitrator

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relied on statistical testimony while also relying on testimony that the nature and progression of CWP can vary from miner to miner. The Commission rejects reliance on such statistical evidence here given the absence of other persuasive, medically accepted evidence establishing a causal connection.

For all of the aforementioned reasons, the Commission is persuaded by the opinions of Dr. Meyer and Dr. Rosenberg over those of Dr. Istanbouly and Dr. Smith. Therefore, the Commission concludes that Petitioner failed to prove by a preponderance of the evidence that he suffers from CWP, COPD, and bronchitis, and that these diseases were all related to his coal mine exposures.

Accordingly, Petitioner's claim for compensation is denied.

IT IS THEREFORE FOUND BY THE COMMISSION that Petitioner failed to prove that he suffers from an occupational disease and that a causal connection exists between the disease and his employment.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's award dated June 26, 2019 is vacated and Petitioner's claim for compensation is hereby denied.

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

DATED: JUN 12 2020
d: 5/7/20
BNF/kcb
045

Barbara N. Flores

Deborah L. Simpson

Dissent

I respectfully dissent from the opinion of the majority and would have affirmed and adopted the well-reasoned decision of the Arbitrator. Petitioner worked as a coal miner for 37 years. He was never a smoker. The only expert in this case to perform an examination of Petitioner was Dr. Istanbouly, a board-certified pulmonologist with significant experience treating and examining coal miners in southern Illinois. He performs the majority of his black lung examinations for the Department of Labor. The Arbitrator found Dr. Istanbouly's opinions more persuasive than Respondent's record reviewers. I agree. The Petitioner's burden is simply

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to show that his coal mining exposure was *a* cause of his CWP, COPD and chronic bronchitis. See *Freeman United Coal Mining Co. v. Industrial Comm'n*, 317 Ill. App. 3d 497, 504 (2000). Based on a careful review of the entire record, I believe it is more likely than not that Petitioner suffers from these conditions and they were caused, at least in part, by his coal mining exposures. Therefore, I respectfully dissent from the decision of the majority.

Marc Parker

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

QUINN, SCOTT
Employee/Petitioner

Case# **16WC031096**

THE AMERICAN COAL COMPANY
Employer/Respondent

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On 6/26/2019, 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:

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

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

STATE OF ILLINOIS)
)SS.
COUNTY OF WILLIAMSON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

SCOTT QUINN
Employee/Petitioner

v.

THE AMERICAN COAL COMPANY
Employer/Respondent

Case # **16** WC **31096**

Consolidated cases: _____

20IWCC0326

An *Application for Adjustment 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 **March 15,2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ Other **Disease/exposure, causation, Sections 1(d)-(f), 19(d).**

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FINDINGS

On **02/06/16**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$116,528.36**; the average weekly wage was $2,240.93.

On the date of accident, Petitioner was **59** years of age, ***married*** with **0** dependent children.

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

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

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

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

ORDER

- The Respondent shall pay the Petitioner the sum of $755.22/week for a further period of 25 weeks, as provided in Section 8(d)(2) of the Act, because the injuries sustained caused a permanent and partial disablement to the extent of 5% MAW.

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

6/20/19
Date

JUN 2 6 2019

STATEMENT OF FACTS

Petitioner, Scott Quinn of Harrisburg, Illinois was 62 years of age at the time of arbitration with a date of birth of November 6, 1956. He graduated high school from Tuscola Community High School in Tuscola, Illinois. He also received an Associates Degree in Forestry at Southwestern Junior College in Harrisburg. He is married to Angela Quinn with no dependant children. He worked approximately 37 years in the coal mine, with approximately half of those being underground. During the course of his mining career, in addition to coal dust he was regularly exposed to and breathed silica dust, roof bolting glue fumes, diesel fumes, and smoke from coal fires.

He last worked in the coal mines on February 6, 2016. On that day he worked for America Coal at their Galatia mine. He was 59 years of age with a job classification of belt manager. Petitioner testified that he retired on that day for several reasons. The mine was closing down and he was having knee problems along with noticing shortness of breath. If he would have chosen to stay in the mining field, he felt he would have been able to find work but he was not physically capable. He first started working in the mines in 1977 for Ziegler Coal Company in Murdock, Illinois. He was hired in as an inside laborer where he did predominately belt shoveling and belt cleaning. From there he moved to the face of the mine where the coal is actually extracted from the walls. Petitioner described shooting the coal, which meant using high pressure air that would extract the coal from the walls. Petitioner described this area as being some of the dustiest areas in the entire mine. After a couple years working at the face, he went into maintenance. This was actually repairing the machines down in the mine when they would break down. Petitioner testified that he was exposed to the same types of exposures working on the machines as the other miners that were around him. Petitioner stayed in maintenance for the majority of the rest of his career. Petitioner worked for Zeigler Coal from 1977-1983. He then went to work for Kerr-McGee Corporation in 1983, which was eventually bought out and became American Coal. Petitioner stayed at this mine from 1983 until he retired.

While working at the Kerr-McGee/American mine Petitioner describes doing a lot of work around the belts and maintaining the shaft. He also did some roof bolting. Roof bolting is where a hole is drilled in the top of the mine approximately five to six feet deep, a glue bolt is placed in the hole and then a bolt is placed up into the glue bolt and spun so that the glue seals up the pin. Petitioner describes the glue as "wicked stuff" that had an odor that would take your breath away. Petitioner also described diesel fume exposures from the machines that were run underground.

Petitioner first started noticing breathing problems a year or two before he retired. He noticed shortness of breath when he would have to walk, climb, and carry belts throughout the mine. From the first time he started noticing breathing problems until the time he left the mine, his condition became progressively worse. From the time he left the mine until the date of arbitration, his breathing has continued to worsen. Petitioner uses a rescue inhaler and a maintenance inhaler daily. His breathing problems do affect his daily life with things such as playing with grandchildren, hunting, and taking care of animals at a place that him and his wife have just outside of town. Petitioner has been a nonsmoker his entire life and takes no medications other than his inhalers. He has also had his left knee replaced.

Dr. Suhail Istanbouly

At Petitioner's attorney's request, Petitioner was examined by Dr. Suhail Istanbouly who performed an evaluation on April 26, 2017. Dr. Istanbouly is board certified in internal medicine, pulmonary medicine, and critical care medicine. (px 1, p 4) During the course of his practice he has had numerous occasions to work with or treat coal miners or former coal miners. (px 1, p 5) In terms of lung diseases he has treated emphysema, COPD, chronic bronchitis, asthma, coal worker's pneumoconiosis. He is currently affiliated with SIH Hospitals including Herrin Hospital, Memorial Hospital of Carbondale and St. Joseph's Hospital. He also holds priviledges at other hospitals including Heartland, Harrisburg Medical Center, Marshall Browning Hospital in DuQuoin, Union County Hospital in Anna. (px 1, p 5) Dr. Istanbouly noted that Petitioner was working six shifts a week and those were twelve hour shifts. That would be approximately 72 hours. (px 1, p 6 & 7) Dr. Istanbouly felt that that extra amount of exposure would be significant in terms of him developing disease and disablement. (px 1, p 7) Dr. Istanbouly indicated that Petitioner is on Albuterol and then later, ProAir. Those are a short and fast acting bronchodilator. They would be used to help with COPD and chronic bronchitis. (px 1, p 10 & 11) Dr. Istanbouly testified that Petitioner's baseline spirometry test was normal. (px 1, p 11) Dr. Istanbouly testified that in light of his diagnosis, he felt that part of Petitioner's COPD and chronic bronchitis may have been reactive airway disease that was related to coal dust inhalation. (px 1, p 11) Dr. Istanbouly testified that coal worker's pneumoconiosis can manifest itself on a chest x-ray even after the miner leaves the mine. Even two or three years or more. (px 1, p 12) The dust that the miner has deposited in his lungs remains for the rest of his life even after he quits mining. (px 1, p 12) It is true that if a person has been determined to have a positive chest x-ray for CWP and sufficient exposure to coal mine dust to cause CWP, those two things combined are sufficient to make a diagnosis of CWP. He went on to state that a negative chest x-ray can never prove that there is no pneumoconiosis in the miner. (px 1, p 15) Dr. Istanbouly gave testimony that in his opinion that Petitioner has clinical or medical CWP and that it was caused by his long term dust inhalation. Dr. Istanbouly gave the opinion that Petitioner has chronic bronchitis that was caused by long term dust inhalation. Based on the diagnosis of CWP Petitioner may have no further exposure to the environment of the coal mine without endangering his health. That opinion would also be true for COPD and chronic bronchitis. (px 1, p 19) Dr. Istanbouly felt that if he were asked about 20 Niosh readings that were negative, if those x-ray readings were 10, 15 or more years before the man left active coal mining, they would have no relevance to question of whether he had coal worker's pneumoconiosis on the day he left mining. (px 1, p 39)

Medical Records of Dr. James Alexander

On an office visit dated 11/24/2017 functional: physical disability but able to perform usual physical activities for age. Severe visual impairment, severe hearing impairment, and severe breathing difficulty. (px 3, p 16) On that same office visit under plan: coal worker's pneumoconiosis, ProAir HFA 108 (90 Base) MCG/ACT inhaler, 2 puffs QID prn wheezing, 30 days, 5 refills. (px 3, p 18) On a single frontal view chest x-ray dated 9/25/15 impression: no significant changes compared to prior study with no evidence of pneumonia, pneumothorax or pleural effusion. The mediastinum and hemidiaphragms are stable. The heart is stable in size and shape. (px 3, p 20) On an office note of 11/12/2010 chief complaint is cold. Symptoms started

four days ago. History of present illness: feeling tired or poorly, headache, sinus pain, cough. (px 3, p 24) On an office note dated 6/29/12 under history of present illness: sinus pain, nasal drainage. (px 3, p 29) On an office visit of 4/29/13 under review of symptoms, pulmonary: pulmonary symptoms recent black lung cxr. No dyspnea and no cough. (px 3, p 33) On an office visit of 1/29/2015 chief complaint: cough. Reason for visit: upper respiratory infection. History of present illness: fever, congested in the chest, cough, coughing up sputum which is purulent, and wheezing. About a month ago he had the flu. However, since then his cough and SOB had gotten worse. He doesn't get anything up when he coughs but he is concerned be the SOB is present and worsening. No n/v/f/d. (px 3, p 47) On an office visit of 1/29/15 lungs: a decrease in breath sounds was heard. Wheezing was heard. (px 3, p 49) On an office visit of 11/18/08 patient complains of cough and congestions and sore throat for ten days. (px 3, p 106) Office note of 4/18/17 has been having some cough, congestion. No sore throat. No nausea or vomiting. More respiratory. Going on for a few days. Under assessment: 1. Upper respiratory infection. 2. Bronchitis. (px 3, p 107)

Medical Records of Dr. James Alexander

On an office note of 4/4/18 under active problems: coal worker's pneumoconiosis. Under review of systems: pulmonary: dyspnea. No cough and no wheezing. (px 4, p 5) On that same office visit under plan: coal worker's pneumoconiosis, ProAir HFA 108 (90 Bade) MCG/ACT inhaler, 2 puffs QID prn wheezing, 30 days, 5 refills. (px 4, p 5)

Methodist Hospital

On a pulmonary function test report dated 6/12/17 under interpretation: normal diffusion capacity. (rx 3, p 2)

NIOSH Records

Medical Records from HMC Clinic/Dr. Alexander

On an office note dated January 14, 2019, under active problems: pneumoconiosis-coal worker's. Chief complaint: patient in for cough, headache, sore throat, drainage and congestion for one week. History of present illness: felt better initially when he was seen beginning of December. Then had to ride on a long trip with a guy in a truck who hacked the entire time. After that, Scott started coughing. Non-productive. Using the Stiolto helps some. He is more short of breath. Thinks he may be dying. Horrible headache and sinus pain. (rx 5, p 2) Under review of symptoms: pulmonary: pulmonary symptoms nonproductive cough. Social History: functional: Physical disability but able to perform usual physical activities for age. Severe visual impairment, severe hearing impairment, and severe breathing difficulty. Physical disability does not affect ability to work. Normal activities of daily living. Under lungs: lung auscultation revealed abnormalities. Wheezing was heard. Inspiratory wheezing was heard. Diffuse inspiratory wheezing was heard. No rhonchi were heard. No rales/crackles were heard. (rx 5, p 4)

Under plan: coal worker's pneumoconiosis. Inj/meds/imm: Kenalog 40mg with Celestone 6mg IM. PrediSONE 10MG (21) pack, as directed, 30 days, 0 refills. Tussionex Pennkinetic ER 10-8 MG/5ML milliliter, 1 tsp p.o. bid prn, 30 days 0 refills. Under cough: lab: CHEST PA/LAT 2 VIEWS. (rx 5, p 5) On an office visit of 12/3/2018 under active problems: pneumoconiosis-coal worker's. Chief complaint: chief complaint is sinus. Under history of present illness: sore throat, cough. (rx 5, p 8) Under social history: functional: physical disability but able to perform usual physical activities for age. Severe visual impairment, severe hearing impairment, and severe breathing difficulty. Physical disability does not affect ability to work. Normal activities of daily living. (rx 5, p 9) Under lungs: lung auscultation revealed abnormalities. Wheezing was heard. Inspiratory wheezing was heard. No rhonchi were heard. No rales/crackles were heard. (rx 5, p 10) Under assessment: coal worker's pneumoconiosis. Under plan: coal worker's pneumoconiosis. PreniSONE 10 MG tablet, 1 p.o. once a day, 8 days, 0 refills. Augmentin 875-125 MG tablet, 1 p.o. bid, 10 days, 0 refills. Stiolto Respimat 2.5-2.5 MCG/ACT inhaler, 2 inhalations daily, 30 days, 0 refills. Levaquin 500 MG tablet, 1 p.o. once a day, 10 days, 0 refills. On an office visit of 10/4/2018 under active problems: coal worker's pneumoconiosis. (rx 5, p 16) Under social history: function: physical disability but able to perform usual physical activities for age. Severe visual impairment, severe hearing impairment. and severe breathing difficulty. Physical disability does not affect ability to work. Normal activities of daily living. (rx 5, p 17) On an office note of 6/11/18 under active problems: coal worker's pneumoconiosis. Under social history: functional: physical disability but able to perform usual physical activities for age. Severe visual impairment, severe hearing impairment, and severe breathing difficulty. Physical disability does not affect ability to work. Normal activities of daily living. (rx 5, p 22) On an office visit of 4/4/18 under history of present illness: chronic dyspnea during exertion. (rx 5, p 25) Under social history: functional: physical disability but able to perform usual physical activities for age. Severe visual impairment, severe hearing impairment, and severe breathing difficulty. Physical disability does not affect ability to work. Normal activities of daily living. (rx 5, p 26) Under plan: coal worker's pneumoconiosis ProAir HFA 108 (90 Base) MCG/ACT inhaler, 2 puffs QID prn wheezing, 30 days, 5 refills. (rx 5, p 29) On an office note dated 11/24/2017, functional: physical disability but able to perform usual physical activities for age. Severe visual impairment, severe hearing impairment, and severe breathing difficulty. Physical disability does not affect ability to work. Normal activities of daily living. (rx 5, p 35) Under plan: coal worker's pneumoconiosis ProAir HFA 108 (90 Base) MCG/ACT inhaler, 2 puffs QID prn wheezing, 30 days, 5 refills. (rx 5, p 37) On an office visit of 1/29/ 2015, chief complaint: cough. History of present illness: fever, feeling congested in chest, Cough, coughing up sputum, which is purulent, wheezing. About a month ago he had the flu. However, ever since then his cough and SOB has gotten worse. He doesn't get anything up when he coughs but he is concerned because the SOB is present worsening. (rx 5, p 69) Under review of systems: pulmonary: cough, wheezy and wheezing. (rx 5, p 70) Under plan: acute bronchitis. Under lungs: a decrease in breath sounds was heard. Wheezing was heard. (rx 5, p 71) On an office date of 6/2/2014 under pulmonary: pulmonary symptoms: recent black lung CXR '13. No dyspnea and no cough. (rx 5, p 76) On an office visit of 11/12/2010 under history of present illness: feeling tired or poorly, headache, sinus pain, cough. (rx 5, p 105)

CONCLUSIONS OF LAW

The Arbitrator resolves the issue of occupational disease and causation in Petitioner's favor. The Arbitrator concludes that Petitioner suffers from coal worker's pneumoconiosis (CWP), and COPD in the form of chronic bronchitis and/or reactive airways disease (RAD), each of which was caused by his exposures as a coal miner. He worked as a coal miner for 37 years, and he is a lifelong never smoker. The Arbitrator found Petitioner to be a candid and credible witness.

Petitioner was examined for occupational disease on only one occasion, by Dr. Istanbouly, a Pulmonologist with significant experience treating and examining coal miners and former coal miners in southern Illinois. He is not a b-reader, but he described that he is qualified by his training and experience in reading x-rays for CWP. "I don't use the terminology of a b-reader but I could tell whether it's positive or negative. I would develop, based on hundreds of cases, my personal opinion. I'm a pulmonologist. I was trained to read chest x-rays and I have been evaluating coal miners for 14 years by now. So based on my personal experience and based on my previous training I could have an impression on each chest x-ray whether it's positive or not. But the b-reader, the details of the b-reader, I will leave for someone else." Dr. Istanbouly described the pathology of COPD. "So COPD mainly we are talking about chronic inflammation of the tiny small airways of the lungs related to multiple irritants including nicotine tars and coal dust...This chronic inflammation will induce eventually irreversible narrowing of the tiny small airways with air entrapment behind it. The air entrapment eventually will lead into destruction of the alveoli walls and cause the emphysema which is the hyperinflation of the lungs." The Arbitrator notes that hyperinflation was seen on Petitioner's chest x-ray not only by Dr. Istanbouly, but by Dr. Youssef when reading for NIOSH and also when reading for Dr. Alexander and the Harrisburg Medical Center for treatment purposes. In addition, Dr. Smith found questionable blebs or bullae in the right upper to mid lung, which Dr. Istanbouly described as being consistent with emphysema.

Dr. Istanbouly testified that his diagnosis of CWP was based on more than just the chest x-ray. As he does the majority of his black lung examinations for the Department of Labor, (DOL) he used the DOL definition of CWP, which includes not just medical CWP, but also COPD, emphysema, chronic bronchitis, and reactive airways disease if such are related to the patient's coal mine exposures. He testified that all these diseases fall under the heading of CWP, and in light of the PFTs obtained from Petitioner, he testified that the diseases were in their early stages. "I get detailed history. And as you see, as detailed as I could, because I know someone will come after me, question me...So it's not fair for this patient after all these years of coal dust exposure, after a positive chest x-ray, after all these symptoms, to claim he does not have anything wrong with his lungs. But I specify based on normal PFT it's got to be early stage."

Regarding chronic bronchitis, Dr. Istanbouly testified that Petitioner related chronic cough by definition. He testified that he knew that Dr. Alexander diagnosed Petitioner with chronic bronchitis, because he was treating Petitioner with Albuterol, a treatment Dr. Istanbouly agreed with. He further described the difference between his diagnoses and those of a physician making his diagnoses based solely on x-rays. "To me it should be specific now. You cannot

compare apples to oranges. The radiologist makes all his decisions based on the x-ray. Me, I'm a clinician. I make my diagnoses based on the history, physical examination, seeing the patient, looking at the PFTs, looking at the x-ray. So you cannot compare my assessment to the radiologist's assessment. They did not do clinical evaluation."

The Arbitrator notes the logic of Dr. Istanbouly as well as his description of the completeness of his examination, based not just on the testing and the x-ray, but also on the patient history and physical examination. Dr. Rosenberg did not have the benefit of a patient history nor a physical examination. He testified that he never met Petitioner. He also testified that he has no reason to doubt Dr. Istanbouly's report of the patient history he took. He admitted that Dr. Istanbouly's patient history documented that at least near the end of his coal mining career, Petitioner was working six days per week with 12-hour shifts, meaning that he had an exposure ratio of 1.8 to 1. Every week of coal mine work equaled 1.8 weeks of coal mine dust exposure in the case of Petitioner. He admitted that this excess exposure beyond a regular work week would increase Petitioner's risk for pulmonary disease.

Dr. Rosenberg admitted that Petitioner is a lifelong never smoker, and that he takes the prescription medication Albuterol. He agreed that hyperinflation, as seen on chest x-ray, can be consistent with COPD, and that a person can have early COPD which manifests itself pathologically or radiographically but is not yet severe enough to be apparent on PFTs. This is consistent with the way that Dr. Istanbouly described Petitioner's lung diseases. Dr. Rosenberg then described the progression of COPD which can make this possible: When a person develops COPD, first there would be changes in the architecture of the lung or pathologic changes at the tissue level. Then, as it becomes more severe, it would begin to show up on PFTs. The Arbitrator notes that in the treatment records, there is an entry showing that Dr. Youssef, while reading a CT of the abdomen, found the lower lung zones to show atelectasis and/or fibrosis in both lower lung zones. Dr. Rosenberg testified that fibrosis at the lung bases could be consistent with CWP.

In weighing the opinions of Dr. Istanbouly against those of Dr. Rosenberg, the Arbitrator notes that Dr. Rosenberg did not perform a patient history of Petitioner, and that he testified that he had no reason to disagree with the patient history taken by Dr. Istanbouly. This patient history is the basis for Dr. Istanbouly's diagnosis of chronic bronchitis. The Arbitrator further notes that Dr. Istanbouly's examination was a complete black lung examination, but that of Dr. Rosenberg was only a records review. Dr. Istanbouly testified that his diagnoses were based on the totality of his examination. Dr. Rosenberg's report was based on far less.

In addition, Dr. Rosenberg's review of records was not complete. The records of treating physician, Dr. Alexander, and the Harrisburg Medical Center contain the following, none of which were in Dr. Rosenberg's report. On 1/14/19, CWP was listed under "Active Problems" and the chief complaint included cough and other symptoms. Petitioner was prescribed Proair HFA and Stiolto Respimat. He was listed as a never smoker who was working full-time, and was found to have severe breathing difficulty, but that his physical disability did not affect his ability to work. Under "Plan" was listed CWP, Prednisone, Cerfuroxime, and Tussionex. Auscultation of the chest revealed diffuse inspiratory wheezing. A chest x-ray, taken due to the cough showed no active disease. CWP was again found to be an active problem on 12/3/18,

10/4/18, 6/11/18, and 4/4/18. A note of 7/3/18 by Elizabeth Eversmann said that due to his Black Lung, Petitioner "should not be working in or around dusty conditions." CWP was also listed in the "Plan" of 11/24/17. During these visits, Petitioner was repeatedly prescribed one or more of Proair, Stiolto Respimat, and Levaquin. An entry of 9/29/15 refers to the lungs being hyperinflated and unchanged compared to the prior study. An entry from 2/22/15 described Dr. Youssef's reading of a CT of the abdomen to include mild dependent atelectasis and/or fibrosis in both lung bases. An entry of 1/29/15, which contained a chief complaint of cough, listed the reason for the visit to be an Upper Respiratory Infection with productive cough and wheezing. The cough and shortness of breath were described as existing for a month and getting worse. Physical examination of the lungs showed decreased breath sounds and wheezing, and the Assessment was acute bronchitis. It was noted that the chest x-ray appeared to have chronic changes, but the physician didn't have a past film to compare it to.

Of all the above entries, the only ones noted by Dr. Rosenberg in his report were partial descriptions of the entries of 1/29/15, and 2/25/25. It may be argued that Dr. Rosenberg wrote his report on 8/9/17, before many of these entries were made; however, this excuse cannot be genuine. Respondent must be aware that Petitioner's date of last exposure was 2/6/16, and his Section 1(f) period didn't run until 2/5/18. The fact that Respondent decided to end its inquiry into Petitioner's medical records prior to the running of the relevant date described in the statute cannot be held against the Petitioner. There was no need to rush development. The Arbitrator also notes that if Respondent had waited until Section 1(f) had run before analyzing the medical records, it would have found that the diagnosis of CWP had begun to appear in the treatment records, and it might have continued to monitor Petitioner's condition or develop further evidence to account for the entries of CWP in the treatment records through 2019. For its own reasons, Respondent determined to have a limited report with no examination---even though it was aware that some of the diagnoses of Dr. Istanbouly depended on a patient history. It decided to end development prior to the running of Section 1(f). It decided to limit the treatment records it made available to Dr. Rosenberg. And it seemed satisfied with Dr. Rosenberg's review of the medical records even though it left out many relevant entries. Dr. Rosenberg's records review also omitted references to entries prior to 2010. Such earlier records included repeated entries of cough and prescriptions for it. Entries of 4/18/07 and 2/20/97 included treatment diagnoses of "bronchitis." These diagnoses were not for "acute bronchitis," and provide support for Dr. Istanbouly's diagnosis of chronic bronchitis. Whether Dr. Rosenberg was not provided with those records or whether he neglected to include them is unknown, but it requires that the opinions of Dr. Rosenberg be given less weight than those of Dr. Istanbouly.

In a similar fashion, Respondent determined it would not enter any x-rays into evidence which would cover the entire period described by Section 1(f). The universal testimony provided that CWP could first manifest itself on x-ray years after the date of last exposure. Petitioner's Section 1(f) period ran on 2/5/18. As a result, x-rays taken prior to the running of Section 1(f) cannot answer whether Petitioner's CWP first manifested itself on x-ray *prior to* the running of Section 1(f) and *after* the date of the last x-ray. Dr. Rosenberg and Dr. Meyer read x-rays taken on 9/25/15 and 9/8/16. The first was taken while Petitioner was still working 72 hours a week as a coal miner, and the second was taken almost 1 1/2 years prior to the running of Section 1(f). Even if such x-rays were properly read as negative, they would only be relevant regarding the question of the existence of CWP on 9/8/16. As was mentioned earlier, the

treatment records contain repeated diagnoses of CWP *after* 9/8/16. Again, it was Respondent's decision to enter no x-ray readings on or after the relevant date of 2/5/18. It was under no compulsion to do so. In its rush to end development, it left itself with no evidence to argue that Petitioner did not have CWP by x-ray on 2/5/18. The Arbitrator notes that in addition to the shortcomings of Respondent's development listed above, both Dr. Meyer and Dr. Rosenberg testified that notwithstanding their negative readings, Petitioner could still have CWP. They both admitted that no negative x-ray can ever prove an absence of CWP. No expert in this record testified that Petitioner could not have CWP.

The Arbitrator notes that the issue at stake is "CWP," not "radiographic CWP," not "clinically significant" CWP, and not "physiologically significant" CWP. Our Appellate Court has noted that CWP is a slowly progressive disease which is composed of abnormalities consisting of coal mine dust wrapped in scar tissue and surrounded by emphysema. There is no cure for it; it results in an impairment in the function of the lung at the site of the scarring, whether such can be measured by testing or not; and the sufferer cannot return to the environment of a coal mine without endangering his health.

The Arbitrator turns to the deposition of Respondent's b-reader/radiologist, Dr. Meyer, to describe the significance of the disease of CWP in this case. Having no medical evidence at all, it would still be more likely than not that Petitioner could have CWP. Dr. Meyer cited studies showing that at autopsy, 50% or more of long-term coal miners have CWP that can be diagnosed pathologically. And he said that there are older studies that show a much higher incidence than that. The Arbitrator notes that Petitioner worked as an underground coal miner for 37 years. This qualifies him as a long-term coal miner. Dr. Meyer further testified that it is possible for a miner to have CWP determined by pathology that was not appreciated on a radiographic study.

Dr. Meyer defined the difference between a positive x-ray and a negative x-ray when looking for CWP. If you have read an x-ray to be positive and the miner has a sufficient history of exposure to cause CWP, that would warrant a diagnosis of CWP; however, if you find the x-ray to be negative, that doesn't necessarily rule out the existence of CWP. Specifically, with regard to his negative b-reading in this case, he testified that such would not rule out the possibility that at autopsy or pathology, there may be found CWP. "It's possible to find coal macules with a negative x-ray." Regarding the nature of pathologic CWP, he testified that the abnormalities found pathologically which were not found radiographically would still have the same constitution as the macules or nodules that would show up on x-ray, just perhaps smaller, but they would still be subject to potential progression as any other CWP abnormality might be. He added that not all miners have the same reaction to coal mine dust. It is possible for a miner to work 30 to 40 years in a mine, develop radiographically-significant CWP, but not have it manifest itself until the last year or even the first year after he leaves the mine. Further, when a miner has CWP that progresses, the rate of that progression would vary from miner to miner, as would the exact shape, size, and location of the macule. These things would also vary within an individual miner. In terms of the miner's awareness of his CWP, Dr. Meyer said that a miner with 1/0 CWP probably won't know he has it, and he won't complain to his doctor. He said it is similar to prostate cancer or colon cancer in that most people won't have any idea that they have it until they take the appropriate test and get the diagnosis. As to the specific nature of the exposure of a coal miner, he testified that the body's ability to clear the dust is important, but that

the amount of dust in the lung can be as much as one-half the total weight of the lung itself. He added that with mixed dust exposure, including silica, there is much more toxicity. The Arbitrator notes that Petitioner's unrebutted testimony is that he was exposed to silica in his mining work. Dr. Meyer said that if he reads the x-ray positive, entries in treatment records of clear lungs wouldn't change his diagnosis. Pulmonary function tests, be they good or bad, wouldn't have a bearing. And complaints of shortness of breath or a failure to find shortness of breath would have no effect on the reading of the x-ray.

For all of the above reasons, the Arbitrator finds Dr. Istanbouly's opinions most persuasive and supported by the treatment records. Petitioner has proven by a preponderance of the evidence that he suffers from CWP, COPD, bronchitis, and that these diseases were all related to his coal mine exposures. The Arbitrator finds that each of these diseases causes a tissue change in the airways and/or lungs and thereby results in an impairment of the lungs and/or airways whether or not such results in abnormal PFTs.

The Arbitrator finds Petitioner to be disabled to the extent of 5% of a person as a whole.

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

SALVATORE BUCARO,

Petitioner,

vs. NO: 16 WC 18424

ILLINOIS GUARANTY FUND,

Respondent.

20IWCC0327

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 vocational rehabilitation and expenses 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 Commission modifies the Arbitrator's Decision and finds that Petitioner was entitled to the vocational rehabilitation services rendered by Kathy Mueller of Independent Rehab Services from October 25, 2016 through April 24, 2017.

In a compensable workers' compensation claim, Section 8(a) of the Act provides that "[t]he employer shall also pay for treatment, instruction and training necessary for the physical, mental and vocational rehabilitation of the employee." *820 ILCS 305/8(a)*. Our Supreme Court stated in *National Tea Co. v. Indus. Comm'n*: "Generally, a claimant has been deemed entitled to rehabilitation where he sustained an injury which caused a reduction in earning power and there is evidence rehabilitation will increase his earning capacity." 97 Ill. 2d 424, 432 (1983). Related factors include a claimant's potential loss of job security due to a compensable injury or the likelihood that he will be able to obtain employment upon completion of his training. *Id.* In contrast, rehabilitation awards have been deemed inappropriate where the claimant unsuccessfully underwent similar treatment in the past, where he received training under a prior rehabilitation program which would enable him to resume employment, or where he is not 'trainable' due to age, education, training, and occupation, or where claimant has sufficient skills to obtain employment without further training or education. *Id.* Other factors outlined in *National Tea* include 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. *Id.* at 433. The Commission's Decision must be supported by the record and not based on mere speculation or conjecture. *Sisbro, Inc. v. Indus. Comm'n*, 207 Ill. 2d 193, 215 (2003).

Petitioner herein, was a 49-year-old, union elevator mechanic and working foreman, who injured his left shoulder while lifting a 250-275 pound elevator cab with his colleagues. As a result of his injury, Petitioner required four injections, two surgeries, and was eventually released with permanent restrictions. Dr. Verma, who was Respondent's Section 12 examiner and later became Petitioner's treating surgeon, determined that Petitioner had reached maximum medical improvement (MMI) on September 23, 2016, and released Petitioner with permanent restrictions per the valid functional capacity evaluation (FCE) Petitioner had completed on August 23, 2016. Dr. Verma gave Petitioner restrictions of floor to waist occasional lift at 70 pounds, 12" to waist occasional lift at 85 pounds, waist to shoulder occasional lift at 60 pounds, overhead occasional lift at 50 pounds, and overhead frequent lift at 25 pounds. Petitioner requested in writing that his employer either accommodate his permanent restrictions or commence vocational rehabilitation services.

After receiving no response from his employer, Petitioner then hired Kathy Mueller of Independent Rehab Services and underwent an initial assessment on October 28, 2016. Ms. Mueller noted the results of Petitioner's FCE in her November 30, 2016 report, and indicated that Petitioner had the ability to perform medium-duty work with two-handed occasional lifting from floor to waist up to 70 pounds and a two-handed occasional waist to shoulder lift of 50 pounds. The FCE report indicated that Petitioner's job was in the heavy physical demand level.

Ms. Mueller further noted in her report that according to the Dictionary of Occupational Titles, the position of elevator mechanic/foreman-in-charge was considered to be in the medium category of physical demands, with lifting, carrying, pushing, and pulling up to 20-50 pounds on an occasional basis, 10-25 pounds frequently, and up to 10 pounds constantly. Notwithstanding this, she noted that Petitioner's position with First Priority, his contracted position through ThyssenKrupp at the time of the accident in April 2013, had different requirements. Ms. Mueller

had the opportunity to review the physical demand analysis for an elevator mechanic and helper from ThyssenKrupp Elevator Corporation. She noted that Petitioner's job duties required continued lifting up to 50 pounds, frequent lifting of 51-74 pounds, and occasional lifting of 75-100 pounds. After reviewing Petitioner's personal and socioeconomic information, medical history, current medical status, education, and work history, Ms. Mueller opined that Petitioner was unable to return to his position with First Priority as the physical demands were outside of the permanent restrictions outlined in the FCE. Petitioner demonstrated that he was physically able to occasionally lift 50 pounds which did not meet the demand of occasional lifting of 75-100 pounds.

Ms. Mueller offered a vocational rehabilitation plan that included training opportunities as an elevator inspector, vocational testing, job readiness preparation, job seeking skills training, and job placement assistance. Ms. Mueller indicated that Petitioner would be able to obtain employment upon completion of training.

The Commission finds that Petitioner was entitled to vocational rehabilitation services as the evidence demonstrated Petitioner's potential loss of job security due to a compensable injury and there was a likelihood that Petitioner would be able to obtain employment upon completion of his training. There is no evidence in the record that Petitioner had previously participated in any vocational rehabilitation. There is also no indication that Petitioner was not "trainable" due to age, education, training, and occupation, or that he had sufficient skills to obtain employment without further training or education. Petitioner had a high school diploma and he went through elevator trade school. As of the date of arbitration, Petitioner had worked as an elevator mechanic for 30 years.

Petitioner worked with Ms. Mueller from October 28, 2016 through March 16, 2017. According to Ms. Mueller's April 24, 2017 report, Respondent Illinois Guaranty Fund had stepped in. Vocational rehabilitation services were suspended for the time being until authorization was received from the new provider. Once authorization was obtained, the plan was to continue with job placement services. However, Petitioner found work on his own and through a friend in April/May 2017 with Smart Elevators. As of the date of arbitration, Petitioner was working for Smart Elevators and had been working for them for nearly two years. Petitioner had the same job title and increased pay due to union scale, but his position was within his permanent restrictions.

The Arbitrator had found Petitioner not credible in his efforts to return to work. However, the evidence demonstrated that Petitioner in fact undertook efforts to return to work and increase his earning capacity through rehabilitation efforts as well as his own connections. Petitioner had testified that with restrictions, he was unable to return to work as an elevator mechanic with First Priority Elevator/ThyssenKrupp. In fact, throughout the pendency of Petitioner's treatment, his employer did not or could not accommodate any of Petitioner's work restrictions. Nevertheless, the Arbitrator found, *inter alia*, that despite Petitioner's injury, Petitioner returned to work with an identical job title and higher earnings and was therefore not entitled to vocational rehabilitation services. The Commission disagrees with the Arbitrator's conclusion as Petitioner's entitlement to vocational rehabilitation should not be determined by the end result achieved by Petitioner's efforts to look for work; the very purpose of vocational rehabilitation is to ultimately find suitable employment.

20IWCC0327

Therefore, the Commission reverses the Arbitrator's Decision with respect to this issue and finds that Petitioner was entitled to the vocational rehabilitation services rendered and that Respondent shall pay for such services through April 2017.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, filed June 5, 2019, is hereby modified as stated above, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner permanent partial disability benefits of $712.55 per week for 100 weeks because the injuries sustained caused twenty-percent (20%) loss of use of the person as a whole under Section 8(d)2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner was entitled to the vocational rehabilitation services rendered. Respondent shall pay the vocational rehabilitation invoice through April 2017, totaling $6,794.22 pursuant to Section 8(a) of the Act.

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

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

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 the Circuit Court.

DATED: JUN 15 2020

D. Douglas McCarthy

DDM/pm
O: 5/6/2020
052

Stephen J. Mathis

DISSENT

I concur with the Majority's decision save its award of vocational rehabilitation expenses and its award of 20% loss of use of the person as a whole pursuant to Section 8(d)2 of the Act. As to these issues, I respectfully dissent.

Vocational Rehabilitation Expenses

Petitioner, a union elevator mechanic injured his left shoulder while building an elevator cab. T. 12-13. Following a course of treatment including surgery, Dr. Verma placed Petitioner at

maximum medical improvement on September 23, 2016 and released Petitioner to return to work within the parameters of the August 23, 2016 FCE, which found Petitioner capable of returning to work at medium demand level. RX5, PX5. It further found Petitioner failed to meet all the requirements necessary to return to his prior occupation; the report reflects this finding was based solely on Petitioner's description of his job duties, although Petitioner's own vocational expert concluded his occupation fell into the medium demand level. PX10.

Petitioner did not return to work for Respondent. Petitioner testified in order to obtain new employment, he need only contact his local union and request job placement, yet Petitioner failed to do. T. 50. Instead, at the direction of his attorney, Petitioner sought the services of Ms. Kathleen Mueller with whom he met with on five occasions. PX10. At Ms. Mueller's direction, Petitioner applied for various positions few of which were associated or consistent with his prior occupation as a union elevator mechanic and his known skill set. *Id.*

In May of 2017, without the assistance of Ms. Mueller, Petitioner obtained employment in his prior occupation as a union elevator mechanic. T. 19. Petitioner testified he earns more currently than prior to his injury. T. 20.

As the Majority aptly noted, in the seminal case of *National Tea Co. v. Industrial Commission*, the Supreme Court of Illinois established the underlying standard for an award of vocational rehabilitation services, holding "a claimant has been deemed entitled to rehabilitation where [*he*] sustained an injury which caused a reduction in earning power and there is evidence rehabilitation will increase [*his*] earning capacity." 97 Ill. 2d 424, 432, 454 N.E.2d 672 (1991). Thusly, the Commission is tasked with weighing certain factors which either substantiate or mitigate the award of vocational services as "the employer is required to 'underwrite' the expenses attendant to rehabilitation, it is essential that any program selected be reasonable and realistic." *Id.* at 433. Moreover, as noted by the Majority, one of the factors to be weighed is whether a "claimant has sufficient skills to obtain employment without further training or education." *Id.*

In the present matter, Petitioner was released to return to work albeit with some restrictions placing him at the medium work level which appears to correspond to his prior job duties. Even leaving such possible discrepancy aside, Petitioner testified in order to obtain employment in his trained profession of 30 years as a union elevator mechanic, he merely needed to contact his union and request job placement. Despite possessing this knowledge, Petitioner simply chose not to ask for a job. The Majority completely ignores this unequivocal testimony and instead focuses on Respondent's alleged failure to accommodate Petitioner's "restriction" which appears to be the main basis for their award of the vocational expenses. This focus ignores the undeniable fact that the vocational services provided by Ms. Mueller in no way helped or led to Petitioner's eventual attainment of employment.

Petitioner chose to embark on an unnecessary course of vocational rehabilitation which virtually ignored all his prior experience and skills. When Petitioner decided to redirect his job search (which coincidentally coincided with Respondent's bankruptcy and therefore the interruption of Petitioner's benefits) to include his skill set and experience as a union mechanic, he immediately found a job within his prior vocation earning more than prior to his injury. As

such, I would affirm the Arbitrator's well-reasoned denial of the vocational rehabilitation expenses.

Permanent Partial Disability

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 view the factors differently from the Majority.

Section 8.1b(b)(i) – impairment report

Dr. Heller evaluated Petitioner and found an impairment rating of 2% of the whole person pursuant to the AMA guidelines. I afford some weight to this factor as being indicative of reduced permanent disability.

Section 8.1(b)(ii) – occupation of the injured employee

Petitioner was a union elevator mechanic. He did not return to his pre-injury job with Respondent but found a new job as a union elevator mechanic. I afford significant weight to this factor as being indicative of reduced permanent disability.

Section 8.1(b)(iii) – age of the employee at the time of the injury

Petitioner was 49 years old on the date of his accidental injury. I note Petitioner has numerous years of his work-life and will, therefore, face his residual disability for a sustained period. I afford some weight to this factor as being indicative of increased permanent disability.

Section 8.1(b)(iv) - future earning capacity

Petitioner returned to work following his injury in his same occupation earning more than prior to his injury. I afford some weight to this factor being indicative of a reduced permanent disability.

Section 8.1(b)(v) – evidence of disability corroborated by treating medical records

Petitioner underwent two arthroscopic shoulder surgeries, October 15, 2015 and June 30, 2016 performed by Dr. Chhadia and Dr. Verma, respectfully. Following the second surgery, Petitioner was released to return to work with medium level restrictions. Petitioner testified to restricted motion and pain in his left shoulder. T. 23-24. The FCE performed on August 23, 2016 documented similar findings. PX5. Petitioner testified, though, he has sought no medical treatment since his final visit with Dr. Verma on September 23, 2016. T. 30. I find these facts evidence a

positive surgical outcome, and, therefore, I afford some weight to this factor being indicative of an increased permanent disability.

Based on the above, I find Petitioner sustained permanent partial disability to the extent of 15% loss of use of the person as a whole pursuant to Section 8(d)2 of the Act.

For the reasons stated above, I respectfully dissent.

L. Elizabeth Coppoletti

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BUCARO, SALVATORE
Employee/Petitioner

Case# **16WC018424**

ILLINOIS GUARANTY FUND
Employer/Respondent

20IWCC0327

On 6/5/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.25% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1747 LAW OFFICES OF MARK N LEE LTD
1101 S SECOND ST
SPRINGFIELD, IL 62704

1886 LEAHY EISENBERG & FRAENKEL
PETER SINK
33 W MONROE ST SUITE 1100
CHICAGO, IL 60603

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Salvatore Bucaro,
Employee/Petitioner

v.

Illinois Guaranty Fund,
Employer/Respondent

Case # **16** WC **18424**

Consolidated cases: _____

20IWCC0327

An *Application for Adjustment 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, IL**, on **February 22, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury? ***Nature & Extent***
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. [x] Other **Is Petitioner's vocational rehab specialist a retained expert or treater / was Petitioner entitled to vocational rehabilitation?**

FINDINGS

On the date of accident, **04-22-2013**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**121,534.40**; the average weekly wage was $**2,337.20**.

On the date of accident, Petitioner was **49** years of age, ***married*** with **1** dependent children.

Respondent ***has*** paid all reasonable and necessary charges for all reasonable and necessary medical services and none are outstanding.

Respondent shall be given a credit of **$114,327.06** for TTD, **$0** for TPD, **$0** for maintenance, and **$0.00** for other benefits, for a total credit of **$0**, representing 86.61 weeks. Respondent shall receive credit for any and all amounts paid on this claim to or on behalf of Petitioner.

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

ORDER

PETITIONER HAS PROVEN BY A PREPONDERANCE OF THE CREDIBLE EVIDENCE THAT HIS CURRENT CONDITION OF ILL-BEING REGARDING HIS LEFT SHOULDER IS CAUSALLY CONNECTED TO THE AGREED ACCIDENT SUSTAINED ON APRIL 22, 2013.

PETITIONER HAS PROVEN BY A PREPONDERANCE OF THE CREDIBLE EVIDENCE THAT HE SUSTAINED PERMANENT PARTIAL LOSS OF USE TO THE PERSON AS A WHOLE UNDER SECTION 8(D)2 OF THE ACT TO THE EXTENT OF 20% (100 WEEKS) THEREOF AT THE PPD RATE OF $712.55 PER WEEK, AS A RESULT OF INJURIES SUSTAINED TO HIS LEFT SHOULDER.

PETITIONER FAILED TO PROVE ENTITLEMENT TO VOCATIONAL REHABILIATION SERVICES AND PAYMENT UNDER SECTION 8(A) OF THE DISPUTED VOCATIONAL REHABILITATION INVOICE IN THE AMOUNT OF $6,794.22 AS FOUND IN PX 10; THEREFORE PAYMENT OF THOSE SERVICES 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

June 4, 2019

Signature of Arbitrator Robert M. Harris — Dated

JUN 5 - 2019

State of Illinois)
) SS
County of Cook)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Salvatore Bucaro,	)		
	)		
Petitioner,	)		
	)		
Vs.	)	**No.:**	**18 WC 018424**
	)	**Arbitrator:**	**Robert M. Harris**
First Priority Elevator,	)	**Hearing:**	**02/22/19**
	)		**Chicago, Illinois**
Respondent.	)		

MEMORANDUM OF DECISION OF ARBITRATOR

STATEMENT OF FACTS

Petitioner's Testimony:

On February 22, 2019, the trial in the above matter was held in Chicago in front of Arbitrator Robert M. Harris. At trial the only disputed issues in the claim were whether Petitioner's current condition of ill-being is causally related to the agreed accidental injury (See Exhibit, Page 6) only as it relates to the issue of nature and extent (Exhibit, Page 6). The parties agreed that the AWW pursuant to Section 10 of the Act was $2,337.20; that all medical bills have been paid; that there is no issue as to 8(j) credits for the Respondent; and that there were no outstanding claims for additional bills (Exhibit, Page 8). All temporary total disability payments were appropriately made totaling $114,327.06, representing 86.61 weeks.

Petitioner testified that on April 22, 2013 he was employed as an Elevator Mechanic for First Priority Elevator. (Transcript, page 11). Petitioner had been so employed for up to 27 years at the time of the accident. (Transcript, page 12). Petitioner was a member of a Labor Union, the International Union of Elevator Constructors, Local 2. (Transcript, page 12). At the time of the accident Petitioner testified, "*we were building the cab, and it's a heavy piece. It's about 250, 275 pounds.....and...somebody shifted or slipped, and all the weight went onto me; and I felt something in my shoulder tear or pop*". (Transcript, page 13). Petitioner ultimately underwent surgery to repair his left rotator cuff with Dr. Chhadia. (Transcript, page 14). Petitioner continued to have problems with it after this surgery. (Transcript, page 15). Petitioner then began to treat with Dr. Verma, who had done a previous IME on him. (Transcript,

page 15). Dr. Verma prescribed and performed a second surgery to Petitioner'ss left shoulder. (Transcript, page 15). After physical therapy, Petitioner underwent a Functional Capacity Evaluation, which placed permanent restrictions on him. (Transcript, page 16). Dr. Verma released Petitioner with those restrictions and his attorney requested that First Priority Elevator return him to work within those restrictions. (Transcript, page 16). Petitioner testified no one from First Priority Elevator contacted him to return him to work. (Transcript, page 16).

Thereafter, Vocational Rehabilitation Services were requested of Respondent, but were not provided. (Transcript, page 17). The last time Petitioner looked for a job was when he got out of high school. (Transcript, page 17).

On cross-examination, Petitioner testified that at as a journeyman for Local Union 2, he can simply report to the union and ask that they place him somewhere. (Transcript, page 50) Petitioner did not request the Union to do this at any time after his release from medical care. (Transcript, page 50) Petitioner testified that rather he and his attorney retained the services of Kathy Mueller of Independent Rehab Services. (Transcript, page 17) Petitioner and Mueller met several times, she made up a resume for him, and he began a job search which did ***not*** include looking for a job in the elevator trades. (Transcript, page 18) This was corroborated on cross-examination when Petitioner further testified again, that at no time after his injury did he ever go to his Union and ask them to place him onto another job. (Transcript, page 50) In April of 2017 Petitioner became aware that AmTrust Insurance was going through "*problems*" and he continued to look for work. (Transcript, page 19). At no time did Petitioner ever report to his Union that he was looking for work to see if he could be placed anywhere in the elevator industry. (Transcript, page 18)

Petitioner was given a job with the assistance of a former co-worker with Smart Elevators as an "*elevator mechanic*". Petitioner found this job in April of 2017 - immediately after he became aware that he may have issues getting his weekly TTD checks. Petitioner testified his friend "*found out that I was having problems because I quit getting paid*". (Transcript, page 19) Petitioner testified his friend "*was worried about me losing my house and making my bills*". (Transcript, page 19). There is no claim at this trial that there are any missing TTD checks. The job Petitioner has today still working for Smart Elevators pays him more than he was paid previously. Petitioner now makes $62.00 per hour, excluding benefits. (Transcript, page 21) Petitioner testified he cannot return to his normal occupation, however, with his restrictions of "*medium*" category work, with floor to waist lifting of 70 pounds and waist to shoulder of

50 pounds. (Transcript, page 21) His new job is "*troubleshooting maintenance", and if something bigger needs to be done, he can call in a repair crew".* (Transcript, page 22)

Petitioner testified that now, "*once I get my arm above my shoulder, it's pretty sharp pain, and even sleeping on his left side, "it wakes me up at night*". (Transcript, page 24) For this pain "*I don't take any kind of narcotics or anything.....just...over-the-counter.....Advil PM or something just to try to sleep at night. But it's always a dull ache*". (Transcript, page 25) Petitioner testified he is right-handed so it was **not** his dominant arm involved. (Transcript, Page 26)

Petitioner agreed that if the medical records reflect that the last day he ever saw a doctor for his left shoulder was September 23, 2016, that would be accurate. (Transcript, page 30) The last time Petitioner was prescribed any kind of medication for his left shoulder would have been sometime prior to this appointment. (Transcript, page 31) Since Petitioner began his new job, he has never had to take a prescription pain medication for his left arm. (Transcript, page 32)

In terms of his job and occupational history, Petitioner served an apprenticeship for four years to be trained as an "***elevator mechanic***". (Transcript, page 33) At the time of his accident, Petitioner's job title was Foreman, Elevator Mechanic. (Transcript, pages 34-36) Today, Petitioner's job title is Foreman, Elevator Mechanic. (Transcript, pages 34-36) Today, while union journeymen make "*scale*", Petitioner actually gets paid a 12% premium even above that due to his foreman status. (Transcript, page 34)

Petitioner discussed his nearly 30-year job at Thyssenkrupp and joint-venture First Priority Elevator with his Vocational Counselor, Kathy Mueller. As a result of their discussions and in fact his own description of his work to her, Mueller's reports indicated that Petitioner's job classification was in the "***medium***" job classification category. (Transcript, page 42, Respondent Group Exhibit 6, Independent Vocational Rehab reports of Kathy Mueller) In her report dated November 30, 2016, Mueller identified that according to the Dictionary of Occupational Titles, Petitioner's job was considered to be in the "*medium*" category of physical demands. (Respondent Group Exhibit 6) Petitioner testified he would not disagree with the findings of his own vocational rehabilitation specialist whom he retained (that is, Mueller). (Transcript, page 43) Mueller specifically went through his prior jobs at First Priority and Thyssenkrupp and identified **both** as "medium" category jobs. (Petitioner's Exhibit 10)

As to hobbies Petitioner testified he can no longer do, fishing was at the very top of his list. (Transcript, pages 43-44) Petitioner has not gone fishing at all since 2016 because "*it hasn't been that*

nice to go fishing"; and, "*I haven't had time*". (Transcript, page 44) When the Arbitrator questioned as to whether he is "*physically able to go fishing*", Petitioner responded "*I haven't tried*". (Transcript, page 44) Petitioner also testified that "*I probably won't try it*; and "*Well I haven't tried fishing. So—*". (Transcript, page 46)

AS TO DISPUTED ISSUE (F) WHETHER PETITIONER'S CURRENT CONDITION OF ILL-BEING IS CAUSALLY RELATED TO THE INJURY, SPECIFICALLY REGARDING THE NATURE AND EXTENT OF THAT CURRENT CONDITION, THE ARBITRATOR FINDS AND CONCLUDES AS FOLLOWS:

Petitioner has proven by a preponderance of the credible evidence a causal connection exists between the agreed accident and his current condition of ill-being as related to his left shoulder, for the reasons set forth below:

> "A causal connection between a condition of ill-being and a work-related accident can be established by showing a chain of events wherein an employee has a history of prior good health, and, following a work-related accident, ***the employee is unable to carry out his duties because of a physical or mental condition***. *BMS Catastrophe v. Industrial Comm'n*, 245 Ill. App. 3d 359, 365 (4th Dist. 1993). "In resolving questions of fact, it is within the province of the [Arbitrator and] Commission to...resolve conflicts in the evidence, assign weight to be accorded the evidence, and draw reasonable inferences from the evidence." *Ghere*, 278 Ill. App. at 847.

The Arbitrator finds and concludes Petitioner's current condition of ill-being (regarding his left shoulder, indicated below) is causally connected to the stipulated accidental injuries sustained on April 22, 2013. The parties stipulated that causation was an issue only in regard to the nature and extent of the injury.

It is the Commission's province to assess the credibility of witnesses, draw reasonable inferences from the evidence, determine what weight to give testimony, and resolve conflicts in the evidence, particularly medical opinion evidence. *Berry v. Industrial Comm'n*, 99 Ill. 2d 401, 406-07, 459 N.E.2d 963, 76 Ill. Dec. 828 (1984); *Hosteny v. Illinois Workers' Compensation Comm'n*, 397 Ill. App. 3d 665, 675, 928 N.E.2d 474, 340 Ill. Dec. 475 (2009); *Fickas v. Industrial Comm'n*, 308 Ill. App. 3d 1037, 1041, 721 N.E.2d 1165 242 Ill. Dec. 634 (1999).

Not only may the Commission decide which medical view is to be accepted, it may attach greater weight to the opinion of the treating physician. *International Vermiculite Co. v. Industrial Comm'n*, 77 Ill.2d 1, 31

Ill.Dec. 789, 394 N.E.2d 1166 (1979); *ARA Services, Inc. v. Industrial Comm'n,* 226 Ill. App. 3d 225, 168 Ill. Dec. 756, 590 N.E. 2d 78 (1992).

At the request of Respondent, Petitioner was examined by two different physicians for the purpose of a Section 12 examination ("IME"). Both of these physicians, both Respondent's examining experts, Dr. Nikhil Verma and Dr. William Heller, opined there was a causal relationship between Petitioner's accident and injury.

Petitioner was first seen by Dr. Ankur Chhadia who, based upon the results of several MRI's and failure of conservative measures, recommended surgery. Prior to this surgical procedure, Petitioner testified he was sent by Respondent for an IME with Dr. Nikhil Verma, an orthopedic surgeon at Midwest Orthopedics at Rush. (Transcript, page 14) Petitioner testified Dr. Verma examined him and that during the examination, Dr. Verma had his medical records. Petitioner testified that after that examination, the surgery recommended by Dr. Verma was approved by the insurance company. (Transcript, page.14)

After his first surgery, Petitioner was examined on June 15, 2016, for a second time by Dr. Verma. In Dr. Verma's report, he wrote, "As you know, I had the opportunity to perform a second opinion evaluation on the above referenced patient in the office today in regard to his left shoulder. The patient was previously seen for an Independent Medical Evaluation exam, at which time, I recommended a surgical procedure. The patient did undergo surgery, and I have reviewed the operative report that indicates rotator cuff repair, subacromial depression, and biceps tenotomy." (PX3)

After this examination, Dr. Verma became Petitioner's treating physician and performed a second surgical procedure.

At Respondent's request, Petitioner was examined again pursuant to Section 12 for an IME by Dr. William Heller, an orthopedic surgeon at Midland Orthopedics. In his deposition, Dr. Heller affirmed his causation opinion that he had originally given in his earlier narrative report. When asked, "You believe there is a causal relationship between the initial injury as Petitioner described to you and the need for the two surgeries correct? Those are connected?" Dr. Heller responded, "Yes." When asked, "So there is a causal relationship there," Dr. Heller responded, "Yes." When asked, "And that would be in agreement with Dr. Verma, correct? I think you referred to his report in your report?" Dr. Heller responded again, "Yes. He did an IME prior to the first surgery and thought that the first surgery was causally linked to the incident of 4-22-13. And I was asked whether I thought the second surgery was a continuation of the first surgery or problem, and I said yes." (RX2p.19)

The Arbitrator places significant weight, reliance and credibility on the opinions of Dr. Verma and Dr. Heller, both of whom - significantly - were retained by Respondent pursuant to Section 12.

The "chain of events" legal theory also supports a finding of causation in this claim: It is well established that prior good health followed by a change immediately following an accident allows an inference that a subsequent condition of ill-being is the result of the accident. *Navistar International Transportation Co. v. Industrial Comm'n,* 315 Ill. App. 3d 1197, 1205 (2000)

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

Petitioner testified that prior to his injury on 4-22-13, he was not having any problems with his left arm. (Tp.13) **No evidence was admitted to the contrary**. Therefore, Petitioner was in relative "good health" relating to his left arm prior to April 22, 2013, as is evidenced by Petitioner's unrebutted testimony and his ability prior to the accident to work full-time and full-duty as an elevator mechanic. Petitioner's average weekly wage prior to the accident was $2,337.20 and is a testament to his ability to work his regular duties.

The parties stipulated Petitioner sustained accidental injuries to his left arm on April 22, 2013. The medical records demonstrate that Petitioner's injury resulted in medical treatment and subsequent disability. Dr. Verma and Dr. Heller, both Section 12 expert evaluators, opined Petitioner's stipulated accident injuries caused the condition to his left arm requiring two surgical procedures. The second surgery was performed by Dr. Verma, who became Petitioner's treating surgeon.

The Arbitrator further notes there has been no superseding or intervening accident to break the chain of causation. The Arbitrator further notes there has been no alternative theory argued with supporting evidence to explain any other etiology.

Petitioner has not seen a physician for his left arm since September 2016 and has not had a prescription for pain prescribed since at some point before that date. Petitioner reached MMI for any injuries he sustained in April 2013 and was released from care on September 23, 2016 by Dr. Verma. The FCE restrictions placed him in the ***medium*** job classification category and specifically included floor to waist lifting occasionally at 70 pounds, 12 inch to waist occasionally at 85 pounds, waist to shoulder at 60 pounds and overhead lifting at 50 pounds. He could frequently lift at 25 pounds at all levels. (Respondent Exhibit 1) Petitioner told IME Dr. Heller those restrictions were not able to be accommodated by his previous employer, yet in his testimony, Petitioner indicated that he never in fact heard back from his employer, that he was waiting for an answer as to whether or not First Priority was going to take him back and that is precisely the reason that he did not go to his Union to seek employment with another elevator company. (Transcript, page 50) Petitioner did not seek employment in his

field until he heard that AmTrust Insurance was going through bankruptcy and that he might not get paid TTD in April 2017. As a result, the Arbitrator notes Petitioner ***immediately*** found work in his field making even a premium over his fellow journeyman elevator mechanics, of ***12% higher pay than the rest of them***.

This begs the question as to whether Petitioner was ever even entitled to Vocational Rehabilitation at all. This is especially so when taken with his own Vocational Rehabilitation Specialist's report dated November 30, 2016 wherein she went over his job duties and determined with him that his prior job was in the "***medium***" job category. Petitioner described to her that before the date of accident, his job was that of "***elevator mechanic***", that he completed training for elevator mechanic in 1988 and that he was trained on the repair of elevators, escalators and moving walkways. (Respondent Exhibit 6) Petitioner's retained Vocational Rehab Specialist compared his description of job duties with the Dictionary of Occupational Titles and determined that an "*elevator mechanic*" "*repairs and maintains elevators, escalators and dumb-waiters to meet safety regulations and building codes, using hand tools, power tools, test lamps, ammeters, voltmeters, and other testing devices: Locates and determines causes of trouble in brakes, motors, switches and signal and control systems, using test lamps, ammeters and voltmeters. Disassembles defective units and repairs or replaces parts, such as locks, gears, cables, electrical wiring and faulty safety devices, using hand tools. Installs push-button controls and other devices to modernize elevators. Lubricates bearings and other parts to minimize friction.* Petitioner's specialist who he described his job to and who researched jobs on his behalf and drew up a resume for him, reported that this job fell into the "***medium category of physical demands***". (Respondent Exhibit 1) As such, Petitioner was actually released to his normal job duties that he performed prior to the date of claimed accident. Petitioner testified he was a foreman before the date of accident with 4 teams underneath him and that he was a foreman after the date of accident with access to call teams in for any physically intensive work demands.

Determination of Petitioner's Permanent Partial Disability:

For accidental injuries that occur on or after September 1, 2011, permanent partial disability shall be established by using 5 factors including the reported level of impairment pursuant to AMA guidelines; the occupation of the employee; the age at the time of injury; the future earning capacity of the Petitioner; and, the evidence of disability corroborated by treating medical records. **820 ILCS 305/8.1(b)** No single enumerated factor shall be the sole determinant of disability but each factor

must be considered and its weight given outlined. *Continental Tire vs. Illinois Workers' Compensation Comm'n,* **43 N.E.3d 556, 397 Ill.Dec. 915 (2015)**

Therefore, going line by line through the requirements which shall be followed to determine permanent and partial disability for a Petitioner pursuant to Section 8.1(b), the Arbitrator finds ans concludes the following:

As to the reported level of impairment pursuant to AMA guidelines:

In Respondent Exhibit 1 Dr. Heller noted he used the AMA Guides to the Evaluation of Permanent Impairment, Sixth Edition, to perform his impairment rating. Utilizing Table 15-5, he selected the appropriate diagnosis of partial thickness rotator cuff tear. Within Class 1, he selected the default extremity impairment value of 3%. This correlated to residual loss with normal motion (Petitioner contradicted this at trial when he testified, "I have quite a bit less motion than before." T.A., 23). This then correlated to a Grade 1 physical examination and did not result in any net modification of the default value. Because Dr. Heller found that clinical studies are not to be utilized as a modifier, the final modification was +1 and the final extremity impairment value therefore 4%. Utilizing Table 15-11, a 4% upper extremity impairment converts to a 2% whole person impairment. Therefore, Dr. Heller found the appropriate whole person value of this claim to be **2% MAW**. The Arbitrator assigns this factor minimal weight.

As to the Occupation of the Employee:

The Arbitrator notes Petitioner holds the identical job title from before the date of accident as he does after his release to MMI and as defined by the Dictionary of Occupational Titles as provided by his Vocational Rehabilitation Counselor, Kathy Mueller. Petitioner confirmed in his testimony at trial his job title is **elevator mechanic**. TA, p. 35. Petitioner himself also testified he was a foreman before the date of accident with 4 teams underneath him and that he is a foreman today. Petitioner indicated he in fact ***makes 12% more than his journeyman elevator mechanic colleagues*** due to his elevated role as a foreman.

Petitioner testified, however, that "*but for*" his friend getting him the job that he has now, he would not be able to work in his field. This is not credible and belies the evidence in this case. Petitioner himself testified he never heard whether or not his first employer was taking him back. **Petitioner confirmed he**

never went to his union to seek work. TA, p. 50. ***The Arbitrator finds this inexplicable.*** Petitioner testified he never sought work in his field at all. ***The Arbitrator also finds this inexplicable.*** Petitioner also testified he got the job he is in now from a man he used to work with at Smart Elevators who offered Petitioner a job as **a maintenance mechanic** when fully aware of his restrictions TA, 19-20. Petitioner testified he has been working at that job since April or May of 2017. TA, 20. It is clear from the evidence and the testimony Petitioner had little trouble landing a job in his usual and customary field of expertise immediately upon actually ***"looking"*. The Arbitrator assigns this factor significant weight.**

Petitioner's Age at the time of his injury:

Petitioner was 49 years old at the time of the injury. He has many years available to his work-life expectancy. There is no evidence in the record that Petitioner's age holds any real significance to a determination of permanent partial disability. The Arbitrator assigns this factor minimal weight.

Future Earning Capacity:

Petitioner testified he is in fact earning more now than his colleagues with the identical qualifications as he gets a 12% premium above journeyman "*pay scale*" as "foreman's pay". TA, 34. Further when asked point blank the question, *"As a result of this accident and your recovery with your shoulder and arm, you did not see a diminution in your ability to earn a living with your elevator union, correct?*

Petitioner responded as follows:

"No, I did see it because if my friend—if the guy that picked me up and hired me didn't hire me, First Priority didn't want me back. Thyssenkrupp didn't want me back because I didn't meet their guidelines". TA, p. 41.

That answer is obviously problematic for several reasons. Petitioner became employed with the identical job title – for the last two full years – and earns union pay scale and ***12% more pay than any other journeyman elevator mechanic***. Therefore, Petitioner cannot realistically and with any sense of credibility claim that he has suffered a diminished earning capacity in his usual and customary trade, or indeed anywhere else. Petitioner has not proven by a preponderance of the evidence any actual or even potential loss, diminishment or impairment of future earning capacity; to the contrary, he continues to earns pay at a premium. The Arbitrator therefore assigns this factor significant weight.

As to Evidence of disability corroborated by the treating medical records:

Dr. Verma is the last doctor Petitioner visited and the only doctor to assess restrictions and what they should be. The only record submitted to assess "*treating physicians*" recommendations are those as listed by Dr. Verma of floor-to-waist lift occasional at 70 pounds, 12 inch to waist occasionally at 85 pounds, waist to shoulder at 60 pounds, and overhead lifting occasionally at 50 pounds. Frequent lifting is at all levels at 25 pounds. Verma then simply stated MMI and had no further discussion as to Petitioner's "*disability*".

The evidence reveals Petitioner is an elevator mechanic and is so right now. The evidence shows unequivocally he is making more money now than he ever did in his career. The evidence shows Petitioner is in the identical trade, with the identical title as he always was – elevator mechanic.

Significantly, the medical records indicate and Petitioner's testimony corroborates he has not seen a single doctor since September 23, 2016 and he has not had a prescription pain medication since before that date. TA, 30-32. Continued treatment and care of a physician would be solid evidence of continued impairment but there is simply nothing here in nearly three years.

Having identified each element as outlined in Section 8.1(b) to consider in order to assess PPD, the Arbitrator finds that the evidence and testimony along with each factor support a determination that Petitioner has sustained the permanent partial disability to the person as a whole pursuant to Section 8(d)2 of the Act to the extent of 20% (100 weeks) thereof. Petitioner sustained a serious left shoulder injury that resulted in permanent restrictions – although not to the proven extent that his restrictions render Petitioner unable to engage or participate in his usual and customary occupation and employment as a union elevator mechanic.

AS TO DISPUTED ISSUE (O) WHETHER THE VOCATIONAL REHABILITATION SPECIALIST KATHY MUELLER IS PETITIONER'S RETAINED EXPERT OR A TREATING PROVIDER, OR ALTERNATIVELY, IF PETITIONER WAS EVEN ENTITLED TO VOCATIONAL REHABILITATION SERVICES, THE ARBITRATOR FINDS AND CONCLUDES AS FOLLOWS:

Regarding the conflicting opinions and evidence herein, the Arbitrator specifically finds and concludes Petitioner has not proven he was entitled to vocational rehabilitation services because he has not proven he was an appropriate vocational candidate nor has he proven he has suffered a "loss of trade" . Further, related to this finding, because vocational services were not proven necessary,

Mueller's bills are not awarded. Lastly, the evidence indicates Petitioner retained Mueller as an expert for the purpose of use in litigation and as such her bills are also denied.

Petitioner through his attorney submitted his Exhibit 10, the Vocational Rehab Reports and bills of Independent Rehab and Kathy Mueller into evidence. Respondent objected to the bills as they had never been tendered prior to the very moment of closing of proofs but that alone is not a basis to deny payment. Respondent contends that Mueller was retained by Petitioner and his attorney in preparation for litigation, specifically, to attempt to allege a wage loss differential claim, by introducing evidence of "*diminished earning capacity*".

In her initial report, Kathy Mueller indicated that she was retained by Attorney Mark Lee and was provided all of the documentation she used by attorney Mark Lee. Mueller indicated in her 11/30/16 report that Petitioner's jobs at First Priority Elevator and at Thyssenkrupp were both in the "***medium***" category job classification. (See Petitioner Exhibit 10, 11/30/16 report, pages 4 and 5.) The November 30, 2016 report did not copy any other individual on it, such as an Employer/Respondent representative, evidencing a "*litigation*" preparation use. A follow up report and rehabilitation plan was drawn up in January, 2017 and is Petitioner' Exhibit 10. It again does not reference an Employer/Respondent interest anywhere within the report—and in fact contains signature lines on the very last page for three people only - Petitioner, his attorney and Mueller. No one else is copied. A January 6, 2017 and February 15th report also attached evidence the exact same lack of any reference to an Employer/Respondent. The insurance company did not in fact announce bankruptcy until at least April, 2017 according to the Petitioner in his testimony (TA 19) and he was getting weekly TTD checks so was well aware as to who the Respondent was. It is not until the 4th such report, issued on 3/15/17, did it get addressed to AmTrust North America. On April 24, 2017 Mueller had indicated that she had been informed that AmTrust had been adjudicated bankrupt and that the claim was being handled through the Illinois Guarantee Fund and that she should suspend her efforts. Along with the above, we know that the Petitioner began working in April 2017. Vocational Rehabilitation would obviously have been inappropriate and unnecessary at that stage. However, the very next act indicates Mueller was a retained expert by Mark Lee in anticipation of litigation.

After the Petitioner had been working for a year and a half, in his field of 30 years, with the identical job title and higher earnings, Mueller met with Petitioner in August 2018, for "*an update regarding his employment status*". Mueller did meet with Petitioner on 8/15/18, knew Petitioner was employed as an

elevator mechanic since at least May of 2017 and wrote her report which indicated exactly what Petitioner testified to on trial, that is, "*but for*" his friend offering him a job Petitioner could not do this line of work ever again. Mueller in fact wrote: *Mr. Bucaro has obtained a unique opportunity through Smart Elevators and his friend. It is this consultant's concern that should Mr. Bucaro lose his current employment, he would not have access to a Viable and Stable Labor Market as an "Elevator* ***Installer****". Mr. Bucaro has physical limitations placed upon him and his ability to perform all aspects of "Elevator* ***Installation****" is limited.*

Mueller for the ***very first time*** in any report changed the job title from that of "*elevator mechanic*" – the specific job title Petitioner testified was his - to "elevator installer". Next in this very same report, Mueller's very last line states very clearly, "*review results of Vocational Update with Attorney Mark Lee to determine if additional services will be requested on the file of Salvatore Bucaro".* That report is not copied to Respondent's counsel or to Respondent. *(Petitioner Exhibit 10, Report dated 8/18/18)*

Acknowledging and using Petitioner's correct job title is obviously significant. It has not been consistently used. The Arbitrator is aware this has been an issue in this claim. One of several such examples is found in Dr. Heller's evidence deposition, where Petitioner's counsel on cross-examination labels Petitioner's occupation as an "elevator constructor" - the **incorrect job title. This has significance.** (Petitioner testified several times he is, and always has been, an "elevator mechanic, e.g., TA, pp. 11-12, 35). **Vocational ability must be assessed applying the correct job title.**

Next, all bills between 10/25/16 and 2/15/16 were only sent to Petitioner's counsel and instructing him as to where to submit payment. No one was copied. 2/16/17 through 4/24/17 only were sent to AmTrust, with none of the prior bills sent to AmTrust or ultimately IIGF. On 8/18/18, all of those bills were sent directly only to Petitioner's attorney, not Respondent, nor Respondent's attorney, and the bulk of those bills are for direct contact with Petitioner's attorney - 8 instances of direct contact with Petitioner's attorney in a one week period in August, again, on the eve of a set Trial on this claim.

A Petitioner is generally entitled to vocational rehabilitation when he sustains a work-related injury which *causes a reduction in his earning power* and there is evidence that rehabilitation will increase his earning capacity. *Greaney v Industrial Comm'n*, 358 Ill. App. 3d 1002, 1019, 832 N.E.2d 331, (2005). If the injured employee has sufficient skills to obtain employment without further training or education, that factor weighs against an award of vocational rehabilitation. *National Tea Company v Industrial Comm'n*,

97 Ill 2d 424, 432, 454 N.E.2d 672 (1983). Rehabilitation is neither mandatory for the employer nor appropriate if an injured employee does not intend, although capable, to return to work. *Schoon v Industrial Comm'n* 259 Ill. App. 3d 587, 594, 630 N.E. 2d (1994).

In this claim, Petitioner testified he is a licensed tradesman, performing the identical job title that he was performing prior to his accident. He is in fact earning more than his colleagues, 12% more as he is a foreman. Petitioner was also a foreman prior to the date of accident, with 4 teams below him. As to going back to his prior employer after reaching MMI, Petitioner indicated that he did not wait to hear if First Priority was going to take him back to work, in fact, he never asked. Petitioner testified he knew he could go directly to his Union Hall and ask to be put to work at another elevator company but never once asked. ***This is inexplicable conduct for a Petitioner claiming to seek employment.*** Petitioner further testified he never asked his Union because he was waiting to hear back from First Priority. This makes little sense (to do nothing, no follow-up, just and wait?) and indicates a lack of credibility and an unwillingness to return to work even though he was released to the medium job category as an elevator mechanic which his own Vocational Specialist indicated was the job category, after sitting with him, discussing his job duties, and researching the Dictionary of Occupational Titles.

Mueller and Petitioner together categorized Petitioner as a licensed "*elevator mechanic*" in each Vocational report, until the very last report, wherein inexplicably Mueller changed Petitioner's title to "*Elevator Installer*". This sudden, new and solitary change is not supported by Petitioner's testimony or any other evidence. It is however important to note, that numerous times throughout direct questioning at trial - Petitioner testified he is a licensed elevator "*mechanic*", but Petitioner was at times referred to as an "*elevator constructor*". (Testimony, Page 21, 22) That was misleading and confusing. Petitioner never called himself an "elevator constructor." Not coincidentally, "elevator constructor" matches the new voc report Mueller issued in apparent preparation for litigation, changing Petitioner's job license, classification and category.

Petitioner had such sufficient skills that he was designated to be a foreman assuming a supervisory role such that the Arbitrator infers he could have obtained suitable employment without further training or education, which he proved he could perhaps not coincidentally at the same time he thought his TTD checks were in danger of being interrupted.

The Arbitrator finds and concludes Petitioner failed to prove he was an appropriate candidate for Vocational Rehabilitation services (especially after he had, on his own, secured suitable gainful employment in his lifelong trade, with a pay raise). Further, it is evident Petitioner had more than sufficient skills, training and experience such that traditional vocational rehabilitation services were not necessary, reasonable or proper for him. Vocational Rehabilitation Services were also inappropriate as Petitioner testified he knew he could go to his Union Hall and ask to be placed somewhere else yet inexplicably failed to do so and never received a rejection from his former employer.

Robert M. Harris

Robert M. Harris, Arbitrator

Dated: May 4, 2019

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Mary Bowles,
Petitioner,

vs.

No: 16 WC 06556

Kraft Foods,
Respondent.

20IWCC0328

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent and Petitioner herein and timely notice given to all parties, the Commission, after considering the issue of 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 18, 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.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $34,000.00. 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 15 2020

Marc Parker

Barbara N. Flores

MP/wj
06/04/20
68

20IWCC0328

DISSENT IN PART AND CONCURRENCE IN PART

I respectfully dissent in part from, and concur in part with, the Decision of the Majority. The Majority affirmed and adopted the Decision of the Arbitrator who found Petitioner sustained her burden of proving that stipulated accidents caused conditions of ill-being of right carpal tunnel syndrome ("CTS"), right cubital tunnel syndrome ("CUTS"), and right lateral epicondylitis. The Arbitrator noted that Respondent had paid all medical and awarded Petitioner 76.225 weeks of PPD representing loss of the use of 12.5% of the right hand and 20% of the right arm. Both parties sought review to the Commission and the only issue presented on review was the nature and extent of Petitioner's permanent disability.

I would have affirmed the portion of the Decision and Award of the Arbitrator regarding Petitioner's CTS condition. That award was relatively standard. However, I would have modified the Decision of the Arbitrator regarding Petitioner's elbow condition by reducing the award from loss of 20% of the right arm to loss of 15% of the right arm. Therefore, I dissent from the Decision of the Majority affirming the Arbitrator's award of loss of 20% of the right arm.

Petitioner had two separate surgeries. On June 2, 2016, Dr. Mall performed debridement of the right lateral epicondyle for epicondylitis. On May 7, 2019, Dr. Kutnik performed right carpal tunnel release, for CTS, and right ulnar nerve neuroplasty for CUTS. In my opinion, the PPD award for Petitioner's arm was based, at least in part, on the fact that she had two separate surgeries on her elbow. In my opinion, that is not a legitimate basis on which to determine a PPD award. Rather, a PPD award must be based on the actual outcome of treatment and her degree of impairment after she reached MMI. Here, Petitioner had an excellent outcome from her surgeries. On August 9, 2019, Dr. Kutnik released her to work at full duty without restrictions as of August 12th only three months after her second elbow surgery. At that time he noted that she had excellent range of motion and could lift 70 pounds. In addition, in my opinion the award should be reduced because she did not establish any loss of income as a result of her injuries. In looking at the entire record, I believe the Arbitrator's award should be reduced from loss of 20% of the right arm to loss of 15% of the right arm.

For the reasons stated above, I concur with the portion of the Decision and Award of the majority affirming the Arbitrator's award of loss of the use of 12.5% of the right hand for Petitioner's CTS condition. However, I would have modified the Decision of the Arbitrator regarding Petitioner's elbow condition by reducing the award from loss of 20% of the right arm to loss of 15% of the right arm. Therefore, I dissent from the Decision of the Majority affirming the Arbitrator's award of loss of 20% of the right arm.

Deborah L. Simpson

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BOWLES, MARY
Employee/Petitioner

Case# **16WC006556**

16WC029246

KRAFT FOODS INC
Employer/Respondent

20IWCC0328

On 12/18/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.55% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0969 RICH RICH COOKSEY CHAPPELL
THOMAS C RICH
6 EXECUTIVE DR SUITE 3
FAIRVIEW HTS, IL 62208

1109 GAROFALO SCHREIBER STORM
JAMES CLUNE
55 W WACKER DR 10TH FL
CHICAGO, IL 60601

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

Mary Bowles
Employee/Petitioner

v.

Kraft Foods Inc.
Employer/Respondent

Case # **16** WC **6556**

Consolidated cases: **16 WC 29246**

20IWCC0328

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael Nowak**, Arbitrator of the Commission, in the city of **Collinsville**, on **10/28/19**. By stipulation, the parties agree:

On the date of accident, **7/23/15**, Respondent was operating under and subject to the provisions of the Act.

On this date, the relationship of employee and employer did exist between Petitioner and Respondent.

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $**39,821.15**, and the average weekly wage was $**765.79**.

At the time of injury, Petitioner was **42** years of age, ***married*** with **one** dependent child.

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

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

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

ORDER

Based on the factors enumerated in §8.1b of the Act, which the Arbitrator addressed in the attached findings of fact and conclusions of law, and the record taken as a whole, Respondent shall pay Petitioner the sum of $**459.47**/week for **74.35** weeks, as provided in Section **8(e)** of the Act, because the injuries sustained caused **12.5 % loss of the right hand (23.75 weeks), and 20 % loss of the right arm (50.6 weeks).**

Respondent shall pay Petitioner compensation that has accrued from **8/9/19** through **10/28/19**, and shall pay the remainder of the award, if any, in weekly payments.

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

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

Michael K. Nowak, Arbitrator

12/10/19
Date

ICArbDecN&E p.2

DEC 18 2019

FINDINGS OF FACT

This matter previously came before an Arbitrator appointed by the Commission on October 26, 2016, on Petitioner's §19(b) Petition following Respondent's dispute of accident, causal connection, liability for medical bills, prospective medical care and TTD in relation to her work accidents of July 23, 2015 and August 12, 2016. (PX8)

On October 20, 2017, the Arbitrator rendered a decision for case number 16 WC 06556 in relation to date of injury July 23, 2015. (PX8, 16 WC 06556) This decision was fully favorable to Petitioner and was affirmed and adopted by the Commission without modification on February 11, 2019. (PX9) Those findings are incorporated herein by reference. Petitioner also filed a claim for an injury date of August 12, 2016, bearing case number 16 WC 29246, which was also tried on October 26, 2016; however, on October 20, 2017, the Arbitrator ruled that Petitioner failed to prove that she sustained accidental injuries in the course of her employment regarding date of injury August 12, 2016, and that it appeared that Petitioner only filed this matter protectively. (PX8, 16 WC 29246) Therefore, case number 16 WC 29246 in relation to injury date August 12, 2016 was concluded.

At Arbitration on October 28, 2019, the parties agreed to proceed using only case number 16 WC 06556, relating to date of injury July 23, 2015. (T. 4, 5) The sole issue at that time being the nature and extent of Petitioner's injuries. (T. 5, 6, 22, 23)

On July 23, 2015, Petitioner was a 42-year-old machine operator for Respondent, and had been working in this capacity for 18 years. (PX8, 16 WC 06556) On that date, Petitioner had been loading pouches into her machine all day when she developed pain at the base of her right thumb that radiated into her wrist and elbow. *Id.* She saw Dr. David Brown and was diagnosed with chronic right lateral epicondylitis. *Id.* Ultimately, Petitioner underwent surgery with Dr. Nathan Mall on June 2, 2016 in the form of a right elbow lateral epicondyle debridement, partial lateral epicondylectomy, microfracture and repair of the ECRL tendon to the lateral epicondyle. *Id.*

Following the hearing on October 26, 2016, Petitioner continued to treat for her symptoms with Dr. Nathan Mall. (PX4, 11/16/16) On December 7, 2016, she returned to him with complaints of right elbow pain and carpal and cubital tunnel symptoms on the right side. *Id.* The physical examination revealed a positive flexion compression test and positive Tinel's sign at the right wrist and elbow. *Id.* Dr. Mall noted that Petitioner brought in a package of the boxes she has to manipulate at work, and Petitioner demonstrated how she did this. *Id.* Dr. Mall felt that this maneuver was likely the source of a lot of her symptoms, and indicated that this type of activity would cause anyone to have symptoms. *Id.*

On April 24, 2019, after the Commission's decision was rendered, Petitioner sought treatment for her symptoms with Dr. Shawn Kutnik. (PX9; PX6, 4/24/19) Dr. Kutnik documented numbness and pain in Petitioner's right hand and arm, wrist and digit pain, burning pain at the elbow and radiation down the fingers and significant nocturnal symptoms. (PX6, 4/24/19) Her symptoms were severe, sharp, burning and aching in quality. *Id.* He noted that she had tried all manner of treatments, including braces, without significant benefit and that her symptoms were aggravated by working with her hands. *Id.* He reviewed an EMG / NCS which was done on April 17, 2019 and demonstrated moderate carpal tunnel syndrome and lower limit functioning of the ulnar nerve. (PX3, 4/17/19; PX6, 4/24/19) His conclusion was that Petitioner had right carpal and cubital tunnel

syndromes, and that her work as a machine operator for upwards of 20 years was a contributing factor in the development of same. (PX6, 4/24/19) He recommended surgical intervention. *Id.*

Surgery was performed by Dr. Kutnik on May 7, 2019 in the form of a right carpal tunnel release and right ulnar nerve neuroplasty in situ. (PX5, 5/7/19) Intraoperatively, Dr. Kutnik noted compression on both the carpal and cubital tunnel regions. *Id.* Following surgery, Petitioner underwent physical therapy. (PX7) Upon completing same, she returned to Dr. Kutnik on August 9, 2019. (PX6, 8/9/19) He noted that she was feeling much better overall, but still had generalized soreness and discomfort. *Id.* She was given a prescription for Meloxicam, a release to return to work full duty as of August 12, 2019 and placed at MMI. *Id.*

At Arbitration, Petitioner testified that she had no intervening accidents between her prior hearing and her most recent surgery. (T. 13) She also testified that she had returned to work for Respondent, but instead of working in the fill room as she had previously, she switched jobs and now works in secondary in order to give her a different range of motion as a result of her injury. (T. 14, 15, 18-21)

Petitioner also testified that she still experiences pain and aching if at the end of a shift if she uses her hands a lot. (T. 15) She uses ice, Aleve and rest to alleviate her symptoms. (T. 15, 16) She also notices difficulty with anything she lifts up. (T. 16)

CONCLUSIONS

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

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

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes Petitioner continues to work for Respondent, but switched jobs from the fill room to secondary in order to give her a different range of motion as a result of her injury. (T. 18-21) She also still experiences pain and aching at the end of her shift. (T. 15) The Arbitrator therefore gives *some* weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 42 years of age at the time of her injury. (AX1) She is a younger individual and must live and work with her disability for an extended period of time. The Arbitrator therefore gives *greater* weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes there is no direct evidence of reduced earning capacity contained in the record. The Arbitrator therefore gives *no* weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes the Petitioner was a credible witness. As a result of her work injuries, Petitioner

developed chronic right lateral epicondylitis, right carpal tunnel syndrome and right cubital tunnel syndrome. (PX8, 16 WC 06556; PX6, 4/24/19) Petitioner managed her condition conservatively with ice/heat, over-the-counter medications, an elbow strap, physical therapy, splints and injections. (PX8, 16 WC 06556) After failing conservative treatment, she underwent a right elbow lateral epicondyle debridement, partial lateral epicondylectomy, microfracture and repair of the ECRL tendon to the lateral epicondyle with Dr. Mall on June 2, 2016, and a subsequent right carpal tunnel release and right ulnar nerve neuroplasty in situ on May 7, 2019 with Dr. Kutnik. (PX8, 16 WC 06556; PX5, 5/7/19) Although her surgeries helped her condition greatly, Petitioner still experiences pain and aching if at the end of a shift if she uses her hands a lot. (T. 15) She uses ice, Aleve and rest to alleviate her symptoms. (T. 15, 16) She also notices difficulty with anything she lifts up. (T. 16) The Arbitrator therefore gives *greater* weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 12.5% loss of use of the right hand and 20% loss of use of the right arm pursuant to §8(e) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Sheila Eaton,

Petitioner,

vs.

No. 10 WC 25336, consolidated w/
11 WC 32885

Morris Hospital,

Respondent.

20IWCC0329

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, prospective medical, temporary disability, permanent disability, penalties and attorney's fees, and being advised of the facts and law, affirms and adopts those parts of the Decision of the Arbitrator which relate to claim number 10 WC 25336, attached hereto and made a part hereof. The Commission is issuing a separate decision for Petitioner's carpal tunnel companion claim, number 11 WC 32885, which was tried concurrently with this claim.

IT IS THEREFORE ORDERED BY THE COMMISSION that those parts of the Decision of the Arbitrator filed July 16, 2019 which relate to claim number 10 WC 25336 are hereby affirmed and adopted. No penalties or attorney's fees relating to Petitioner's companion claim for carpal tunnel syndrome, number 11 WC 32885, are awarded herein.

IT IS FURTHER ORDERED BY THE COMMISSION that the Arbitrator's awards of medical expenses under §8(a) and §8.2 (except those related to carpal tunnel syndrome); temporary total disability benefits under §8(b); maintenance benefits under §8(a); permanent total disability benefits under §8(f); and penalties and attorney's fees under §19(k), §19(l) and

20IWCC0329

§16 of the Act (except those related to carpal tunnel syndrome), are affirmed and adopted. Those awards are related to and solely awarded in this claim, number 10 WC 25336, and not claim number 11 WC 32885.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $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 15 2020
o-05/21/2020
MP/mcp
68

Marc Parker

Deborah L. Simpson

Barbara N. Flores

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

EATON, SHEILA
Employee/Petitioner

Case# **10WC025336**
11WC032885

MORRIS HOSPITAL
Employer/Respondent

20IWCC0329

On 7/16/2019, 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 2.01% 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:

1357 RATHBUN CSEVENYAK & KOZOL
LUIS MAGANA
3260 EXECUTIVE DR
JOLIET, IL 60431

5354 STEPHEN P KELLY
ATTORNEY AT LAW
2710 N KNOXVILLE AVE
PEORIA, IL 61604

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

Sheila Eaton,
Employee/Petitioner
v.

Case # **10** WC **25336**

Consolidated cases: **11 WC 32885**

Morris Hospital,
Employer/Respondent

20IWCC0329

An *Application for Adjustment 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 May 22, 2019. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ 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 **6-22-10 and 9-8-09**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$52,721.24**; the average weekly wage was **$1,013.87**.

On the date of accident, Petitioner was **47** years of age, ***married*** with **1** 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 **$126,022.43** for TTD for the time period 1/28/11 – 3/16/14, **$4,157.82** for TPD, **$0** for maintenance, and **$40,041.65** for other benefits paid (permanent partial disability), for a total credit of **$170,221.75**.

Respondent is entitled to a credit of **$56,997.13** under Section 8(j) of the Act.

ORDER

RESPONDENT IS LIABLE FOR PAYMENT OF PETITIONER'S MEDICAL TREATMENT BILLS AS OUTLINED IN PETITIONER'S EXHIBIT #1 PURSUANT TO SECTIONS 8(A) AND 8.2 COMMISSION MEDICAL FEE SCHEDULE. RESPONDENT SHALL RECEIVE CREDIT FOR ALL MEDICAL BILLS PAID.

RESPONDENT SHALL PAY PETITIONER TEMPORARY TOTAL DISABILITY BENEFITS AT THE RATE OF **$675.91 PER WEEK** FOR THE PERIODS OF AUGUST 19, 2010 TO AUGUST 12, 2012 AND MARCH 11, 2013 TO NOVEMBER 13, 2017, TOTALING 347-1/7 WEEKS OR $234,637.42 ($675.91 X 347.143 = $234,637.42).

RESPONDENT IS LIABLE FOR MAINTENANCE BENEFITS PAYABLE TO PETITIONER FROM AUGUST 13, 2012 TO MARCH 11, 2013 TOTALING 30 WEEKS, AT THE RATE OF $675.91 PER WEEK, OR THE SUM OF $20,277.30.

PETITIONER IS PERMANENTLY AND TOTALLY DISABLED PURSUANT TO SECTION 8(F) OF THE ACT EFFECTIVE NOVEMBER 13, 2017, THE DATE PETITIONER REACHED MMI. RESPONDENT IS LIABLE FOR UNPAID BENEFITS OF **$675.91 PER WEEK** FROM NOVEMBER 13, 2017 TO MAY 22, 2019 TOTALING 79-1/7 WEEKS OR $53,493.54 AND IS LIABLE FOR CONTINUING BENEFITS FOR THE LIFE OF PETITIONER.

RESPONDENT IS TO PAY PENALTIES TO PETITIONER UNDER THE ACT PURSUANT TO SECTION 19(K) AMOUNTING TO 50% OF UNPAID MEDICAL BILLS BEFORE ANY ADJUSTMENTS PURSUANT TO SECTION 8.2.

RESPONDENT IS TO PAY PENALTIES TO PETITIONER UNDER THE ACT PURSUANT TO SECTION 19(K) AMOUNTING TO 50% OF UNPAID TTD AND MAINTENANCE BENEFITS, IF ANY.

RESPONDENT SHALL PAY PENALTIES TO PETITIONER UNDER THE ACT PURSUANT TO SECTION 19(L) TOTALING $10,000.00.

RESPONDENT SHALL PAY ATTORNEY FEES UNDER THE ACT PURSUANT TO SECTION 16 AMOUNTING TO 20% OF THE AWARD OF SECTION 19(K) PENALTIES.

PETITIONER SHALL RECEIVE ADDITIONAL COMPENSATION AT THE RATE OF **$608.32 PER WEEK** FOR A TOTAL OF **66.625 WEEKS** BECAUSE SHE SUSTAINED THE PERMANENT PARTIAL LOSS OF USE OF HER RIGHT HAND UNDER SECTION 8(E)9 OF THE ACT TO THE EXTENT OF 17.5% THEREOF, OR 35.875 WEEKS, AND BECAUSE SHE SUSTAINED THE PERMANENT PARTIAL LOSS OF USE OF HER LEFT HAND UNDER SECTION 8(E)9 OF THE ACT TO THE EXTENT OF 15.0% THEREOF, OR 30.75 WEEKS.

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

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

Robert M. Harris

Signature of Arbitrator Robert M. Harris

July 15, 2019
Date

JUL 16 2019

MEMORANDUM OF DECISION OF ARBITRATOR

STATEMENT OF FACTS

On the date of hearing, Petitioner, Sheila Eaton, confirmed she had previously testified in this matter on January 27th and September 27th, 2011. (T17) Following those 19(b) hearings, Arbitrators Fratianni and Falcioni entered decisions which were not appealed. In her decision dated March 25, 2011, marked as Petitioner's Exhibit 2, Arbitrator Fratianni found that Petitioner's suffered a compensable accident on June 22, 2010 and that her lumbar condition was causally related to the accident. Arb. Fratianni ordered that Petitioner was owed TTD benefits from August 19, 2010 to January 27, 2011, TPD benefits from June 23, 2010 through August 18, 2010 and that Respondent shall pay reasonable and necessary medical services and approve prospective medical treatment prescribed by Petitioner's treating physician, Dr Kube. (PX 2)

Respondent again sent Petitioner to a Section 12 examination with Dr. Kern Singh as they had prior to the first 19(b) hearing. Based on his opinions, Respondent again denied liability for TTD benefits as well as medical treatment. At hearing, Petitioner indicated she elected not to undergo spinal surgery and instead wanted to proceed with an epidural steroid injection prescribed by Dr. Khan and undergo a functional capacity evaluation prescribed by Dr. Vohra.

In his decision dated December 16, 2011, Arbitrator Falcioni found that Petitioner suffered a compensable accident and that her condition was causally related to her June 22, 2010 work accident. (PX 6) Petitioner was awarded additional TTD benefits, medical benefits and prospective medical treatment and testing as prescribed by Dr. Vohra. Arbitrator Falcioni found that Dr. Singh's testimony was not credible and was not supported by the medical evidence submitted. (PX 6)

Petitioner testified that following her second hearing, she continued to have lower back pain down the back of both of her legs and numbness into the toes of both of her feet. (T21) Despite her symptoms, she did not have spinal fusion surgery and continued seeking conservative treatment with Dr. Vohra for her lumbar condition. (T21) Given her familiarity with lumbar surgery from her experience as a nurse, Petitioner indicated she was concerned with the fusion procedure because of the amount of failed surgeries. (T19) During 2011, Petitioner indicated she was undergoing physical therapy, pain management and injections but would only get temporary

relief of her symptoms. (T21) Petitioner was primarily treating with Dr. Vohra who continuously indicated Petitioner was suffering from chronic low back pain, chronic L5 radiculopathy and disc displacement. (PX 4) Given this, on July 29, 2011, Dr. Vohra referred Petitioner to Dr. Khan for pain management treatment. (PX 4) During her September 21, 2011 appointment, Dr. Vohra also referred Petitioner for a functional capacity evaluation ("FCE"). (PX 4) Petitioner underwent a FCE on November 16, 2011 at Brightmore Physical therapy that found she gave a maximal effort, participated fully in all of the FCE test items and that she was on the light to low end of medical US department of Labor Physical Demand Level. (RX 17) The findings of the FCE noted Petitioner was not a job match to return to her previous work as a registered nurse. (RX 17) Amongst other limitations, the report noted,

> Client was limited in her ability to tolerate prolonged sitting. Client sat uninterrupted for 11 minutes and a total of 38 minutes; however, required 6 standing breaks due to pain reports and was observed to have constant weight shifting left and right throughout the interview, had tests, and coordination tests. Client also was somewhat limited in her tolerance to static standing, forward bend, and floor to waist lift abilities. (RX 17)

This physical motion observation by the FCE examiner, David Brightmore, PT, was also noted on the day of hearing. At hearing, it was noted for the record Petitioner was standing against the wall and was observed distributing her weight from foot to foot. (T20)

After her FCE, Petitioner was given restrictions from Dr. Vohra that coincided with the results. (PX 22) Petitioner testified Respondent did not offer her a job within her restrictions and had, in fact, terminated her prior to the FCE. (T23) Respondent, via Erin Murphy-Frobish, terminated Petitioner in a letter dated May 26, 2011, indicating she had exhausted all of leave of absence time. (RX 18)

Given Dr. Vohra's referral, Petitioner saw Dr. Mohammed Khan at Rush-Copley Medical Center on December 30, 2011. (PX 13) At that time, Petitioner reported her pain complaints and the accident lifting a patient on June 22, 2010. (PX 13) After his physical examination, Dr. Khan diagnosed Petitioner with chronic low back pain secondary to lumbar radiculopathy and prescribed an epidural steroid injection along with therapy. (PX13) Similar to Petitioner's presentation at hearing, Dr. Khan noted Petitioner was trying to look for a comfortable position in his office but could only get relief when she leaned over or when she leaned on the wall. (PX 13) After two injections, Dr. Khan indicated he would not recommend additional injections because, although Petitioner's symptoms were temporarily better, she had similar pain and radiation into her

extremities as prior to the injections. (PX 13) This is consistent with Petitioner's testimony throughout the hearing wherein she indicated that after most of her treatment, she would get temporary relief but that her pain and symptoms would return. At her March 6, 2013 appointment, Dr. Khan recommended that Petitioner to see either Dr. Sani or Dr. Rabin at Rush-Copley to discuss a minimally invasive lumbar discectomy. (PX 13) Petitioner testified that workers' compensation did not approve this referral. (T25)

Following her FCE results and restrictions by Dr. Vohra, Petitioner testified she met with Charlotte Bishop, a vocational counselor hired by Respondent on February 5, 2012. (T26) On that date, Bishop interviewed Petitioner for the purpose of obtaining background information that would be useful for her to do a transferable skills analysis and labor market survey. (PX 18) In her initial report from that date, Ms. Bishop documented Petitioner's restrictions, "light to low medium physical demand level with restrictions (lifting/carrying 30-35 pounds) and allowing changes of position as needed, limits sitting and avoids repetitive or sustained forward trunk positions." (PX 18) Bishop identified thirty-eight medically appropriate positions within 35 miles of Petitioner's home with wages from $50,000.00 to $78,000.00 or more per year. (PX 18)

Petitioner confirmed she then began working with Bishop in August, 2012 to find a job and that they met weekly. (T27-28) Petitioner indicated that Bishop told her there was a viable job market and that she gave her reading materials, assignments and job leads weekly. (T29) During this period, Petitioner testified she worked 35-40 plus hours per week on the vocational process. (T29) Although Bishop indicated Petitioner was a good candidate for vocational placement, Bishop conceded there were significant impediments to placing Petitioner including her physical restrictions and use of Tramadol (PX 18) Ultimately, Bishop indicated appropriate positions for Petitioner within the nursing field were as a consultant, a supervisor, a school nurse, infection control, a nurse anesthetist or as an office nurse. (PX 18) Bishop did not report the fact the FCE indicated Petitioner could not work as a registered nurse. (RX 17)

After meeting with Petitioner and beginning the job search process, Bishop then created weekly to bi-weekly reports of her interactions with Petitioner. (RX 18) Petitioner testified the most demanding part of the vocational process was filling out applications for jobs. (T30) Petitioner indicated each application would take about 90 minutes because she would typically have to take a test first and then give all of her background information before filling out the application. (T30) Petitioner testified she would have a lot of back pain from sitting to fill out each

application. (T30) Petitioner testified working at the computer especially exacerbated her low back and leg pain. (T31) Despite her lower back symptoms, Petitioner testified she felt Bishop was good at her job and she continued with the vocational process. (T31)

In her vocational reports, Bishop documented the job search process and on April 25, 2012, documented that Petitioner had confidence in her employability once the pain in her back and left leg have resolved and she had always been successful finding employment. (PX 18) From her initial report forward, Bishop documented Petitioner was compliant with the process and there was reports of Petitioner's not following through on her assignments. (PX 18) However, Bishop did document that Petitioner's level of pain and her need to move around rather than sit is a distraction to the job search process. (PX 18)

In her August 12, 2012 report, Bishop documented that Petitioner created a home office for the job search process. (PX 18) Bishop also indicated the time frame for resolution would be 10 sessions of her services. (PX 18) Bishop's reports typically indicated she gave Petitioner 10-15 job leads and that she would identify leads herself in each period. (PX 18) The leads by Bishop and Petitioner were consistently between 10-15 each as documented in Bishop's reports. (PX 18)

Petitioner was compliant throughout the process. (PX 18) For example, in her September 22, 2012 report, Bishop indicated Petitioner "demonstrated good follow through with the assignment given to her" and was "pleasant and cooperative throughout the meeting." (PX 18) The section of this report entitled, "HOMEWORK FOLLOW-UP:" demonstrates the amount of effort put into this process by Bishop and Petitioner. (PX 18) This section lists off nine distinct tasks given to Petitioner in the course of a single week and indicated that 8 of 9 were completed and the one not fully completed was partially completed. (PX 18) This is representative of all of Bishop's reports throughout the vocational process. Petitioner showed this level of commitment despite her low back pain and symptoms.

In the same September 22, 2018 report, Bishop documented that Petitioner continued to complain of significant pain but was, "committed to cooperating with the guided job search efforts." (PX 18) Ms. Bishop further acknowledged, "The VCM remains cautiously optimistic that the guided job search will be successful, however, the consistent use of pain medication, need to rest and ongoing back and leg pain will be issues which will need to be addressed as conversations with employer take place." (PX 18)

In her November 23, 2012 report, Bishop again noted that Petitioner, "continues to demonstrate a good faith effort in the guided job search. The documentation provided by Ms. Eaton is clear and thorough" and that Petitioner completed all of her tasks. (PX 18) The report also indicated, "TIME FRAME TO RESOLUTION: 1 session, additional sessions will be added as approved." (PX 18) This report, as well as all of the preceding reports, did not indicate that Petitioner had any job interviews or job offers. (PX 18)

Despite the vocational process and Bishop's guidance throughout, Petitioner testified she was never offered a job. (T36) Petitioner clarified she did not have 15 interviews, as was indicated by the Vocamotive report by Kari Stafseth dated January 25, 2016, but only had a single 15-minute phone interview and no in person interviews. (PX 26 & T36) Petitioner was not offered any job in the nursing field or any other job of any kind. (T37) Petitioner testified she did not get any responses to her resume or applications. (T37) This is confirmed by Bishop's reports that document the entire process but never indicate Petitioner had an in-person interview or was ever offered a job. (PX 18)

At hearing, Petitioner confirmed she continued to have low back symptoms throughout the vocational process and she sought additional avenues to decrease her pain. (T32) Petitioner was referred by Dr. Vohra to Dr. Katherine Borchardt, a pain psychologist and Dr. Randy Cybulski for therapy and chiropractic treatment. (T32)

Dr. Borchardt testified she is board certified in clinical psychology and specializes in behavioral medicine and neuropsychology and specializes in non-pharmacological pain treatment to address chronic pain or a disease process. (PX 17 at 4-6) Petitioner began treatment with Dr. Borchardt on January 24, 2013 and explained her accident, symptoms and various treatments she had undergone since her injury. (PX 17 at 9) Petitioner testified Dr. Borchardt offered her distraction techniques, pacing activities and ways to decrease her stress in order to decrease her pain. (T33) After reviewing Petitioner's medical records, therapy records, MRIs and the FCE, Dr. Borchardt began seeing Petitioner on a regular basis offering her pain control techniques. (PX 17) Dr. Borchardt also documented that Petitioner constantly changed position and indicated, "she was in chronic pain. When she was talking she wasn't even aware that she was changing positions, but she just couldn't sit in one position for very long at all." (P17 at 20)

Following her initial examination, Dr. Borchardt drafted a letter dated February 25, 2013, regarding her assessment of Petitioner and her opinion that Petitioner should not be involved in

the vocational process. (PX 16) Dr. Borchardt noted that the FCE indicated, "Client's inability to tolerate prolonged sitting and her decreased lifting ability present potential barriers to return to work as an R.N., Client is presently not a job match to return to her previous work as an R.N. She will function best in a position that limits setting and allowed changes in position prn." (PX 16) After discussing Petitioner's symptoms with her and the vocational process, Dr. Borchardt concluded that working at a computer and engaging in writing activities takes an inordinate amount of time for Petitioner to complete and exacerbates her chronic pain and, given that, Petitioner should not be engaged in vocational rehabilitation. (PX 16) Dr. Borchardt further indicted that the FCE indicated that nursing jobs were not suitable for Petitioner based on the FCE alone despite Ms. Bishop's direction. (PX 16)

Bishop confirmed in her deposition testimony that Petitioner contacted her deposition testimony that Petitioner indicated she would not be doing vocational rehabilitation. (RX 15 at 20) In her last vocational report dated March 11, 2019, Bishop documented that Petitioner told her vocational assistance had been discontinued and that she could no longer participate in vocational rehabilitation. (PX 18) Bishop noted, "Ms. Eaton has historically demonstrated consistent a (sic) good faith effort in her job search." (PX 18) Petitioner continued her treatment with Dr. Borchardt who immediately documented in her March 15, 2013 note that Petitioner seemed more relaxed after the vocational rehabilitation process had ceased. (PX 16) Through a combination of Dr. Borchardt's treatment, therapy, manipulation and decompression with Dr. Cybulski and massage therapy, Petitioner indicated her symptoms were temporarily alleviated but that it was, "like a Band-Aid. It works to keep me moving, but it always comes back." (T35)

Dr. Borchardt then referred Petitioner to a neurosurgeon, Dr. Douglas Johnson, to again discuss the possibility of surgery but that was not approved by workers' compensation. (PX 16) As of her appointment on September 23, 2013, Dr. Borchardt indicated Dr. Johnson had passed away but Petitioner should still seek a surgical consultation. (PX 22) Petitioner confirmed she saw both Dr. Ronjon Paul and Dr. Cary Templin. (T38) As opposed to surgery, Petitioner indicated that Dr. Vohra and Dr. Borchardt referred her to another pain management physician, Dr. Ira Goodman. (T39) Petitioner confirmed she began seeing Dr. Goodman in 2013 and has continuously treated with her up to the date of hearing. (T39)

Petitioner indicated she ceased seeing Dr. Vohra in 2013 because workers' compensation was not approving treatment and that, beginning in 2013, her treatment was not paid by workers'

compensation at all. (T44) Petitioner began receiving Social Security Disability in 2013 and her treatment was paid for by herself and Medicare. (T44) Instead of approving medical treatment as was ordered by Arbitrator Falcioni, Respondent sent Petitioner to Dr. Timothy McManus, a licensed clinical Psychologist, for a Section 12 independent medical examination. In his report dated July 13, 2013, Dr. McManus administered multiple psychological testing and indicated, "Ms. Eaton scored with in normal limits on all five clinical scales and the total raw score on the general measure of symptom validity." (RX 1) Dr. McManus then opined, "there are no barriers from either a psychological or neuropsychological perspective that would prohibit Ms. Eaton from seeking employment within the physical parameters, restrictions, and limitations outlined by her physicians should she wish to do so." (RX 1) Dr. McManus offered no opinion regarding Petitioner's ***medical*** treatment. Even if he did, Dr. McManus is a psychologist and not a licensed physician and is therefore not qualified and in no position to comment on Petitioner's actual medical treatment. Despite this, Respondent no longer approved or paid for any of Petitioner's ongoing medical treatment. This is further confirmed by Respondent's exhibit 22 that documents the last payment related to Petitioner's actual medical treatment was to Dr. Vohra on January 7, 2013. (RX 22)

When Petitioner initially tried to see Dr. Goodman, her appointment was denied by Karen Mika at Illinois Compensation Trust. In a letter dated November 27, 2013 addressed to Dr. Goodman's office, Mika indicated that the evaluation was denied because it exceeded the claimant's two choices of physicians. (PX 20) This is not accurate given the referral from Dr. Vohra and Dr. Borchardt (who was referred by Dr. Vohra). Despite this, Petitioner initially presented to Dr. Goodman on December 5, 2013, using her Medicare insurance. Petitioner described her accident and her symptoms including pain and burning in her back radiating into her bilateral buttocks and legs. (PX 20) Dr. Goodman noted that Petitioner paced the floor and had a difficult time finding a comfortable position. (PX 20) After an examination, Dr. Goodman indicated Petitioner was suffering from a lumbar disc problem with radicular components and recommend epidural steroid injection at L3-4 and L4-5 and consider facet joint injections and a discography if those procedures were not effective. (PX 20)

At her follow-up appointment on January 20, 2014, Dr. Goodman also continued Petitioner's referral to Dr. Cymbulski to continue soft tissue work and again prescribed epidural steroid injections. (PX 20) Petitioner underwent the first epidural steroid injection on January 23,

2014 and reported only temporary improvement when the local anesthetic was in effect (PX 20) Given that Petitioner's symptoms returned to baseline after the injections, Dr. Goodman indicated that she should undergo facet joint injections for diagnostic purposes. (PX 20) **On January 23, 2014 Dr. Goodman also noted, "she is permanently disabled."** (PX 20) Petitioner underwent the medial nerve block injection at L2, L3, L4 and L5 on February 17, 2014. (PX 20) In her follow up appointment with the doctor on March 5, 2014, Dr. Goodman noted, "she had 90% relief on the day of the procedure, 60% the day after, and 20-30% since. Her muscle spasms are improved. Some of her more deeply seated low back pain is not as obvious to her." (PX 20)

Based on the results of the nerve block injections, Dr. Goodman recommended RF (radiofrequency) lesioning and referred her to primary care physician, Dr. Spiro Analytis. (PX 20) Petitioner underwent a left sided ablation procedure on March 13, 2014, that decreased the area of her left sided back pain and a right sided procedure on April 24, 2014, that did not help her right sided pain. (PX 20)

At hearing, Petitioner confirmed that the relief from the procedures was only temporary. (T53) In his May 28, 2014, post-procedure note, Dr. Goodman noted that the left sided procedure gave only temporary relief and the right sided injected was not effective and indicated that the next treatment step is for Petitioner to undergo a discogram and follow up CT scan. (PX 20) Petitioner underwent the discography and CT scan on June 5, 2014 at Adventist Hinsdale Hospital. (PX 20) Petitioner followed up with Dr. Goodman on June 18, 2014, wherein he noted, "**Discogram and post-discogram CT were reviewed today. These correlate well and demonstrate very clearly that the L2-3 disc was a normal control disc and that L3-4, L4-5 and L5-S1are abnormal morphologically and cause concordant pain." (PX 20) Dr. Goodman then offered Petitioner treatment including 3 level spinal fusion, IDET and SCS (spinal cord stimulator)**, noting that Petitioner wanted to try the IDET procedure. (PX 20)

At hearing, Petitioner indicated that the IDET procedure was not carried out because Medicare would not cover it and workers' compensation was not paying for any of her treatment. (T54)

Petitioner then continued on a course of treatment with Dr. Goodman that included medication and injections throughout 2014, 2015 and 2016 with her condition largely unchanged. (PX 25, 28, 29, and 31) Dr. Goodman did attempt to treat Petitioner with Fentanyl patches but

indicated that Petitioner was allergic to this so he continued her on Valium and Tramadol to control her pain symptoms (PX 25)

Throughout her treatment with Dr. Goodman, Petitioner continued her regimen with Dr. Borchardt as well as receiving massage therapy. During this period, 2015, 2016 and 2017, Petitioner had the same type of symptoms including low back pain and leg pain that continued to get worse. (T55) Although Petitioner got some leg pain relief from ongoing injections, Dr. Goodman stopped prescribing those on February 22, 2017 because she got side effects including nausea, dyspepsia and hot flashed. (PX 31)

By her next appointment on April 17, 2017, however, Petitioner's symptoms were severe enough that she agreed to have another steroid injection. (PX 31) At that appointment, Dr. Goodman provided Petitioner with educational materials regarding a spinal cord stimulator. (PX 31) Petitioner testified that Dr. Goodman then referred her for a trial spinal cord stimulator which she received on September 7, 2017. (T57 & P47) Given the positive results of the trial stimulator, Dr. Goodman referred Petitioner to Dr. Borchardt for presurgical psychological evaluation to determine if she was an appropriate candidate for spinal cord stimulator placement surgery. (P34)

In her Presurgical Personality and Cognitive Evaluation reported dated July 31, 2017, Dr. Borchardt summarized Petitioner's results after administering the Minnesota Multiphasic Personality Inventory, 2nd Ed., Restructured Format (MMPI-2-RF). Dr. Borchart summarized,

> Sheila's MMPI-2 profile is considered within normal limits, with no evidence of disordered thinking or maladaptive behaviors. Her current profile suggests she has adequate coping skills, typically engaging not only in optimism, but rational thinking and good planning. She is able to reach out to trusted others to discuss concerns and seek reasonable opinions. Sheila displays a confidence in her medical team and appears to be approaching the spinal cord stimulator surgery in a realistic manner. Successful spinal cord stimulator surgery is likely to lead to a decrease in Sheila's occasional experiences of helpfulness by placing some more of her chronic pain under her control. **She also appears to have no secondary pain components to her chronic pain. Overall, Sheila appears to be a good candidate for spinal cord stimulator placement surgery.** (PX 34)

Following her psychological clearance, Petitioner was referred by Dr. Goodman to Dr. Joshua Rosenow at Northwestern Medicine for second opinion on a permanent spinal cord stimulator. (P38) In his notes dated September 20, 2017, Dr. Rosenow documents that after the trial stimulator, Petitioner indicated, "she felt so good she did not want to have the leads removed." (PX 38) Following an examination and review of Petitioner's treatment history, Dr. Rosenow concluded that this was reasonable for Petitioner to consider a permanent spinal cord stimulation

system implantation. (PX 38) **Petitioner then underwent the implantation of the stimulator by Dr. Rosenow on November 13, 2017. (PX 38)**

Following the procedure, Petitioner has continued treatment with Dr. Goodman, who documented on February 28, 2018, that Petitioner's low back pain was reduced by 15% and her bilateral buttock and leg pain has been reduced by 75% by the stimulator. (PX 35) At hearing, Petitioner confirmed that the stimulator has helped, especially in her leg symptoms that she only notices when she stands a lot. (T59)

Petitioner testified that after the stimulator implantation, she continues to receive treatment from Dr. Goodman, Dr. Borchardt and some rehabilitation including therapy and chiropractic treatments. (T59) Petitioner indicated that this treatment temporarily alleviates her symptoms but that the symptoms have never gone away completely and have been continuous since her 2010 injury. (T59) Further, while Petitioner has had relief of a lot of her leg symptoms, she continues to have back pain that gets worse the more she stands or sits continuously. (T59) Petitioner also noted that she has had the batteries reprogrammed on three occasions. (T60) Given the ongoing symptoms, Petitioner indicated she bought a residence in Florida because the winters made her back pain intolerable. (T59)

In addition to her back injury, Petitioner testified that while working for Morris Hospital as a nurse, she noticed pain in her hands and arms that interfered with her sleep. (T64) After reporting her problems to Respondent, Petitioner sought treatment from Dr. Tom Karnezis at The Illinois Orthopeadic and Hand Center. (PX 8) Dr. Karnezis diagnosed Petitioner with bilateral carpal tunnel syndrome and performed bilateral releases on December 13, 2011. (PX 8) Dr. Karnezis then released Petitioner to all activities on March 16, 2012. (PX 8) Of note, Dr. Karnezis' notes on December 7, 2012 indicated that Petitioner worked in a bank doing data entry. (PX 8) At hearing, Petitioner clarified that she was not working in a bank, had never worked in a bank and that this was an incorrect notation. (T67) Petitioner indicated she was doing vocational rehabilitation at that time. (T67) This is verified by Bishop's notes and reports. (PX 18)

At hearing, Petitioner testified that she has not worked anywhere since her injury, she has never been offered a job, she has never been released back to work and she has never suffered any other injuries of accidents of any kind to her lower back since her day of accident. (T67, 83, 55) Although Petitioner testified that she is satisfied with the spinal cord stimulator, she indicates she still has symptoms related to low back pain. (T60, 61 & 63) Petitioner indicated that all of her daily

activities are limited and that she has to pace and plan her day due to her symptoms. (T67) Her intention is to continue with pain management and conservative treatment on a maintenance basis. (T68)

CONCLUSIONS OF LAW

10 WC 25336 – Lumbar Spine

ISSUE F. CAUSATION: THE ARBITRATOR FINDS AND CONCLUDES PETITIONER'S CURRENT LUMBAR SPINE CONDITION OF-ILL-BEING IS CAUSALLY RELATED TO HER WORK ACCIDENT SUSTAINED ON JUNE 22, 2010.

The Arbitrator incorporates all Findings of Fact into this Section.

The issue of causation has been adjudicated before the Commission twice prior to the current Arbitration hearing held on May 22, 2019 and both Arbitrator Fratianni and Arbitrator Falcioni ruled that Petitioner's lumbar spine condition was causally related to her work accident. This Arbitrator highlights that neither of these Arbitration awards were appealed to the Commission; therefore, by operation of law they became final awards of the Commission.

The preponderance of the credible evidence indicates that from the date of the last hearing before Arbitrator Falcioni on September 27, 2011 to the date of this hearing on May 22, 2019, Petitioner has had consistent and ongoing treatment for her lumbar spinal condition and she credibly testified that she has suffered no other injuries of any kind to her lower back. (T67) There is no evidence that Petitioner suffered another accident and there is no notation of any other injury in any of the numerous exhibits submitted by both Petitioner and Respondent. The evidence clearly demonstrates there has been an unbroken chain of treatment with no evidence of any intervening accidents since Petitioner's date of lumbar injury on June 22, 2010.

The Arbitrator further emphasizes that Respondent's causation dispute relies solely on Dr. Singh's opinions in his Section 12 report dated April 23, 2018. Dr. Singh indicated that Petitioner exhibited extreme signs of symptoms magnification and malingering and specifically noted, "I reemphasize my position from my 2011 independent medical examination. The patient's pain complaints are nonanatomic in nature. I believe she is capable of returning back to work full duty without restrictions. Her treatment has been excessive in nature and unrelated to any work event in 2010." (RX 7 at 3) **The Arbitrator emphasizes that Dr. Singh's opinions were deemed not credible by both previous arbitrator's and this Arbitrator finds similarly that the**

overwhelming weight of the credible evidence demonstrates his opinions are also not credible now. In his causation finding, Arbitrator Falcioni reasoned, "Contrary to Dr. Singh, Petitioner's testimony and report of symptoms is credible and supported by the evidence submitted. Her complaints of pain were consistent for the date of accident to the present time. Review of Dr. Vohra's current records demonstrates this. The history of symptoms note a combination of symptoms including lower back pain and pain and numbness into Petitioner's lower extremities with radiculopathy. These are the same set of symptoms testified to and documented in medical records during the initial hearing." (PX 6) **Presently, the facts are the same as they were when Arbitrator Falcioni found causation. The Arbitrator also emphasozes that all of the numerous medical records submitted by Petitioner including, but not limited to, Dr. Vohra, Dr. Khan, Dr. Goodman, Dr. Borchardt, Dr. McCarty and Dr. Rosenow, record the same symptoms including lower back pain and pain and numbness into the legs.** These were consistently reported by Petitioner over a span of years. Even Petitioner's constant movement to get comfortable at appointments, the same as at this Arbitration hearing, were consistently noted throughout the evidence submitted.

Further, as noted in his previous reports, **Dr. Singh is the only physician**, besides Respondent's Section 12 psychologist Dr. McManus, **to note any malingering or that Petitioner's complaints were non-organic in nature. In all of the multiple medical documents submitted by multiple physicians, no other physician noted malingering or anything of the nature.** From Dr. Vohra all the way through the implantation for the spinal cord stimulator by Dr. Rosenow, there is not a single notation of Petitioner's symptoms not being valid. The only other medical expert to insinuate this is Dr. McManus in his Section 12 reports. However, it is obvious Dr. McManus simply chose to rely on Dr. Singh's 2011 opinions. Again, Dr. Singh's opinions had already been deemed not credible by that point.

Given the plain fact that two prior Arbitrators had concluded – without Respondent filing a Review on the matters - that Dr. Singh was not credible, it is inexplicable why he was again retained to offer his opinions in this case pursuant to Section 12.

The most critical, credible and persuasive evidence to consider on the issue of malingering - outside of the records of Petitioner's treating medical providers - however, is found in Bishop's vocational reports and the Functional Capacity Evaluation performed by David Brightmore. Bishop indicated throughout her reports statements directly contradicting that Petitioner was

malingering ***and she repeatedly indicated that Petitioner complied with the vocational process and was motivated to return to work***. (PX 18) This is very significant evidence.

In her September 22, 2012 assessment report, Bishop noted, "Meanwhile, Ms. Eaton verbalizes her desire to both be pain free and return to work. She has repeatedly stated that she is proud of her work as a nurse and would like to return to gainful activity." (PX 18)

On September 30, 2012, Bishop further noted, "Ms. Eaton continues to demonstrate a good faith effort in the guided job search. She has contacted the VCM (vocational case manager) if she has questions and is very professional in all of her encounters with the VCM. Ms Eaton has provided documentation to support her activities. However, her report of pain which compromises her ability to sit or stand for any length of time continues." (PX 18) **As discussed, Bishop saw Petitioner almost weekly for a period of almost 9 months. (PX 18) Dr. Singh, on the other hand, saw Petitioner for a single short examination and submitted a very brief 3 page report.**

Petitioner performed the FCE on November 16, 2011 by David Brightmore, PT, and the FCE was deemed a **valid evaluation**. In the Pain Report section, Mr. Brightmore noted,

> "client reports that pain is present at all times and reported such throughout the FCE and physical examination. Client reported lumbar pain with all test items but voiced a significant increase in pain after stat sitting, static forward bending, repetitive squat, floor-to-waist lift, and sustained kneeling. When aggravation was reported, client reported that pain progressed distally into the left buttocks, left posterior thigh, and a times into the left lateral leg. **Appropriate pain behaviors**, including holding and rubbing of the lumbar spine as well as frequent weight shifting and changing of position, **were observed throughout the FCE**. Pain was under control and client was able to progress to the next item with the exception of during static sitting. Client became very uncomfortable in static sitting and required weight shifting or getting up out of sitting due to pain. Grimacing, increased heart rate, increased respiration rate were noted consistent with her complaints." (RX 17 at 2) (emphasis added)

Notably, the observations Brightmore indicated above are consistent with observations made throughout Petitioner's medical treatment records as well as what was noted during Petitioner's trial testimony. Here, however, Brightmore had the ability to test the validity of Petitioner's complaints via physiological changes including elevated heart rate and elevated respiration. These changes demonstrate that Petitioner's report of symptoms were consistent with physiological changes, thus demonstrating consistency. **This is credible and objective evidence Petitioner was suffering from the symptoms reported.** ***But even more***

significant is the fact that Brightmore's evaluation findings were never rebutted or refuted, nor did Brightmore offer any criticism of Petitioner or her complaints.

In addition to the above, Dr. Singh's opinions are plainly not credible because he failed to review any of Petitioner's treatment records from 2011 to the time he saw her again in 2018 - a period of about seven years. **Dr. Singh's indication in his report that there are no medical records to review is factually accurate but also very disingenuous.**

It is the Commission's province to assess the credibility of witnesses, draw reasonable inferences from the evidence, determine what weight to give testimony, and resolve conflicts in the evidence, particularly medical opinion evidence. *Berry v. Industrial Comm'n*, 99 Ill. 2d 401, 406-07, 459 N.E.2d 963, 76 Ill. Dec. 828 (1984); *Hosteny v. Illinois Workers' Compensation Comm'n*, 397 Ill. App. 3d 665, 675, 928 N.E.2d 474, 340 Ill. Dec. 475 (2009); *Fickas v. Industrial Comm'n*, 308 Ill. App. 3d 1037, 1041, 721 N.E.2d 1165, 242 Ill. Dec. 634 (1999). Expert testimony shall be weighed like other evidence with its weight determined by the character, capacity, skill and opportunities for observation, as well as the state of mind of the expert and the nature of the case and its facts. *Madison Mining Company v. Industrial Commission*, 309 Ill. 91, 138 N.E. 211 (1923). The proponent of expert testimony must lay a foundation sufficient to establish the reliability of the bases for the expert's opinion. *Gross v. Illinois Workers' Compensation Comm'n*, 2011 IL App (4th) 100615WC, 960 N.E.2d 587, 355 Ill. Dec. 705. If the basis of an expert's opinion is grounded in guess or surmise, it is too speculative to be reliable. Expert opinions must be supported by facts and are only as valid as the facts underlying them. *In re Joseph S.*, 339 Ill. App. 3d 599, 607, 791 N.E.2d 80, 87, 274 Ill. Dec. 284 (2003). A finder of fact is not bound by an expert opinion on an ultimate issue, but may look 'behind' the opinion to examine the underlying facts. Expert testimony shall be weighed like other evidence with its weight determined by the character, capacity, skill and opportunities for observation, as well as the state of mind of the expert and the nature of the case and its facts. *Madison Mining Company v. Industrial Commission*, 309 Ill. 91, 138 N.E. 211 (1923). The proponent of expert testimony must lay a foundation sufficient to establish the reliability of the bases for the expert's opinion." Gross v. Illinois Workers' Compensation Comm'n, 2011 IL App (4th) 100615WC, 960 N.E.2d 587, 355 Ill. Dec. 705. "If the basis of an expert's opinion is grounded in guess or surmise, it is too speculative [**18] to be reliable." Id. "Expert

opinions must be supported by facts and are only as valid as the facts underlying them." In re Joseph S., 339 Ill. App. 3d 599, 607, 791 N.E.2d 80, 87, 274 Ill. Dec. 284 (2003). **Not only may the Commission decide which medical view is to be accepted, it may attach greater weight to the opinion of the treating physician.** *International Vermiculite Co. v. Industrial Comm'n*, 77 Ill.2d 1, 31 Ill. Dec. 789, 394 N.E.2d 1166 (1979); *ARA Services, Inc. v. Industrial Comm'n*, 226 Ill. App. 3d 225, 168 Ill. Dec. 756, 590 N.E. 2d 78 (1992). **That is what the Arbitrator has decided to do in this matter.**

Dr. Singh indicates Petitioner clearly made him aware she was treating with Dr. Goodman, had numerous epidurals, radiofrequency ablations, medical branch blocks and placement of a spinal cord stimulator, physical therapy and other conservative treatment. (RX 7) Yet, despite years of various treatments, Dr. Singh inexplicably did not even bother to review any medical records covering this extensive seven-year period of medical treatment, nor ask for records to any to review, indicating a distinct lack of interest in this case; therefore, this failure - which appears deliberate - only reinforces the Arbitrator's conclusion that Dr. Singh's opinions cannot be given any weight or credibility (again, beyond the significant fact that two prior Arbitrators in this case found him to be not credible). **The Arbitrator questions how Dr. Singh could have offered his opinions with such conviction given he did not review any medical records for the past almost seven years and given the Commission's prior determination of his credibility.**

If Dr. Singh had reviewed the multiple medical records documenting, for example, that Petitioner underwent a discogram by Dr. Goodman that demonstrated concordant pain (unchallenged results), or that Petitioner underwent a Functional Capacity Evaluation that was deemed valid (unchallenged results) or that a spinal cord stimulator was implanted (supported by Respondent's own Utilization Review), perhaps his opinions may have been different – or perhaps not. (PX 48 at 17 & RX 17) Although pain reports are largely subjective, Dr. Singh didn't even review these two pieces of objective information used to correlate subjective findings. It is not a coincidence that the physician who saw Petitioner the least is the only one who opined that Petitioner was malingering and not honest with her symptoms. Dr. Singh simply lacks the requisite information to give any opinions - let alone credible ones - regarding Petitioner's condition.

Further, even though Dr. Singh was made aware that Petitioner had undergone multiple treatment and procedures (including a spinal cord stimulator) his diagnosis was "**lumbar muscular strain.**" **It strains credulity that Dr. Singh would only offer a "lumbar muscular strain" as a diagnosis, given, for example, the voluminous medical records indicating a more serious condition, such as the extensive treatment performed, the success of the spinal cord stimulator and the *unchallenged* results of the June 5, 2014 lumbar discogram and CT scan, which indicated and correlated well and "demonstrate very clearly" the discs at L34, L4-5, and L5-S1 "are abnormal morphologically and cause concordant pain" per Dr. Goodman's report dated June 18, 0214 (PX 20). But Dr. Singh never reviewed any of these records so has no standing to criticize what they report.**

Further, Dr. Singh had no comment regarding the Utilization Review (PX 47) dated February 19, 2018 which certified the spinal cord stimulator implant and opined, "Thus, the spinal cord stimulator is reasonable, necessary, and appropriate." The Arbitrator places strong credibility, reliance and weight on this UR opinion.

There is nothing in the evidence submitted that demonstrates or even suggests Dr. Singh should be deemed any more credible than he was in 2011. Although his opinions had been discredited, and one can infer he must have known this in 2018, Dr. Singh nonetheless indicated he would "reemphasize" his position from 2011. Dr. Singh also opined Petitioner's medical treatment – apparently all of it – "has been excessive in nature and unrelated to any work-related event in 2010." This opinion not only defies the prior Commission Decisions, it defies the opinions of the multitude of treating providers who have rendered treatment over the years. Therefore, Respondent's reliance on Dr. Singh's opinions unsupported opinions was unsupportable and unreasonable.

Regarding causation, in addition to the evidence discussed above, Petitioner relies on the opinions of Dr. Goodman. In his deposition testimony taken on June 15, 2017, Dr. Goodman confirmed that he had seen Petitioner consistently over the course of years. Dr. Goodman testified that he never had any reason to doubt Petitioner's reporting of symptoms and has always found her to be honest and truthful in her report of symptoms to him. (PX 48 at 27) In addition to discussing his treatment with Petitioner, he testified in depth about prescribing her a discogram. (PX 48 at 16) Dr. Goodman explained that the idea of the procedure is to determine if a patient's report of pain correlates with injured disks. (PX 48 at 16) Following Petitioner's discogram, Dr.

Goodman confirmed Petitioner had a "positive provocative diskography" that demonstrated her symptoms correlated with the level of her lumbar spine that were abnormal. (PX 48 at 17) When asked about causation, Dr. Goodman answered that he believed Petitioner's current lumbar condition was caused by her work accident and reasoned, "Well, if you just consider the temporal relationship between the work injury and the onset of her symptoms and that she did not have a pre-accident history of lumbar spine pain requiring medical attention it all fits pretty well using simple deductive reasoning." (PX 48 at 29)

Dr. Borchardt also discussed the cause of Petitioner's condition of ill-being during her July 1, 2013 evidence deposition. At that time, Dr. Borchardt testified she believed Petitioner was suffering from chronic pain that was related to the back injury suffered. (PX 23 at 31) She further indicated that she believed Ms. Eaton would continue to suffer from chronic pain until her structural abnormalities shown on MRI were resolved. (PX 23 at 31) Finally, Dr, Borchardt was directly asked if she believed Ms. Eaton was malingering or being untruthful in anyway. She responded that she never observed it and that her observations of Ms. Eaton were consistent with someone suffering from chronic pain. (PX 23 at 32.) Dr. Borchardt was well positioned to make these comments given her extensive dealings with Petitioner over her long course of treatment.

Based on the greater weight of the evidence, the Arbitrator finds that Petitioner's current condition of ill-being is causally related to her work accident sustained on June 22, 2010. Petitioner has proven causation by a preponderance of the credible evidence. The evidence demonstrates that Petitioner's treatment and complaints have remained consistent from the date of the accident, through the first two hearings to the present time without Petitioner suffering any intervening accidents or injuries of any kind to her lumbar spine. The Arbitrator further finds Dr. Singh's opinions to not be credible and instead places weight, credibility and reliance on the opinions and testimony of Dr. Goodman and Dr. Borchardt.

J. THE ARBITRATOR FINDS AND CONCLUDES RESPONDENT IS LIABLE FOR PAYMENT OF PETITIONER'S REASONABLE AND NECESSARY MEDICAL TREATMENT UNDER SECTIOS 8(a) AND 8.2 OF THE ACT.

The Arbitrator incorporates all Findings of Fact into this Section.

Given the Arbitrator's finding that Petitioner's lumbar condition is causally related to her June 22, 2010 work accident, the Arbitrator finds and concludes Respondent is liable for payment of Petitioner's reasonable and necessary medical treatment. Again, in this regard, Respondent, relies on the discredited opinions of Dr. Singh, and the opinions of Dr. McManus, who is not a medical doctor.

In his report dated April 23, 2018, Dr. Singh opines that Petitioner reached maximum medical improvement and that her condition required no further medical treatment. (R7) Dr. Singh also indicated Petitioner's treatment was excessive and unrelated . (R7) Based on the same analysis and conclusions discussed above, Dr. Singh's opinions here are also not credible. Again, Dr. Singh did not review Petitioner's medical records before or after his examination. On the contrary, Dr. Borchardt and Dr. Goodman continually managed Petitioner's medical condition over a period of years. Both doctors disclosed their opinions regarding Petitioner via deposition testimony. Dr. Borchardt indicated that Petitioner's management of her chronic pain had improved since she began her treatment regimen but that she still recommended that Petitioner see a neurosurgeon to address her condition. (PX 23 at 29 & 32) Dr. Borchardt further testified that from a pain management and chronic pain perspective, Petitioner's treatment was reasonable and necessary and explained, "chronic pain patients—study upon study has show that a multi-faceted approach to treating chronic pain is appropriate and the best outcomes come from such a team approach, so physiatry, massage therapy, chiropractic, behavioral medicine are all important treatments in the treatment of most people's chronic pain and in Ms. Eaton's case I would definitely agree." (PX 23 at 34) **This was exactly the same approach Dr. Vohra, Dr. Borchardt and Dr. Goodman took in treating Petitioner**. At different points, one of the three physicians above referred Petitioner to pain management (Dr. Khan, Dr. Goodman and Dr. Rosenow), chiropractic care (Dr. Cybulski and Naperville Rehabilitation Clinic), physical therapy (Dr. McCarty, Willowbrook Rehabilitation Institute), mobility specialists (Shirley Ryan Ability Lab) and massage therapy.

In addition to Dr. Borchardt, Dr. Goodman offered his opinions regarding Petitioner's medical treatment. During his deposition testimony on June 15, 2017, Dr. Goodman testified that his treatment was reasonable and necessary for the diagnosis he gave Petitioner. (PX 48 at 28) Dr. Goodman also opined Petitioner's future medical treatment should consist of the IDET procedure and then he would recommend a spinal cord stimulator. (PX 48 at 30) Dr. Borchardt indicated that he would recommend permanent implantation after a psychological evaluation. (PX 48 at 31) At

hearing, as discussed above, Petitioner indicated she underwent the testing and then had a permanent stimulator placed by Dr. Rosenow.

In addition to relying on Dr. Singh to deny payment of Petitioner's medical treatment, Dr. McManus indicated in his August 26, 2014 addendum report that Dr. Borchardt's psychological services were not necessary. Dr. McManus' opinions are plainly not credible. Dr. McManus comes to this conclusion because Dr. Borchardt did not disclose the raw data findings of the tests she administered to Petitioner and, he suggests, this meant that Dr. Borchardt was hiding non-credible symptom reporting or the absence of a psychological disorder. (RX 3) This opinion makes no sense in light of the evidence. First, Dr. McManus did not disclose the raw data used in his administering of Petitioner's testing. So, based on his rationale, he was [also] clearly "hiding" a finding not supportive of Respondent's position. More substantially and directly on point, however, Dr. Borchardt was **not** treating Petitioner for a psychological condition, she was treating Petitioner for chronic pain related to her lumbar spine. Again, in both previous decisions, Arbitrators Fratianni and Falcioni found that Petitioner suffered a lumbar spine condition that required medical treatment. Dr. Borchardt was part of the treatment regimen for Petitioner's condition.

Respondent also submitted a series of reports related to partial certification and non-certification of Petitioner's chiropractic treatment. Dr. Zipser from the Physicians Review Network offered a series of reports dated November 2, 2017, December 12, 2017 and November 1, 2017. Dr. Zipser indicated that only the first six chiropractic sessions were necessary. (RX 12, 13 & 14) Dr. Zipser's opinions are not credible for a number of reasons. Most significantly, it is clear that his opinion is based on his review of the IME report by Dr. McManus that indicated that Petitioner had positive Waddell findings. (RX 13 & 14) Again, Dr. McManus offered this opinion based on Dr. Singh's opinions that there were positive Waddell findings. These are the only two physicians involved in Petitioner's claim that indicate any malingering or positive Waddell signs. **Significantly, none of the many treating physicians noted any malingering or positive Waddell findings**. The physicians who treated Petitioner on multiple occasions were best positioned to note any malingering or untruthfulness and never did. **Further, both Arbitrators Fratianni and Falcioni found Petitioner to be credible.**

Although Respondent relies on the above discussed reports, they have chosen to ignore **Physician's Review Network report dated February 9, 2018 that certified Petitioner's Spinal**

Cord Stimulator implant. (PX 47) In his report, Dr. Gregory Polston, Board Certified in Anesthesiology/Pain Medicine, indicated,

> **The stimulator was necessary and appropriate and consistent with medical guidelines.** The patient has a longstanding low back and radicular component to her pain with primarily axial pain. The patient had failed conservative care, including controlled medications, nonsteroidal anti-inflammatory medications and, anticonvulsants. She had failed physical therapy and chiropractic treatment. The patient was not a surgical candidate and had pain consistent with pain that could be relieved with a spinal cord stimulator. It is also consistent with the Official Disability Guidelines for a spinal cord stimulator. **Thus, the spinal cord stimulator is reasonable, necessary, and appropriate. (PX 47)**

Despite this objectively clear Utilization Review certifying treatment, Respondent inexplicably and unreasonably refused to pay for the spinal cord stimulator.

Finally, in their Decisions, both Arbitrators Fratianni and Falcioni found that Respondent was liable for Petitioner's prospective medical treatment related to her lumbar spine. Respondent simply ignored the Commission's order.

Based on the preponderance of the credible weight of the evidence, the Arbitrator finds and concludes Respondent is liable for Petitioner's medical treatment. The Arbitrator further finds and concludes Petitioner's medical treatment has been reasonable, necessary and causally related to her work-injury.

K. THE ARBITRATOR FINDS AND CONCLUDES RESPONDENT IS LIABLE FOR PAYMENT OF PETITIONER'S TEMPORARY TOTAL DISABILITY.

L. THE ARBITRATOR FINDS AND CONCLUDES PETITIONER PROVED SHE IS PERMANENTLY AND TOTALLY DISABLED UNDER SECTION 8(F)AS A RESULT OF HER WORK ACCIDENT.

The Arbitrator incorporates all Findings of Fact into these Sections.

Given the Arbitrator's finding of causation, Respondent is liable for payment of Petitioner's temporary total disability benefits. At hearing, Petitioner claims that her temporary total disability period is from August 19, 2010 to August 21, 2012 and March 16, 2014 to November 13, 2017. From August 21, 2012 to March 16, 2014, the parties agree that Petitioner was pursuing vocational rehabilitation with Ms. Bishop and paid maintenance benefits. The main issue is if Respondent is liable for benefits after Dr. Borchardt indicated that Petitioner should no longer participate in the vocational rehabilitation program initiated by Respondent through Ms.

Bishop. Dr. Borchardt discussed her rationale for suspending Petitioner's participation in the program during her deposition testimony. Dr. Borchardt indicated that she was able to review Petitioner's FCE results from Brightmore that indicated, "Client is presently not a job match to return to her previous work as an R.N." (RX 17 at 3) Dr. Borchardt then questioned why Petitioner's vocational program focused on this and added Petitioner was not sleeping and that the process was presenting her with too much stress. Finally, Dr. Borchartdt indicated, "She was in chronic pain, there weren't treatments that were actually reducing her pain at that point in time and she couldn't sit to do this vocational rehabilitation, so no, I did not think that she could engage in that type of activity." (PX 23 at 15)

To counter this, as previously discussed, Respondent offered opinions from Dr. McManus who indicated that based on his testing, Petitioner could participate in vocational rehabilitation and that she displayed elements of malingering and secondary gain. (RX 1, 2, 3, & 4) Again, besides Dr. McManus and Dr. Singh, no other evidence substantiates this. Further, Dr. Borchardt administered like testing to Petitioner prior to Dr. McManus and indicated the test results were consistent with Petitioner's condition and related symptoms. Most significantly, however, Petitioner submitted to additional psychological testing prior to implantation of the permanent spinal cord stimulator. After the testing was completed, Dr. Rosenow determined that Ms. Eaton was an appropriate candidate for the permanent stimulator and went ahead with implantation. (PX 38) It was after this procedure, that Petitioner indicated that she had relief from the symptoms she had into her lower extremities. The fact that this procedure was not carried out for years after first being suggested by Dr. Goodman was because Respondent refused to pay for Petitioner's treatment. This is verified by Respondent's payment ledger marked as Respondent's Exhibit 22. Petitioner only received the treatment after becoming Medicare eligible after being deemed disabled. Respondent even refused payment for this after their utilization review report deemed the procedure reasonable, necessary and appropriate. (PX 47)

The evidence demonstrates that Petitioner did not reach maximum medical improvement until after implantation of the permanent spinal cord stimulator on November 13, 2017. (PX 38) The treatment prior to that date maintained Petitioner's condition but she did not get permanent relief of symptoms until after she received the stimulator. While Petitioner continued with conservative treatment including injections following the procedure, the treatment again centers on maintenance of Petitioner's symptoms. (PX 42) For example, consistent with Petitioner's

testimony at trial, on June 18, 2018, Dr. Goodman reports that the stimulator works well for Petitioner's leg pain but that she continues to deal with low back pain. (PX 42)

Pursuant to the Act, a claimant is entitled to receive TTD benefits until maximum medical improvement is reached. *Nascote Indus. v. Indus. Comm'n*, 353 Ill. App. 3d 1067, 1072 (2004). It is clear that, despite undergoing the FCE, Petitioner did not reach MMI until implantation of the spinal cord stimulator. Given the Arbitrator's above finding and based on the greater weight of the evidence, Respondent is liable for temporary total disability benefits from August 19, 2010 to August 12, 2012 and from March 16, 2014 to November 13, 2017. Petitioner has further met her burden of proof entitling her to permanent disability benefits under the Act from November 14, 2017 to May 22, 2019.

As discussed herein above, the notation from Petitioner's hand surgeon that indicated that Petitioner was working in a bank is clearly inaccurate. Any reliance on this notation from Respondent to deny TTD is misguided, unreasonable and not based on the evidence presented. Petitioner's testimony at trial indicating she was not working in a bank at that time is confirmed by Ms. Bishop's December 10, 2012 report that documented Petitioner was doing vocational rehabilitation at that time. Ms. Bishop's reports document her ongoing meetings with Petitioner that would make it impossible for Petitioner to have been working at that time. (PX 18)

Petitioner is permanently and totally disabled based on her odd-lot status. It has been held an employee may not be completely incapacitated from working but is handicapped to the degree that she is unable to find employment in any well-known branch of the labor market. *City of Chicago v. Illinois Workers' Comp. Comm'n,* 373 Ill. App. 3d 1080, 1089 (2007). To successfully prevail on this claim, a Petitioner must show evidence which either indicates diligent searches were performed unsuccessfully to find employment or that due to Petitioner's age, skills, training, experience and education will not produce employment in a well-known branch of the labor market. Id. If such evidence can be produced, the Respondent then has the burden to show the Petitioner is employable in a stable labor market and the market exists. Id. at 1091.

Petitioner not only searched diligently for a job but did so under the guidance of a vocational rehabilitation specialist. Petitioner participated in vocational rehabilitation with Ms. Bishop who was hired by the Respondent. Not only did Petitioner participate in the program for a period of seven months, but Ms. Bishop noted in numerous reports that Petitioner was motivated and complied with assignments. (PX 18) There was no evidence indicating Petitioner lacked effort

in looking for a job during this period. The Commission has previously indicated that six months of unsuccessful job search activities was sufficient in showing a diligent job search was performed in the labor market and shifting the burden to the Respondent. *Carl Hill, Petitioner*, 05 IL. W.C. 16042 (Ill. Indus. Com'n Feb. 5, 2009).

Despite her participation and Bishop's knowledge of job placement, vocational rehabilitation only yielded Petitioner one 15-minute phone interview. Out of the numerous contacts and applications to employers, Petitioner never had an in-person interview or a job offer of any kind. Following this process, Petitioner continued and ultimately had the placement of a permanent spinal cord stimulator. Pagella testified that this only added to a potential employers' reluctance to hire Petitioner. (PX 46 at 29) This evidence is more than enough to shift the burden on Respondent to show employability in a stable labor market and that the market exists.

As a side issue regarding the vocational process, Respondent alludes that Petitioner unilaterally stopped vocational rehabilitation. (PX 46 at 41 & RX 15 at 21) This is not substantiated by the evidence submitted. Petitioner's treating physician, Dr. Borchardt indicated that Petitioner should not be involved in the process. Ms. Bishop was aware of this at the time of her deposition testimony in 2018. (RX 15 at 45)

Petitioner has also presented evidence showing that due to her age, skills, training, experience and education that employment does not exist in a well-known branch of the labor market. Petitioner relies on the opinions given by Ed Pagella, certified rehabilitation counselor. Pagella rendered his opinions regarding Petitioner during his November 12, 2018 deposition. (PX 46) At that time, Pagella testified he is a certified rehabilitation counselor and that he owns a vocational rehabilitation consulting firm, Health Connection. (PX 46 at 4) When asked to describe his business and practice, Pagella testified, "I am a vocational expert. I perform employability studies. I'm also an expert witness for the federal government as well as the railroad retirement board in determining the employability of individuals who have a wide variety of physical and/or mental limitations." (PX 46 at 6) Pagella indicated that he testifies on vocational issues in front of federal administrative law judges approximately 20 times a week and 80 times per month. (PX 46 at 7) In the realm of workers' compensation, Pagella testified that he does equal work for Petitioners and Respondents. (PX 46 at 12)

Pagella indicated that he drafted a report on behalf of Petitioner to determine her employability and relied on information including physical limitations, work history, residency,

labor market and educational history. (PX 46 at 14) To do this, he reviewed Petitioner's records from Midwest Orthopeadics, Dr. Rhode, Dr, Goodman, Northwestern Memorial Hospital, Brightmore Physical Therapy, Pain Specialists of Chicago, Vocamotive, Dr. McManus, Midwest Hand Surgery and Dr. Borchardt. (PX 46 at 16) Pagella also indicated that Petitioner is "currently receiving Social Security Disability Benefits as a Federal Administrative Law Judge has found her to be completely and totally disabled," (PX 41 at 2) In addition, Pagella was aware that Creative Case Management helped Petitioner with a job search that was unsuccessful. (PX 46 at 25) After discussing the records he reviewed and the totality of Petitioner's vocational profile including her age, her education, her work history and her physical and mental limitations, Pagella opined that Petitioner was unemployable. (PX 46 at 28)

In support of his opinion, Pagella testified he did not consider Dr. Borchardt's opinion that Petitioner should not be involved in vocational rehabilitation and, instead, focused on Petitioner's entire vocational profile. (PX 46 at 27 & 28) Pagella found it very relevant that Petitioner was involved in a job search through Creative Case Management and was still unsuccessful in finding alternative employment. (PX 46 at 28) Pagella noted Petitioner was also entering advanced age at 55, that she was found to be disabled by a federal law judge and that she had a spinal cord stimulator. (PX 46 at 19 & 29)

Pagella also reviewed a vocational assessment report from Vocamotive. (PX 46 at 28) On behalf of the Petitioner, Vocamotive also offered opinions on Petitioner's employability. Ms. Kari Stafseth, certified rehabilitation counselor, offered her opinions in a report dated January 25, 2016. (PX 26) After reviewing medical records, Petitioner's FCE and the reports from Creative Case Management authored by Bishop, Stafseth gave a number of opinions. Stafseth concluded;

- Ms. Eaton lost access to her usual and customary job of nurse.
- Ms. Eaton had put forth a reasonable effort in her previous vocational rehabilitation efforts (as was noted in Ms. Bishop's report submitted as PX 18).
- Ms. Eaton had been applying for several positions that she was not qualified for and required additional training or credentials that she did not have.
- Several of the job targets required the ability to sit for extend periods of times which exceeded the FCE restrictions.

- Petitioner was prospectively employable but that the job targets including front desk representative, concierge, security guard, cashier and retail sales associate require lifting or sitting capabilities beyond her capacity.

In conclusion, Stafseth found that she could not recommend vocational rehabilitation for Petitioner. Pagella indicated that in addition to his expertise, he also relied on Stafseth's opinions in concluding that Petitioner was unemployable. (PX 46 at 33). The Arbitrator finds these opinions credible and supported by evidence in the record and accordingly adopts them as his own.

Further, these opinions and evidence presented regarding Petitioner's age, skills, training, experience and education show employment does not exist in a well-known branch of the labor market and shifts the burden to Respondent to prove the contrary.

On the issue of employability in a stable labor market and the existence of such market, Respondent offered the opinions of Ms. Bishop via her December 5, 2018 deposition. At that time, Bishop agreed that Petitioner complied with the program and that she had not wanted to leave her job as a nurse. (RX 15 at 22 &14) Bishop testified that she drafted two updated labor market surveys dated October 9, 2016 and November 8, 2018 and it was her opinions that there was a viable labor market for Petitioner. (RX 15 at 23-27) Despite indicating that she reviewed Petitioner's FCE, Bishop again opined that the six areas she identified from the Dictionary of Occupational Titles were within nursing. (RX 15 at 34) Again, the FCE indicated that Petitioner could not work as a nurse given her restrictions. Respondent offered no evidence to dispute the findings of the FCE. Clearly, Petitioner does not qualify for the positions that Bishop indicated substantiated her opinion that there is a viable labor market for Petitioner in 2012, 2016 and 2018. Even if the FCE is disregarded, as Bishop has done, the preponderance of the credible facts of the case substantiate that Petitioner has proven she is permanently and totally disabled. Bishop confirmed as much in her deposition testimony and indicated;

- Petitioner never secured employment during the seven-month vocational rehabilitation process despite being a good candidate. (RX 15 at 33)
- Petitioner was provided professional services but did not find a job through the vocational process. (RX 15 at 33)
- Petitioner did resume training, mock interviews and followed up on job leads but did not find a job. (RX 15 at 33)
- Petitioner did not sabotage the vocational process and still did not find a job. (RX 15 at 34)

- Petitioner looked for jobs in all six categories identified in nursing that she qualified for but did not find a job. (RX 15 at 34)
- Petitioner applied for the positions identified but did not find a job. (RX 15 at 34)
- Even if an employer accommodated Petitioner's need to frequently move around, Petitioner was never offered a job. (RX 15 at 36)
- A spinal stimulator is an additional impediment to finding a job. (RX 15 at 36)
- That even if Petitioner were to find a job as of 2018, it would not be full time employment. (RX 15 at 38)
- That Petitioner is being prescribed Tramadol and Valium for her condition and would probably fail a drug test. (RX 15 at 43)
- That if Petitioner failed a drug test, it would be not be beneficial to securing employment. (RX 15 at 43)

The facts demonstrate Petitioner is permanently and totally disabled. The date of disability is the date Petitioner underwent permanent implantation of the spinal cord stimulator on November 13, 2017, when Petitioner reached MMI. Pagella reached his conclusions after that date. Even if, however, this is not deemed the date of permanent disability, the evidence demonstrates that Petitioner was permanently and totally disabled as of March 11, 2013, the date when vocational rehabilitation ceased. (RX 15 at 18) Bishop directed Petitioner's program and was well qualified to do so by review of her curriculum vitae submitted as Respondent's Exhibit 20. Despite this and Petitioner's commitment to the program, Petitioner had only one phone interview, no in person interviews and was not offered employment of any kind. Bishop documented the single phone interview in her November 7, 2012 vocational report. (PX 18) From that point forward, Petitioner's condition and limitations were unchanged. Petitioner now has a spinal cord stimulator which Pagella and Bishop agree is a further impediment to Petitioner securing employment.

The Arbitrator also places great significance, weight, credibility and reliance on Dr. Goodman's note dated January 23, 2014, where Dr. Goodman also indicates Petitioner is totally disabled. (PX 20)

Based on the weight of the preponderance of the credible evidence, the Arbitrator finds and concludes Petitioner is permanently and totally disabled under Section 8(f) of the Act. The

Arbitrator finds the date of permanent total disability to be effective on November 13, 2017, the date Petitioner reached MMI. Given this finding, the Arbitrator awards TTD benefits from August 19, 2010 to August 12, 2012, maintenance benefits from August 13, 2012 to March 11, 2013 and TTD benefits from March 12, 2013 to November 13, 2017. From November 13, 2017 to the present, the Arbitrator finds Petitioner to be permanently and totally disabled and awards benefits of **$675.91 per week for the life** of Petitioner pursuant to Section 8(f) commensurate with this ruling.

M. THE ARBITRATOR FINDS AND CONCLUDES RESPONDENT IS LIABLE FOR PENALTIES UNDER SECTIONS 19(K), 19(L) AND 16 UNDER THE ACT.

Petitioner has filed a penalties petition in this matter. Sections 19(k) and 19(l) of the Act provides for penalties and Section 16 provides for attorney fees. Under Section 19(k), the Act provides that if the Respondent's conduct has been unreasonable and vexatious, the Commission may award compensation additional to that otherwise payable under this Act equal to 50% of the amount payable at the time of the award. Respondent's payment ledger demonstrates they stopped paying bills submitted, documented in Petitioner's Exhibit 1. (RX 22) Further, throughout her testimony, Petitioner indicates that her benefits stopped along with approval of medical treatment.

Section 19(l) of the Act holds, "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." Presently, Respondent's conduct in refusing to pay Section 8(a) and 8(b) was unreasonable and vexatious.

Section 16 of the Act holds that when employer have been guilty of unreasonable or vexatious delay of payment of benefits, the Commission may award all or any part of attorney's fee and costs against such employer.

According to the Illinois Supreme Court, the intent of Sections 16, 19(k) and 19(1) of the Workers' Compensation Act is to implement the Act's purpose to expedite the compensation of industrially injured workers and to penalize an employer who unreasonably, or in bad faith, delays or withholds compensation due an employee. *Avon Products, Inc. v. Industrial Commission*, 82 111.2d 297, 412 N.E.2d 468, 45 III. Dec. 117 at 119 (1980). The Court has held that the standard to consider is "objective reasonableness" of Respondent's conduct, burden of proof, and question of fact for the Commission apply to the imposition of Section 19(k) attorneys fees and attorneys'

fees and costs under Section 16. *Board of Education of the City of Chicago v. Industrial Commission,* 93 1I1.2d 1, 442 N.E.2d 861, 66 III. Dec. 300 (1982).

Presently, Respondent refused to pay benefits to Petitioner after vocational rehabilitation ceased. The last payment was for the period from March 10, 2014 to March 16, 2014. (PX 49) From that date forward, Petitioner only received advances based on trial continuances. As discussed, the vocational process was frivolous to begin with given that Bishop refused to acknowledge the FCE that indicated Petitioner could not return to her line of work as a nurse. Despite Bishop's misguided program and Petitioner's loyalty to it, Petitioner completed 7 months of vocational rehabilitation and found no job of any kind. Despite this, Respondent refused to pay Petitioner any benefits. Respondent seems to rely on Dr. McManus' report. This report only indicated, however, that Petitioner's psychological profile did not preclude her from doing vocational rehabilitation. As discussed herein, Petitioner's treatment physician, Dr. Borchardt directed that Petitioner stop vocational rehabilitation to focus on her recovery. Prior to this time, however, Petitioner underwent this process and did not find a job. Dr. Borchardt continually discusses the impact Respondent's actions had on Petitioner's condition and her inability to address her symptoms. (PX 27)

Respondent's reliance on Dr. McManus' opinions does not preclude the award of penalties. As discussed, Dr. McManus opined that Petitioner's mental profile allowed her to continue with the vocational process. Respondent's reliance on Dr. McManus' opinion to stop paying Petitioner benefits was unreasonable. Dr. McManus' opinions were based on the vocational program directed by Bishop. This program was frivolous from the beginning given that Bishop ignored the findings of the FCE.

In addition to unreasonably refusing to pay Petitioner's benefits, Respondent refused to pay for any of Petitioner's medical treatment after January 2013. Respondent's only plausible - and available - basis for denial is Dr. Singh's April 23, 2018 report, which report is again not credible and was issued 5 years later, and almost 7 years after his prior Section 12 examination. It is unreasonable for a Respondent to base its decision not to pay benefits on the opinion of a physician (issued years after the fact) who had been previously found to lack credibility in the same case. *Scroggins v. Yellow Freight*, 04 IIC 74. This is precisely the situation at bar. Arbitrator Falcioni specifically indicated that he found Dr. Singh to lack credibility. (PX 6) Even if this Arbitrator were to find that the report gave a reasonable basis for denial (thereby

potentially avoiding penalties) this examination was not carried out until 2018, five years after benefits were denied, and continued to be died, since 2013. That half-decade delay was objectionably unreasonable.

As discussed above, the only inclination that Dr. Goodman's treatment was denied prior to this was the adjustor's letter found in Dr. Goodman's records that treatment was denied because Petitioner violated the two-doctor rule. (PX 20) Again, this is not accurate given that Dr. Goodman was in the chain of referrals.

Finally, regarding Petitioner's spinal stimulator, Respondent's utilization report indicated it was reasonable, necessary and related to her condition. Despite this, Respondent did not approve or pay for this treatment. **How could Respondent assert this denial of medical treatment was reasonable when such denial contradicted its own Utilization Review certification?**

Further, if Respondent's dispute is based on Dr. McManus, that is also is unreasonable. Dr. McManus is a board-certified Rehabilitation Psychologist and Neuropsychologist. **Therefore, Dr. MacManus is not in a position to dispute medical treatment.**

In his decision, Arbitrator Falcioni found, "Given the finding of causation, the Arbitrator further finds the treatment and testing recommended by Dr. Vohra, the epidural steroid injection, referral to Dr. Khan and the FCE, to be reasonable and necessary for treatment Petitioner's compensable work accident and awards same." (PX 6) As demonstrated by the evidence, all of the treatment prescribed to Petitioner stemmed from Dr. Vohra's referrals. Respondent was unreasonable and vexatious in ignoring Arbitrator's award of treatment.

Respondent's conduct is aptly characterized and summarized by Dr. Borchardt in her November 3, 2014 note wherein she indicated, "Sheila's pain levels have become very bad lately. She can't sleep because she can't get comfortable. The wait time for her treatments to be approved by workers compensation is inhumane, in my opinion." (PX 27) Dr. Borchardt further noted on December 10, 2014, "Sheila feels that she is controlled by workers compensation because her pain is uncontrolled and workers compensation won't approve recommended treatments." (PX 27) Notations of the hardship Petitioner endured because of the Respondent's unreasonable and vexatious conduct are described throughout Dr. Borchardt's treatment records. (PX 27)

Based on the greater weight of the evidence, the Arbitrator awards Petitioner penalties under 19(k) of the Act for Respondent's unreasonable and vexatious refusal to pay Petitioner's TTD benefits, permanent total benefits and medical treatment. The Arbitrator also awards penalties

totaling $10,000.00 under Section 19(l) of the Act as well as attorney fees under Section 16 of the Act commensurate with penalties awarded under 19(k).

CONCLUSIONS OF LAW

11WC 32885 – Bilateral carpal tunnel

C. THE ARBITRATOR FINDS AND CONCLUDES PETITIONER'S BILATERAL CARPAL TUNNEL SYNDROME AROSE OUT OF AND IN THE COURSE OF HER EMPLOYMENT WITH RESPONDENT.

F. THE ARBITRATOR FINDS AND CONCLUDES PETITIONER'S BILATERAL CARPAL TUNNEL SYNDROME IS CAUSALLY RELATED TO HER EMPLOYMENT WITH RESPONDENT.

As discussed herein above, Petitioner indicated that she noticed symptoms in her hand while working in her nursing position with Respondent. For this, she sought treatment with Dr. Karnezis who performed bilateral carpal tunnel syndrome releases on December 13, 2011. (PX 8) In his noted dated June 15, 2012, Dr. Karnezis noted,

> Work description was obtained which revealed evidence of repetitive and gripping activities to be performed at her work duties. This was specifically is part of her job requirements. This was listed under the physical demands with use of hands and fingers for push and pulls activities as well as for repetitive use of hands and fingers for push and pulls activities as well as for repetitive use of both hands for seven or more hours grasping. (PX 8)

It is unrebutted that Petitioner was a nurse with the above job duties discussed by Dr. Karnezis. Further, no other activities or hobbies are discussed in any of the evidence that would cause carpal tunnel syndrome.

It is the Commission's function, to choose between conflicting medical opinions. *International Vermiculite Co. v. Industrial Comm'n*, 77 Ill.2d 1, 4, 31 Ill.Dec. 789, 394 N.E.2d 1166, 1168 (1979); *ARA Services, Inc. v. Industrial Comm'n*, 226 Ill. App. 3d 225, 232, 168 Ill. Dec. 756, 590 N.E. 2d 78, 82 (1992). **Not only may the Commission decide which medical view is to be accepted, it may attach greater weight to the opinion of the treating physician.** *International Vermiculite Co. v. Industrial Comm'n*, 77 Ill.2d 1, 4, 31 Ill.Dec. 789, 394 N.E.2d 1166, 1168 (1979); *ARA Services, Inc. v. Industrial Comm'n*, 226 Ill. App. 3d 225, 232, 168 Ill. Dec. 756, 590 N.E. 2d 78, 82 (1992). **In this matter, after careful review, the Arbitrator places**

greater credibility, weight and reliance on the opinions of Petitioner's treating physician Dr. Karnezis over that of Respondent's Section 12 examiner.

Based on the greater weight of the evidence, the Arbitrator finds that Petitioner has proven by the preponderance of the credible evidence that her bilateral carpal tunnel conditions arose out of and in the course of her employment with Respondent and are causally related to her work activities.

J. THE ARBITRATOR FINDS AND CONCLUDES RESPONDENT IS LIABLE FOR PAYMENT OF PETITIONER'S REASONABLE AND NECESSARY MEDICAL TREATMENT.

Given the Arbitrator's finding of compensability, Respondent is liable for the reasonable and necessary medical treatment rendered for Petitioner's condition as submitted in Petitioner's exhibit 1. In his note dated June 15, 2012, Dr. Karnezis indicated that the surgeries improved Petitioner's conditions and she could return to full duty work.

L. THE ARBITRATOR FINDS AND CONCLUDES RESPONDENT IS LIABLE FOR PERMANENCY RELATED TO PETITIONER'S BIALTERAL HAND CONDITIONS.

Given the Arbitrator's finding that Petitioner suffered a compensable work accident related to her bilateral hands, Respondent is liable for permanency related to those conditions and bilateral carpal tunnel syndrome releases performed on December 13, 2011 At hearing, Petitioner testified that she continues to have weakness and permanent nerve damage in her hands that has never resolved. (T65) Based on the greater weight of the evidence, the Arbitrator finds that Petitioner suffered permanent partial disability for a total period of 66.625 weeks: the permanent partial los of use of her right hand to the extent of 17.5% thereof under Section 8(e)9, or 35.875 weeks, and the permanent partial loss of use of her left hand to the extent of 15% thereof under Section 8(e 09, or 30.75 weeks. **Petitioner's weekly PPD rate is $608.32.**

Robert M. Harris

Signature of Arbitrator Robert M. Harris

Dated: July 15, 2019

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Sheila Eaton,

Petitioner,

vs.

No. 11 WC 32885, consolidated w/
10 WC 25336

Morris Hospital,

Respondent.

20IWCC0330

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, prospective medical, temporary disability, permanent disability, penalties and attorney's fees, and being advised of the facts and law, reverses those parts of the Decision of the Arbitrator which relate to claim number 11 WC 32885, attached hereto and made a part hereof. The Commission is issuing a separate decision for Petitioner's companion claim, number 10 WC 25336, which was tried concurrently with this claim.

Petitioner filed claim number 11 WC 32885, alleging she developed bilateral carpal tunnel syndrome as a result of repetitive work activities on September 8, 2009. The Arbitrator found that Petitioner proved that she sustained accidental injuries arising out of and in the course of her employment, and that her bilateral carpal tunnel syndrome was causally related to her work activities on that date. The Arbitrator awarded Petitioner 17.5% loss of use of the right hand, 15% loss of use of the left hand, and the medical expenses incurred in treating her bilateral carpal tunnel syndrome.

The Arbitrator relied upon Dr. Karnezis's June 15, 2012 note in which that doctor reported he had reviewed Petitioner's written job description, which suggested that Petitioner was required to use her hands and fingers for pushing, pulling and repetitive grasping for seven

20IWCC0330

or more hours a day. In finding for Petitioner, the Arbitrator found the opinion in Dr. Karnezis's note more persuasive than the opinions offered by Dr. Ramsey Ellis in his Section 12 report.

The Commission views the evidence regarding the onset and cause of Petitioner's carpal tunnel condition differently than the Arbitrator. Dr. Karnezis's causation opinion appears to have been based upon assumptions he made after reviewing Petitioner's job description, regarding the activities Petitioner actually performed and how often she performed them. However, Petitioner presented no testimony that she repetitively grasped or pulled objects for 7 hours per day, or for any amount of time. She offered no testimony that she experienced hand or wrist symptoms while performing any work activities on or about September 8, 2009. She did not testify she had seen any doctor for hand or wrist problems around September 2009, and she offered no contemporaneous medical records to show that she had. Records from Morris Hospital dating back to September 8, 2009 documented no treatment for hand or wrist complaints.

At arbitration, the only testimony Petitioner presented regarding the onset of her carpal tunnel symptoms was that she experienced nighttime pain in her hands and arms which made it difficult for her to sleep. Petitioner's first documented carpal tunnel syndrome symptom – burning in her extremities – was not found in her records until the May 13, 2011 note of Dr. Vohra. That was nearly one year after Petitioner had last worked for Respondent. Subsequent NCV testing confirmed, for the first time, the diagnosis of carpal tunnel syndrome.

Dr. Ellis conducted a physical examination of Petitioner, reviewed her medical records, and took a history from her. He opined that her bilateral carpal tunnel syndrome was not related to any occupational exposure to highly repetitive flexion and wrist extension coupled with forceful grasping, or to prolonged exposure to vibratory tools. He opined that Petitioner's carpal tunnel syndrome was idiopathic in origin. At arbitration, Petitioner acknowledged that she performed no work activities which involved fine manipulation, and that she did not work with power tools.

Based on the foregoing, the Commission finds that Dr. Ellis's opinions were based upon a reasonable degree of medical certainty. Dr. Ellis had a more accurate and complete understanding of Petitioner's medical condition and her work where Dr. Karnezis did not. The Commission finds the opinions of Dr. Ellis more persuasive than those of Dr. Karnezis, and finds Petitioner failed to prove her carpal tunnel syndrome was caused or aggravated by any accident or exposure at work on or about September 8, 2009.

IT IS THEREFORE ORDERED BY THE COMMISSION that those parts of the Arbitrator's July 16, 2019 Decision which related to Petitioner's bilateral carpal tunnel claim, number 11 WC 32885, are reversed.

IT IS FURTHER ORDERED BY THE COMMISSION that the Arbitrator's award of medical expenses incurred for the treatment of Petitioner's bilateral carpal tunnel syndrome in this claim, number 11 WC 32885, is vacated. All other medical expenses awarded by the Arbitrator under §8(a) and §8.2 of the Act are related to Petitioner's companion claim, number 10 WC 25336, and are affirmed in the Commission's decision for that claim.

IT IS FURTHER ORDERED BY THE COMMISSION that the Arbitrator's award of temporary total disability benefits under §8(b), maintenance benefits under §8(a), and permanent total disability benefits under §8(f) of the Act, are not related to this claim, number 11 WC 32885; but rather, to Petitioner's companion claim, number 10 WC 25336. The Arbitrator's award of those temporary total disability, maintenance, and permanent total disability benefits are affirmed by the Commission in its companion decision, number 10 WC 25336.

IT IS FURTHER ORDERED BY THE COMMISSION that the Arbitrator's award of 17.5% loss of use of the right hand and 15% loss of use of the left hand under §8(e) of the Act is 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.

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.

JUN 15 2020

DATED:
o-05/21/2020
MP/mcp
68

Marc Parker

Deborah L. Simpson

Barbara N. Flores

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

EATON, SHEILA
Employee/Petitioner

Case# **10WC025336**

11WC032885

MORRIS HOSPITAL
Employer/Respondent

20IWCC0330

On 7/16/2019, 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 2.01% 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:

1357 RATHBUN CSEVENYAK & KOZOL
LUIS MAGANA
3260 EXECUTIVE DR
JOLIET, IL 60431

5354 STEPHEN P KELLY
ATTORNEY AT LAW
2710 N KNOXVILLE AVE
PEORIA, IL 61604

20IWCC0330

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

Sheila Eaton,
Employee/Petitioner
v.

Case # **10** WC **25336**

Consolidated cases: **11 WC 32885**

Morris Hospital,
Employer/Respondent

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

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ 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 **6-22-10 and 9-8-09**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**52,721.24**; the average weekly wage was $**1,013.87**.

On the date of accident, Petitioner was **47** years of age, ***married*** with **1** 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 $**126,022.43** for TTD for the time period 1/28/11 – 3/16/14, $**4,157.82** for TPD, $**0** for maintenance, and $**40,041.65** for other benefits paid (permanent partial disability), for a total credit of $**170,221.75**.

Respondent is entitled to a credit of $**56,997.13** under Section 8(j) of the Act.

ORDER

RESPONDENT IS LIABLE FOR PAYMENT OF PETITIONER'S MEDICAL TREATMENT BILLS AS OUTLINED IN PETITIONER'S EXHIBIT #1PURSUANT TO SECTIONS 8(A) AND 8.2 COMMISSION MEDICAL FEE SCHEDULE. RESPONDENT SHALL RECEIVE CREDIT FOR ALL MEDICAL BILLS PAID.

RESPONDENT SHALL PAY PETITIONER TEMPORARY TOTAL DISABILITY BENEFITS AT THE RATE OF **$675.91 PER WEEK** FOR THE PERIODS OF AUGUST 19, 2010 TO AUGUST 12, 2012 AND MARCH 11, 2013 TO NOVEMBER 13, 2017, TOTALING 347-1/7 WEEKS OR $234,637.42 ($675.91 X 347.143 = $234,637.42).

RESPONDENT IS LIABLE FOR MAINTENANCE BENEFITS PAYABLE TO PETITIONER FROM AUGUST 13, 2012 TO MARCH 11, 2013 TOTALING 30 WEEKS, AT THE RATE OF $675.91 PER WEEK, OR THE SUM OF $20,277.30.

PETITIONER IS PERMANENTLY AND TOTALLY DISABLED PURSUANT TO SECTION 8(F) OF THE ACT EFFECTIVE NOVEMBER 13, 2017, THE DATE PETITIONER REACHED MMI. RESPONDENT IS LIABLE FOR UNPAID BENEFITS OF **$675.91 PER WEEK** FROM NOVEMBER 13, 2017 TO MAY 22, 2019 TOTALING 79-1/7 WEEKS OR $53,493.54 AND IS LIABLE FOR CONTINUING BENEFITS FOR THE LIFE OF PETITIONER.

RESPONDENT IS TO PAY PENALTIES TO PETITIONER UNDER THE ACT PURSUANT TO SECTION 19(K) AMOUNTING TO 50% OF UNPAID MEDICAL BILLS BEFORE ANY ADJUSTMENTS PURSUANT TO SECTION 8.2.

RESPONDENT IS TO PAY PENALTIES TO PETITIONER UNDER THE ACT PURSUANT TO SECTION 19(K) AMOUNTING TO 50% OF UNPAID TTD AND MAINTENANCE BENEFITS, IF ANY.

RESPONDENT SHALL PAY PENALTIES TO PETITIONER UNDER THE ACT PURSUANT TO SECTION 19(L) TOTALING $10,000.00.

RESPONDENT SHALL PAY ATTORNEY FEES UNDER THE ACT PURSUANT TO SECTION 16 AMOUNTING TO 20% OF THE AWARD OF SECTION 19(K) PENALTIES.

PETITIONER SHALL RECEIVE ADDITIONAL COMPENSATION AT THE RATE OF **$608.32 PER WEEK** FOR A TOTAL OF **66.625 WEEKS** BECAUSE SHE SUSTAINED THE PERMANENT PARTIAL LOSS OF USE OF HER RIGHT HAND UNDER SECTION 8(E)9 OF THE ACT TO THE EXTENT OF 17.5% THEREOF, OR 35.875 WEEKS, AND BECAUSE SHE SUSTAINED THE PERMANENT PARTIAL LOSS OF USE OF HER LEFT HAND UNDER SECTION 8(E)9 OF THE ACT TO THE EXTENT OF 15.0% THEREOF, OR 30.75 WEEKS.

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

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

Robert M. Harris

Signature of Arbitrator Robert M. Harris

July 15, 2019
Date

JUL 16 2019

MEMORANDUM OF DECISION OF ARBITRATOR

STATEMENT OF FACTS

On the date of hearing, Petitioner, Sheila Eaton, confirmed she had previously testified in this matter on January 27th and September 27th, 2011. (T17) Following those 19(b) hearings, Arbitrators Fratianni and Falcioni entered decisions which were not appealed. In her decision dated March 25, 2011, marked as Petitioner's Exhibit 2, Arbitrator Fratianni found that Petitioner's suffered a compensable accident on June 22, 2010 and that her lumbar condition was causally related to the accident. Arb. Fratianni ordered that Petitioner was owed TTD benefits from August 19, 2010 to January 27, 2011, TPD benefits from June 23, 2010 through August 18, 2010 and that Respondent shall pay reasonable and necessary medical services and approve prospective medical treatment prescribed by Petitioner's treating physician, Dr Kube. (PX 2)

Respondent again sent Petitioner to a Section 12 examination with Dr. Kern Singh as they had prior to the first 19(b) hearing. Based on his opinions, Respondent again denied liability for TTD benefits as well as medical treatment. At hearing, Petitioner indicated she elected not to undergo spinal surgery and instead wanted to proceed with an epidural steroid injection prescribed by Dr. Khan and undergo a functional capacity evaluation prescribed by Dr. Vohra.

In his decision dated December 16, 2011, Arbitrator Falcioni found that Petitioner suffered a compensable accident and that her condition was causally related to her June 22, 2010 work accident. (PX 6) Petitioner was awarded additional TTD benefits, medical benefits and prospective medical treatment and testing as prescribed by Dr. Vohra. Arbitrator Falcioni found that Dr. Singh's testimony was not credible and was not supported by the medical evidence submitted. (PX 6)

Petitioner testified that following her second hearing, she continued to have lower back pain down the back of both of her legs and numbness into the toes of both of her feet. (T21) Despite her symptoms, she did not have spinal fusion surgery and continued seeking conservative treatment with Dr. Vohra for her lumbar condition. (T21) Given her familiarity with lumbar surgery from her experience as a nurse, Petitioner indicated she was concerned with the fusion procedure because of the amount of failed surgeries. (T19) During 2011, Petitioner indicated she was undergoing physical therapy, pain management and injections but would only get temporary

relief of her symptoms. (T21) Petitioner was primarily treating with Dr. Vohra who continuously indicated Petitioner was suffering from chronic low back pain, chronic L5 radiculopathy and disc displacement. (PX 4) Given this, on July 29, 2011, Dr. Vohra referred Petitioner to Dr. Khan for pain management treatment. (PX 4) During her September 21, 2011 appointment, Dr. Vohra also referred Petitioner for a functional capacity evaluation ("FCE"). (PX 4) Petitioner underwent a FCE on November 16, 2011 at Brightmore Physical therapy that found she gave a maximal effort, participated fully in all of the FCE test items and that she was on the light to low end of medical US department of Labor Physical Demand Level. (RX 17) The findings of the FCE noted Petitioner was not a job match to return to her previous work as a registered nurse. (RX 17) Amongst other limitations, the report noted,

> Client was limited in her ability to tolerate prolonged sitting. Client sat uninterrupted for 11 minutes and a total of 38 minutes; however, required 6 standing breaks due to pain reports and was observed to have constant weight shifting left and right throughout the interview, had tests, and coordination tests. Client also was somewhat limited in her tolerance to static standing, forward bend, and floor to waist lift abilities. (RX 17)

This physical motion observation by the FCE examiner, David Brightmore, PT, was also noted on the day of hearing. At hearing, it was noted for the record Petitioner was standing against the wall and was observed distributing her weight from foot to foot. (T20)

After her FCE, Petitioner was given restrictions from Dr. Vohra that coincided with the results. (PX 22) Petitioner testified Respondent did not offer her a job within her restrictions and had, in fact, terminated her prior to the FCE. (T23) Respondent, via Erin Murphy-Frobish, terminated Petitioner in a letter dated May 26, 2011, indicating she had exhausted all of leave of absence time. (RX 18)

Given Dr. Vohra's referral, Petitioner saw Dr. Mohammed Khan at Rush-Copley Medical Center on December 30, 2011. (PX 13) At that time, Petitioner reported her pain complaints and the accident lifting a patient on June 22, 2010. (PX 13) After his physical examination, Dr. Khan diagnosed Petitioner with chronic low back pain secondary to lumbar radiculopathy and prescribed an epidural steroid injection along with therapy. (PX13) Similar to Petitioner's presentation at hearing, Dr. Khan noted Petitioner was trying to look for a comfortable position in his office but could only get relief when she leaned over or when she leaned on the wall. (PX 13) After two injections, Dr. Khan indicated he would not recommend additional injections because, although Petitioner's symptoms were temporarily better, she had similar pain and radiation into her

extremities as prior to the injections. (PX 13) This is consistent with Petitioner's testimony throughout the hearing wherein she indicated that after most of her treatment, she would get temporary relief but that her pain and symptoms would return. At her March 6, 2013 appointment, Dr. Khan recommended that Petitioner to see either Dr. Sani or Dr. Rabin at Rush-Copley to discuss a minimally invasive lumbar discectomy. (PX 13) Petitioner testified that workers' compensation did not approve this referral. (T25)

Following her FCE results and restrictions by Dr. Vohra, Petitioner testified she met with Charlotte Bishop, a vocational counselor hired by Respondent on February 5, 2012. (T26) On that date, Bishop interviewed Petitioner for the purpose of obtaining background information that would be useful for her to do a transferable skills analysis and labor market survey. (PX 18) In her initial report from that date, Ms. Bishop documented Petitioner's restrictions, "light to low medium physical demand level with restrictions (lifting/carrying 30-35 pounds) and allowing changes of position as needed, limits sitting and avoids repetitive or sustained forward trunk positions." (PX 18) Bishop identified thirty-eight medically appropriate positions within 35 miles of Petitioner's home with wages from $50,000.00 to $78,000.00 or more per year. (PX 18)

Petitioner confirmed she then began working with Bishop in August, 2012 to find a job and that they met weekly. (T27-28) Petitioner indicated that Bishop told her there was a viable job market and that she gave her reading materials, assignments and job leads weekly. (T29) During this period, Petitioner testified she worked 35-40 plus hours per week on the vocational process. (T29) Although Bishop indicated Petitioner was a good candidate for vocational placement, Bishop conceded there were significant impediments to placing Petitioner including her physical restrictions and use of Tramadol (PX 18) Ultimately, Bishop indicated appropriate positions for Petitioner within the nursing field were as a consultant, a supervisor, a school nurse, infection control, a nurse anesthetist or as an office nurse. (PX 18) Bishop did not report the fact the FCE indicated Petitioner could not work as a registered nurse. (RX 17)

After meeting with Petitioner and beginning the job search process, Bishop then created weekly to bi-weekly reports of her interactions with Petitioner. (RX 18) Petitioner testified the most demanding part of the vocational process was filling out applications for jobs. (T30) Petitioner indicated each application would take about 90 minutes because she would typically have to take a test first and then give all of her background information before filling out the application. (T30) Petitioner testified she would have a lot of back pain from sitting to fill out each

application. (T30) Petitioner testified working at the computer especially exacerbated her low back and leg pain. (T31) Despite her lower back symptoms, Petitioner testified she felt Bishop was good at her job and she continued with the vocational process. (T31)

In her vocational reports, Bishop documented the job search process and on April 25, 2012, documented that Petitioner had confidence in her employability once the pain in her back and left leg have resolved and she had always been successful finding employment. (PX 18) From her initial report forward, Bishop documented Petitioner was compliant with the process and there was reports of Petitioner's not following through on her assignments. (PX 18) However, Bishop did document that Petitioner's level of pain and her need to move around rather than sit is a distraction to the job search process. (PX 18)

In her August 12, 2012 report, Bishop documented that Petitioner created a home office for the job search process. (PX 18) Bishop also indicated the time frame for resolution would be 10 sessions of her services. (PX 18) Bishop's reports typically indicated she gave Petitioner 10-15 job leads and that she would identify leads herself in each period. (PX 18) The leads by Bishop and Petitioner were consistently between 10-15 each as documented in Bishop's reports. (PX 18)

Petitioner was compliant throughout the process. (PX 18) For example, in her September 22, 2012 report, Bishop indicated Petitioner "demonstrated good follow through with the assignment given to her" and was "pleasant and cooperative throughout the meeting." (PX 18) The section of this report entitled, "HOMEWORK FOLLOW-UP:" demonstrates the amount of effort put into this process by Bishop and Petitioner. (PX 18) This section lists off nine distinct tasks given to Petitioner in the course of a single week and indicated that 8 of 9 were completed and the one not fully completed was partially completed. (PX 18) This is representative of all of Bishop's reports throughout the vocational process. Petitioner showed this level of commitment despite her low back pain and symptoms.

In the same September 22, 2018 report, Bishop documented that Petitioner continued to complain of significant pain but was, "committed to cooperating with the guided job search efforts." (PX 18) Ms. Bishop further acknowledged, "The VCM remains cautiously optimistic that the guided job search will be successful, however, the consistent use of pain medication, need to rest and ongoing back and leg pain will be issues which will need to be addressed as conversations with employer take place." (PX 18)

In her November 23, 2012 report, Bishop again noted that Petitioner, "continues to demonstrate a good faith effort in the guided job search. The documentation provided by Ms. Eaton is clear and thorough" and that Petitioner completed all of her tasks. (PX 18) The report also indicated, "TIME FRAME TO RESOLUTION: 1 session, additional sessions will be added as approved." (PX 18) This report, as well as all of the preceding reports, did not indicate that Petitioner had any job interviews or job offers. (PX 18)

Despite the vocational process and Bishop's guidance throughout, Petitioner testified she was never offered a job. (T36) Petitioner clarified she did not have 15 interviews, as was indicated by the Vocamotive report by Kari Stafseth dated January 25, 2016, but only had a single 15-minute phone interview and no in person interviews. (PX 26 & T36) Petitioner was not offered any job in the nursing field or any other job of any kind. (T37) Petitioner testified she did not get any responses to her resume or applications. (T37) This is confirmed by Bishop's reports that document the entire process but never indicate Petitioner had an in-person interview or was ever offered a job. (PX 18)

At hearing, Petitioner confirmed she continued to have low back symptoms throughout the vocational process and she sought additional avenues to decrease her pain. (T32) Petitioner was referred by Dr. Vohra to Dr. Katherine Borchardt, a pain psychologist and Dr. Randy Cybulski for therapy and chiropractic treatment. (T32)

Dr. Borchardt testified she is board certified in clinical psychology and specializes in behavioral medicine and neuropsychology and specializes in non-pharmacological pain treatment to address chronic pain or a disease process. (PX 17 at 4-6) Petitioner began treatment with Dr. Borchardt on January 24, 2013 and explained her accident, symptoms and various treatments she had undergone since her injury. (PX 17 at 9) Petitioner testified Dr. Borchardt offered her distraction techniques, pacing activities and ways to decrease her stress in order to decrease her pain. (T33) After reviewing Petitioner's medical records, therapy records, MRIs and the FCE, Dr. Borchardt began seeing Petitioner on a regular basis offering her pain control techniques. (PX 17) Dr. Borchardt also documented that Petitioner constantly changed position and indicated, "she was in chronic pain. When she was talking she wasn't even aware that she was changing positions, but she just couldn't sit in one position for very long at all." (P17 at 20)

Following her initial examination, Dr. Borchardt drafted a letter dated February 25, 2013, regarding her assessment of Petitioner and her opinion that Petitioner should not be involved in

the vocational process. (PX 16) Dr. Borchardt noted that the FCE indicated, "Client's inability to tolerate prolonged sitting and her decreased lifting ability present potential barriers to return to work as an R.N., Client is presently not a job match to return to her previous work as an R.N. She will function best in a position that limits setting and allowed changes in position prn." (PX 16) After discussing Petitioner's symptoms with her and the vocational process, Dr. Borchardt concluded that working at a computer and engaging in writing activities takes an inordinate amount of time for Petitioner to complete and exacerbates her chronic pain and, given that, Petitioner should not be engaged in vocational rehabilitation. (PX 16) Dr. Borchardt further indicted that the FCE indicated that nursing jobs were not suitable for Petitioner based on the FCE alone despite Ms. Bishop's direction. (PX 16)

Bishop confirmed in her deposition testimony that Petitioner contacted her deposition testimony that Petitioner indicated she would not be doing vocational rehabilitation. (RX 1 5 at 20) In her last vocational report dated March 11, 2019, Bishop documented that Petitioner told her vocational assistance had been discontinued and that she could no longer participate in vocational rehabilitation. (PX 18) Bishop noted, "Ms. Eaton has historically demonstrated consistent a (sic) good faith effort in her job search." (PX 18) Petitioner continued her treatment with Dr. Borchardt who immediately documented in her March 15, 2013 note that Petitioner seemed more relaxed after the vocational rehabilitation process had ceased. (PX 16) Through a combination of Dr. Borchardt's treatment, therapy, manipulation and decompression with Dr. Cybulski and massage therapy, Petitioner indicated her symptoms were temporarily alleviated but that it was, "like a Band-Aid. It works to keep me moving, but it always comes back." (T35)

Dr. Borchardt then referred Petitioner to a neurosurgeon, Dr. Douglas Johnson, to again discuss the possibility of surgery but that was not approved by workers' compensation. (PX 16) As of her appointment on September 23, 2013, Dr. Borchardt indicated Dr. Johnson had passed away but Petitioner should still seek a surgical consultation. (PX 22) Petitioner confirmed she saw both Dr. Ronjon Paul and Dr. Cary Templin. (T38) As opposed to surgery, Petitioner indicated that Dr. Vohra and Dr. Borchardt referred her to another pain management physician, Dr. Ira Goodman. (T39) Petitioner confirmed she began seeing Dr. Goodman in 2013 and has continuously treated with her up to the date of hearing. (T39)

Petitioner indicated she ceased seeing Dr. Vohra in 2013 because workers' compensation was not approving treatment and that, beginning in 2013, her treatment was not paid by workers'

compensation at all. (T44) Petitioner began receiving Social Security Disability in 2013 and her treatment was paid for by herself and Medicare. (T44) Instead of approving medical treatment as was ordered by Arbitrator Falcioni, Respondent sent Petitioner to Dr. Timothy McManus, a licensed clinical Psychologist, for a Section 12 independent medical examination. In his report dated July 13, 2013, Dr. McManus administered multiple psychological testing and indicated, "Ms. Eaton scored with in normal limits on all five clinical scales and the total raw score on the general measure of symptom validity." (RX 1) Dr. McManus then opined, "there are no barriers from either a psychological or neuropsychological perspective that would prohibit Ms. Eaton from seeking employment within the physical parameters, restrictions, and limitations outlined by her physicians should she wish to do so." (RX 1) Dr. McManus offered no opinion regarding Petitioner's ***medical*** treatment. Even if he did, Dr. McManus is a psychologist and not a licensed physician and is therefore not qualified and in no position to comment on Petitioner's actual medical treatment. Despite this, Respondent no longer approved or paid for any of Petitioner's ongoing medical treatment. This is further confirmed by Respondent's exhibit 22 that documents the last payment related to Petitioner's actual medical treatment was to Dr. Vohra on January 7, 2013. (RX 22)

When Petitioner initially tried to see Dr. Goodman, her appointment was denied by Karen Mika at Illinois Compensation Trust. In a letter dated November 27, 2013 addressed to Dr. Goodman's office, Mika indicated that the evaluation was denied because it exceeded the claimant's two choices of physicians. (PX 20) This is not accurate given the referral from Dr. Vohra and Dr. Borchardt (who was referred by Dr. Vohra). Despite this, Petitioner initially presented to Dr. Goodman on December 5, 2013, using her Medicare insurance. Petitioner described her accident and her symptoms including pain and burning in her back radiating into her bilateral buttocks and legs. (PX 20) Dr. Goodman noted that Petitioner paced the floor and had a difficult time finding a comfortable position. (PX 20) After an examination, Dr. Goodman indicated Petitioner was suffering from a lumbar disc problem with radicular components and recommend epidural steroid injection at L3-4 and L4-5 and consider facet joint injections and a discography if those procedures were not effective. (PX 20)

At her follow-up appointment on January 20, 2014, Dr. Goodman also continued Petitioner's referral to Dr. Cymbulski to continue soft tissue work and again prescribed epidural steroid injections. (PX 20) Petitioner underwent the first epidural steroid injection on January 23,

2014 and reported only temporary improvement when the local anesthetic was in effect (PX 20) Given that Petitioner's symptoms returned to baseline after the injections, Dr. Goodman indicated that she should undergo facet joint injections for diagnostic purposes. (PX 20) **On January 23, 2014 Dr. Goodman also noted, "she is permanently disabled."** (PX 20) Petitioner underwent the medial nerve block injection at L2, L3, L4 and L5 on February 17, 2014. (PX 20) In her follow up appointment with the doctor on March 5, 2014, Dr. Goodman noted, "she had 90% relief on the day of the procedure, 60% the day after, and 20-30% since. Her muscle spasms are improved. Some of her more deeply seated low back pain is not as obvious to her." (PX 20)

Based on the results of the nerve block injections, Dr. Goodman recommended RF (radiofrequency) lesioning and referred her to primary care physician, Dr. Spiro Analytis. (PX 20) Petitioner underwent a left sided ablation procedure on March 13, 2014, that decreased the area of her left sided back pain and a right sided procedure on April 24, 2014, that did not help her right sided pain. (PX 20)

At hearing, Petitioner confirmed that the relief from the procedures was only temporary. (T53) In his May 28, 2014, post-procedure note, Dr. Goodman noted that the left sided procedure gave only temporary relief and the right sided injected was not effective and indicated that the next treatment step is for Petitioner to undergo a discogram and follow up CT scan. (PX 20) Petitioner underwent the discography and CT scan on June 5, 2014 at Adventist Hinsdale Hospital. (PX 20) Petitioner followed up with Dr. Goodman on June 18, 2014, wherein he noted, "**Discogram and post-discogram CT were reviewed today. These correlate well and demonstrate very clearly that the L2-3 disc was a normal control disc and that L3-4, L4-5 and L5-S1are abnormal morphologically and cause concordant pain." (PX 20) Dr. Goodman then offered Petitioner treatment including 3 level spinal fusion, IDET and SCS (spinal cord stimulator)**, noting that Petitioner wanted to try the IDET procedure. (PX 20)

At hearing, Petitioner indicated that the IDET procedure was not carried out because Medicare would not cover it and workers' compensation was not paying for any of her treatment. (T54)

Petitioner then continued on a course of treatment with Dr. Goodman that included medication and injections throughout 2014, 2015 and 2016 with her condition largely unchanged. (PX 25, 28, 29, and 31) Dr. Goodman did attempt to treat Petitioner with Fentanyl patches but

indicated that Petitioner was allergic to this so he continued her on Valium and Tramadol to control her pain symptoms (PX 25)

Throughout her treatment with Dr. Goodman, Petitioner continued her regimen with Dr. Borchardt as well as receiving massage therapy. During this period, 2015, 2016 and 2017, Petitioner had the same type of symptoms including low back pain and leg pain that continued to get worse. (T55) Although Petitioner got some leg pain relief from ongoing injections, Dr. Goodman stopped prescribing those on February 22, 2017 because she got side effects including nausea, dyspepsia and hot flashed. (PX 31)

By her next appointment on April 17, 2017, however, Petitioner's symptoms were severe enough that she agreed to have another steroid injection. (PX 31) At that appointment, Dr. Goodman provided Petitioner with educational materials regarding a spinal cord stimulator. (PX 31) Petitioner testified that Dr. Goodman then referred her for a trial spinal cord stimulator which she received on September 7, 2017. (T57 & P47) Given the positive results of the trial stimulator, Dr. Goodman referred Petitioner to Dr. Borchardt for presurgical psychological evaluation to determine if she was an appropriate candidate for spinal cord stimulator placement surgery. (P34)

In her Presurgical Personality and Cognitive Evaluation reported dated July 31, 2017, Dr. Borchardt summarized Petitioner's results after administering the Minnesota Multiphasic Personality Inventory, 2nd Ed., Restructured Format (MMPI-2-RF). Dr. Borchart summarized,

> Sheila's MMPI-2 profile is considered within normal limits, with no evidence of disordered thinking or maladaptive behaviors. Her current profile suggests she has adequate coping skills, typically engaging not only in optimism, but rational thinking and good planning. She is able to reach out to trusted others to discuss concerns and seek reasonable opinions. Sheila displays a confidence in her medical team and appears to be approaching the spinal cord stimulator surgery in a realistic manner. Successful spinal cord stimulator surgery is likely to lead to a decrease in Sheila's occasional experiences of helpfulness by placing some more of her chronic pain under her control. **She also appears to have no secondary pain components to her chronic pain. Overall, Sheila appears to be a good candidate for spinal cord stimulator placement surgery.** (PX 34)

Following her psychological clearance, Petitioner was referred by Dr. Goodman to Dr. Joshua Rosenow at Northwestern Medicine for second opinion on a permanent spinal cord stimulator. (P38) In his notes dated September 20, 2017, Dr. Rosenow documents that after the trial stimulator, Petitioner indicated, "she felt so good she did not want to have the leads removed." (PX 38) Following an examination and review of Petitioner's treatment history, Dr. Rosenow concluded that this was reasonable for Petitioner to consider a permanent spinal cord stimulation

system implantation. (PX 38) **Petitioner then underwent the implantation of the stimulator by Dr. Rosenow on November 13, 2017. (PX 38)**

Following the procedure, Petitioner has continued treatment with Dr. Goodman, who documented on February 28, 2018, that Petitioner's low back pain was reduced by 15% and her bilateral buttock and leg pain has been reduced by 75% by the stimulator. (PX 35) At hearing, Petitioner confirmed that the stimulator has helped, especially in her leg symptoms that she only notices when she stands a lot. (T59)

Petitioner testified that after the stimulator implantation, she continues to receive treatment from Dr. Goodman, Dr. Borchardt and some rehabilitation including therapy and chiropractic treatments. (T59) Petitioner indicated that this treatment temporarily alleviates her symptoms but that the symptoms have never gone away completely and have been continuous since her 2010 injury. (T59) Further, while Petitioner has had relief of a lot of her leg symptoms, she continues to have back pain that gets worse the more she stands or sits continuously. (T59) Petitioner also noted that she has had the batteries reprogrammed on three occasions. (T60) Given the ongoing symptoms, Petitioner indicated she bought a residence in Florida because the winters made her back pain intolerable. (T59)

In addition to her back injury, Petitioner testified that while working for Morris Hospital as a nurse, she noticed pain in her hands and arms that interfered with her sleep. (T64) After reporting her problems to Respondent, Petitioner sought treatment from Dr. Tom Karnezis at The Illinois Orthopeadic and Hand Center. (PX 8) Dr. Karnezis diagnosed Petitioner with bilateral carpal tunnel syndrome and performed bilateral releases on December 13, 2011. (PX 8) Dr. Karnezis then released Petitioner to all activities on March 16, 2012. (PX 8) Of note, Dr. Karnezis' notes on December 7, 2012 indicated that Petitioner worked in a bank doing data entry. (PX 8) At hearing, Petitioner clarified that she was not working in a bank, had never worked in a bank and that this was an incorrect notation. (T67) Petitioner indicated she was doing vocational rehabilitation at that time. (T67) This is verified by Bishop's notes and reports. (PX 18)

At hearing, Petitioner testified that she has not worked anywhere since her injury, she has never been offered a job, she has never been released back to work and she has never suffered any other injuries of accidents of any kind to her lower back since her day of accident. (T67, 83, 55) Although Petitioner testified that she is satisfied with the spinal cord stimulator, she indicates she still has symptoms related to low back pain. (T60, 61 & 63) Petitioner indicated that all of her daily

activities are limited and that she has to pace and plan her day due to her symptoms. (T67) Her intention is to continue with pain management and conservative treatment on a maintenance basis. (T68)

CONCLUSIONS OF LAW

10 WC 25336 – Lumbar Spine

ISSUE F. CAUSATION: THE ARBITRATOR FINDS AND CONCLUDES PETITIONER'S CURRENT LUMBAR SPINE CONDITION OF-ILL-BEING IS CAUSALLY RELATED TO HER WORK ACCIDENT SUSTAINED ON JUNE 22, 2010.

The Arbitrator incorporates all Findings of Fact into this Section.

The issue of causation has been adjudicated before the Commission twice prior to the current Arbitration hearing held on May 22, 2019 and both Arbitrator Fratianni and Arbitrator Falcioni ruled that Petitioner's lumbar spine condition was causally related to her work accident. This Arbitrator highlights that neither of these Arbitration awards were appealed to the Commission; therefore, by operation of law they became final awards of the Commission.

The preponderance of the credible evidence indicates that from the date of the last hearing before Arbitrator Falcioni on September 27, 2011 to the date of this hearing on May 22, 2019, Petitioner has had consistent and ongoing treatment for her lumbar spinal condition and she credibly testified that she has suffered no other injuries of any kind to her lower back. (T67) There is no evidence that Petitioner suffered another accident and there is no notation of any other injury in any of the numerous exhibits submitted by both Petitioner and Respondent. The evidence clearly demonstrates there has been an unbroken chain of treatment with no evidence of any intervening accidents since Petitioner's date of lumbar injury on June 22, 2010.

The Arbitrator further emphasizes that Respondent's causation dispute relies solely on Dr. Singh's opinions in his Section 12 report dated April 23, 2018. Dr. Singh indicated that Petitioner exhibited extreme signs of symptoms magnification and malingering and specifically noted, "I reemphasize my position from my 2011 independent medical examination. The patient's pain complaints are nonanatomic in nature. I believe she is capable of returning back to work full duty without restrictions. Her treatment has been excessive in nature and unrelated to any work event in 2010." (RX 7 at 3) **The Arbitrator emphasizes that Dr. Singh's opinions were deemed not credible by both previous arbitrator's and this Arbitrator finds similarly that the**

overwhelming weight of the credible evidence demonstrates his opinions are also not credible now. In his causation finding, Arbitrator Falcioni reasoned, "Contrary to Dr. Singh, Petitioner's testimony and report of symptoms is credible and supported by the evidence submitted. Her complaints of pain were consistent for the date of accident to the present time. Review of Dr. Vohra's current records demonstrates this. The history of symptoms note a combination of symptoms including lower back pain and pain and numbness into Petitioner's lower extremities with radiculopathy. These are the same set of symptoms testified to and documented in medical records during the initial hearing." (PX 6) **Presently, the facts are the same as they were when Arbitrator Falcioni found causation. The Arbitrator also emphasozes that all of the numerous medical records submitted by Petitioner including, but not limited to, Dr. Vohra, Dr. Khan, Dr. Goodman, Dr. Borchardt, Dr. McCarty and Dr. Rosenow, record the same symptoms including lower back pain and pain and numbness into the legs.** These were consistently reported by Petitioner over a span of years. Even Petitioner's constant movement to get comfortable at appointments, the same as at this Arbitration hearing, were consistently noted throughout the evidence submitted.

Further, as noted in his previous reports, **Dr. Singh is the only physician**, besides Respondent's Section 12 psychologist Dr. McManus, **to note any malingering or that Petitioner's complaints were non-organic in nature. In all of the multiple medical documents submitted by multiple physicians, no other physician noted malingering or anything of the nature.** From Dr. Vohra all the way through the implantation for the spinal cord stimulator by Dr. Rosenow, there is not a single notation of Petitioner's symptoms not being valid. The only other medical expert to insinuate this is Dr. McManus in his Section 12 reports. However, it is obvious Dr. McManus simply chose to rely on Dr. Singh's 2011 opinions. Again, Dr. Singh's opinions had already been deemed not credible by that point.

Given the plain fact that two prior Arbitrators had concluded – without Respondent filing a Review on the matters - that Dr. Singh was not credible, it is inexplicable why he was again retained to offer his opinions in this case pursuant to Section 12.

The most critical, credible and persuasive evidence to consider on the issue of malingering - outside of the records of Petitioner's treating medical providers - however, is found in Bishop's vocational reports and the Functional Capacity Evaluation performed by David Brightmore. Bishop indicated throughout her reports statements directly contradicting that Petitioner was

malingering ***and she repeatedly indicated that Petitioner complied with the vocational process and was motivated to return to work***. (PX 18) This is very significant evidence.

In her September 22, 2012 assessment report, Bishop noted, "Meanwhile, Ms. Eaton verbalizes her desire to both be pain free and return to work. She has repeatedly stated that she is proud of her work as a nurse and would like to return to gainful activity." (PX 18)

On September 30, 2012, Bishop further noted, "Ms. Eaton continues to demonstrate a good faith effort in the guided job search. She has contacted the VCM (vocational case manager) if she has questions and is very professional in all of her encounters with the VCM. Ms Eaton has provided documentation to support her activities. However, her report of pain which compromises her ability to sit or stand for any length of time continues." (PX 18) **As discussed, Bishop saw Petitioner almost weekly for a period of almost 9 months. (PX 18) Dr. Singh, on the other hand, saw Petitioner for a single short examination and submitted a very brief 3 page report.**

Petitioner performed the FCE on November 16, 2011 by David Brightmore, PT, and the FCE was deemed a **valid evaluation**. In the Pain Report section, Mr. Brightmore noted,

> "client reports that pain is present at all times and reported such throughout the FCE and physical examination. Client reported lumbar pain with all test items but voiced a significant increase in pain after stat sitting, static forward bending, repetitive squat, floor-to-waist lift, and sustained kneeling. When aggravation was reported, client reported that pain progressed distally into the left buttocks, left posterior thigh, and a times into the left lateral leg. **Appropriate pain behaviors**, including holding and rubbing of the lumbar spine as well as frequent weight shifting and changing of position, **were observed throughout the FCE**. Pain was under control and client was able to progress to the next item with the exception of during static sitting. Client became very uncomfortable in static sitting and required weight shifting or getting up out of sitting due to pain. Grimacing, increased heart rate, increased respiration rate were noted consistent with her complaints." (RX 17 at 2) (emphasis added)

Notably, the observations Brightmore indicated above are consistent with observations made throughout Petitioner's medical treatment records as well as what was noted during Petitioner's trial testimony. Here, however, Brightmore had the ability to test the validity of Petitioner's complaints via physiological changes including elevated heart rate and elevated respiration. These changes demonstrate that Petitioner's report of symptoms were consistent with physiological changes, thus demonstrating consistency. **This is credible and objective evidence Petitioner was suffering from the symptoms reported.** ***But even more***

significant is the fact that Brightmore's evaluation findings were never rebutted or refuted, nor did Brightmore offer any criticism of Petitioner or her complaints.

In addition to the above, Dr. Singh's opinions are plainly not credible because he failed to review any of Petitioner's treatment records from 2011 to the time he saw her again in 2018 - a period of about seven years. **Dr. Singh's indication in his report that there are no medical records to review is factually accurate but also very disingenuous.**

It is the Commission's province to assess the credibility of witnesses, draw reasonable inferences from the evidence, determine what weight to give testimony, and resolve conflicts in the evidence, particularly medical opinion evidence. *Berry v. Industrial Comm'n*, 99 Ill. 2d 401, 406-07, 459 N.E.2d 963, 76 Ill. Dec. 828 (1984); *Hosteny v. Illinois Workers' Compensation Comm'n*, 397 Ill. App. 3d 665, 675, 928 N.E.2d 474, 340 Ill. Dec. 475 (2009); *Fickas v. Industrial Comm'n*, 308 Ill. App. 3d 1037, 1041, 721 N.E.2d 1165, 242 Ill. Dec. 634 (1999). Expert testimony shall be weighed like other evidence with its weight determined by the character, capacity, skill and opportunities for observation, as well as the state of mind of the expert and the nature of the case and its facts. *Madison Mining Company v. Industrial Commission*, 309 Ill. 91, 138 N.E. 211 (1923). The proponent of expert testimony must lay a foundation sufficient to establish the reliability of the bases for the expert's opinion. *Gross v. Illinois Workers' Compensation Comm'n*, 2011 IL App (4th) 100615WC, 960 N.E.2d 587, 355 Ill. Dec. 705. If the basis of an expert's opinion is grounded in guess or surmise, it is too speculative to be reliable. Expert opinions must be supported by facts and are only as valid as the facts underlying them. *In re Joseph S.*, 339 Ill. App. 3d 599, 607, 791 N.E.2d 80, 87, 274 Ill. Dec. 284 (2003). A finder of fact is not bound by an expert opinion on an ultimate issue, but may look 'behind' the opinion to examine the underlying facts. Expert testimony shall be weighed like other evidence with its weight determined by the character, capacity, skill and opportunities for observation, as well as the state of mind of the expert and the nature of the case and its facts. *Madison Mining Company v. Industrial Commission*, 309 Ill. 91, 138 N.E. 211 (1923). The proponent of expert testimony must lay a foundation sufficient to establish the reliability of the bases for the expert's opinion." Gross v. Illinois Workers' Compensation Comm'n, 2011 IL App (4th) 100615WC, 960 N.E.2d 587, 355 Ill. Dec. 705. "If the basis of an expert's opinion is grounded in guess or surmise, it is too speculative [**18] to be reliable." Id. "Expert

opinions must be supported by facts and are only as valid as the facts underlying them." In re Joseph S., 339 Ill. App. 3d 599, 607, 791 N.E.2d 80, 87, 274 Ill. Dec. 284 (2003). **Not only may the Commission decide which medical view is to be accepted, it may attach greater weight to the opinion of the treating physician.** *International Vermiculite Co. v. Industrial Comm'n*, 77 Ill.2d 1, 31 Ill. Dec. 789, 394 N.E.2d 1166 (1979); *ARA Services, Inc. v. Industrial Comm'n*, 226 Ill. App. 3d 225, 168 Ill. Dec. 756, 590 N.E. 2d 78 (1992). **That is what the Arbitrator has decided to do in this matter.**

Dr. Singh indicates Petitioner clearly made him aware she was treating with Dr. Goodman, had numerous epidurals, radiofrequency ablations, medical branch blocks and placement of a spinal cord stimulator, physical therapy and other conservative treatment. (RX 7) Yet, despite years of various treatments, Dr. Singh inexplicably did not even bother to review any medical records covering this extensive seven-year period of medical treatment, nor ask for records to any to review, indicating a distinct lack of interest in this case; therefore, this failure - which appears deliberate - only reinforces the Arbitrator's conclusion that Dr. Singh's opinions cannot be given any weight or credibility (again, beyond the significant fact that two prior Arbitrators in this case found him to be not credible). **The Arbitrator questions how Dr. Singh could have offered his opinions with such conviction given he did not review any medical records for the past almost seven years and given the Commission's prior determination of his credibility.**

If Dr. Singh had reviewed the multiple medical records documenting, for example, that Petitioner underwent a discogram by Dr. Goodman that demonstrated concordant pain (unchallenged results), or that Petitioner underwent a Functional Capacity Evaluation that was deemed valid (unchallenged results) or that a spinal cord stimulator was implanted (supported by Respondent's own Utilization Review), perhaps his opinions may have been different – or perhaps not. (PX 48 at 17 & RX 17) Although pain reports are largely subjective, Dr. Singh didn't even review these two pieces of objective information used to correlate subjective findings. It is not a coincidence that the physician who saw Petitioner the least is the only one who opined that Petitioner was malingering and not honest with her symptoms. Dr. Singh simply lacks the requisite information to give any opinions - let alone credible ones - regarding Petitioner's condition.

Further, even though Dr. Singh was made aware that Petitioner had undergone multiple treatment and procedures (including a spinal cord stimulator) his diagnosis was "**lumbar muscular strain.**" **It strains credulity that Dr. Singh would only offer a "lumbar muscular strain" as a diagnosis, given, for example, the voluminous medical records indicating a more serious condition, such as the extensive treatment performed, the success of the spinal cord stimulator and the *unchallenged* results of the June 5, 2014 lumbar discogram and CT scan, which indicated and correlated well and "demonstrate very clearly" the discs at L34, L4-5, and L5-S1 "are abnormal morphologically and cause concordant pain" per Dr. Goodman's report dated June 18, 0214 (PX 20). But Dr. Singh never reviewed any of these records so has no standing to criticize what they report.**

Further, Dr. Singh had no comment regarding the Utilization Review (PX 47) dated February 19, 2018 which certified the spinal cord stimulator implant and opined, "Thus, the spinal cord stimulator is reasonable, necessary, and appropriate." The Arbitrator places strong credibility, reliance and weight on this UR opinion.

There is nothing in the evidence submitted that demonstrates or even suggests Dr. Singh should be deemed any more credible than he was in 2011. Although his opinions had been discredited, and one can infer he must have known this in 2018, Dr. Singh nonetheless indicated he would "reemphasize" his position from 2011. Dr. Singh also opined Petitioner's medical treatment – apparently all of it – "has been excessive in nature and unrelated to any work-related event in 2010." This opinion not only defies the prior Commission Decisions, it defies the opinions of the multitude of treating providers who have rendered treatment over the years. Therefore, Respondent's reliance on Dr. Singh's opinions unsupported opinions was unsupportable and unreasonable.

Regarding causation, in addition to the evidence discussed above, Petitioner relies on the opinions of Dr. Goodman. In his deposition testimony taken on June 15, 2017, Dr. Goodman confirmed that he had seen Petitioner consistently over the course of years. Dr. Goodman testified that he never had any reason to doubt Petitioner's reporting of symptoms and has always found her to be honest and truthful in her report of symptoms to him. (PX 48 at 27) In addition to discussing his treatment with Petitioner, he testified in depth about prescribing her a discogram. (PX 48 at 16) Dr. Goodman explained that the idea of the procedure is to determine if a patient's report of pain correlates with injured disks. (PX 48 at 16) Following Petitioner's discogram, Dr.

Goodman confirmed Petitioner had a "positive provocative diskography" that demonstrated her symptoms correlated with the level of her lumbar spine that were abnormal. (PX 48 at 17) When asked about causation, Dr. Goodman answered that he believed Petitioner's current lumbar condition was caused by her work accident and reasoned, "Well, if you just consider the temporal relationship between the work injury and the onset of her symptoms and that she did not have a pre-accident history of lumbar spine pain requiring medical attention it all fits pretty well using simple deductive reasoning." (PX 48 at 29)

Dr. Borchardt also discussed the cause of Petitioner's condition of ill-being during her July 1, 2013 evidence deposition. At that time, Dr. Borchardt testified she believed Petitioner was suffering from chronic pain that was related to the back injury suffered. (PX 23 at 31) She further indicated that she believed Ms. Eaton would continue to suffer from chronic pain until her structural abnormalities shown on MRI were resolved. (PX 23 at 31) Finally, Dr, Borchardt was directly asked if she believed Ms. Eaton was malingering or being untruthful in anyway. She responded that she never observed it and that her observations of Ms. Eaton were consistent with someone suffering from chronic pain. (PX 23 at 32.) Dr. Borchardt was well positioned to make these comments given her extensive dealings with Petitioner over her long course of treatment.

Based on the greater weight of the evidence, the Arbitrator finds that Petitioner's current condition of ill-being is causally related to her work accident sustained on June 22, 2010. Petitioner has proven causation by a preponderance of the credible evidence. The evidence demonstrates that Petitioner's treatment and complaints have remained consistent from the date of the accident, through the first two hearings to the present time without Petitioner suffering any intervening accidents or injuries of any kind to her lumbar spine. The Arbitrator further finds Dr. Singh's opinions to not be credible and instead places weight, credibility and reliance on the opinions and testimony of Dr. Goodman and Dr. Borchardt.

J. THE ARBITRATOR FINDS AND CONCLUDES RESPONDENT IS LIABLE FOR PAYMENT OF PETITIONER'S REASONABLE AND NECESSARY MEDICAL TREATMENT UNDER SECTIOS 8(a) AND 8.2 OF THE ACT.

The Arbitrator incorporates all Findings of Fact into this Section.

Given the Arbitrator's finding that Petitioner's lumbar condition is causally related to her June 22, 2010 work accident, the Arbitrator finds and concludes Respondent is liable for payment of Petitioner's reasonable and necessary medical treatment. Again, in this regard, Respondent, relies on the discredited opinions of Dr. Singh, and the opinions of Dr. McManus, who is not a medical doctor.

In his report dated April 23, 2018, Dr. Singh opines that Petitioner reached maximum medical improvement and that her condition required no further medical treatment. (R7) Dr. Singh also indicated Petitioner's treatment was excessive and unrelated . (R7) Based on the same analysis and conclusions discussed above, Dr. Singh's opinions here are also not credible. Again, Dr. Singh did not review Petitioner's medical records before or after his examination. On the contrary, Dr. Borchardt and Dr. Goodman continually managed Petitioner's medical condition over a period of years. Both doctors disclosed their opinions regarding Petitioner via deposition testimony. Dr. Borchardt indicated that Petitioner's management of her chronic pain had improved since she began her treatment regimen but that she still recommended that Petitioner see a neurosurgeon to address her condition. (PX 23 at 29 & 32) Dr. Borchardt further testified that from a pain management and chronic pain perspective, Petitioner's treatment was reasonable and necessary and explained, "chronic pain patients—study upon study has show that a multi-faceted approach to treating chronic pain is appropriate and the best outcomes come from such a team approach, so physiatry, massage therapy, chiropractic, behavioral medicine are all important treatments in the treatment of most people's chronic pain and in Ms. Eaton's case I would definitely agree." (PX 23 at 34) **This was exactly the same approach Dr. Vohra, Dr. Borchardt and Dr. Goodman took in treating Petitioner**. At different points, one of the three physicians above referred Petitioner to pain management (Dr. Khan, Dr. Goodman and Dr. Rosenow), chiropractic care (Dr. Cybulski and Naperville Rehabilitation Clinic), physical therapy (Dr. McCarty, Willowbrook Rehabilitation Institute), mobility specialists (Shirley Ryan Ability Lab) and massage therapy.

In addition to Dr. Borchardt, Dr. Goodman offered his opinions regarding Petitioner's medical treatment. During his deposition testimony on June 15, 2017, Dr. Goodman testified that his treatment was reasonable and necessary for the diagnosis he gave Petitioner. (PX 48 at 28) Dr. Goodman also opined Petitioner's future medical treatment should consist of the IDET procedure and then he would recommend a spinal cord stimulator. (PX 48 at 30) Dr. Borchardt indicated that he would recommend permanent implantation after a psychological evaluation. (PX 48 at 31) At

hearing, as discussed above, Petitioner indicated she underwent the testing and then had a permanent stimulator placed by Dr. Rosenow.

In addition to relying on Dr. Singh to deny payment of Petitioner's medical treatment, Dr. McManus indicated in his August 26, 2014 addendum report that Dr. Borchardt's psychological services were not necessary. Dr. McManus' opinions are plainly not credible. Dr. McManus comes to this conclusion because Dr. Borchardt did not disclose the raw data findings of the tests she administered to Petitioner and, he suggests, this meant that Dr. Borchardt was hiding non-credible symptom reporting or the absence of a psychological disorder. (RX 3) This opinion makes no sense in light of the evidence. First, Dr. McManus did not disclose the raw data used in his administering of Petitioner's testing. So, based on his rationale, he was [also] clearly "hiding" a finding not supportive of Respondent's position. More substantially and directly on point, however, Dr. Borchardt was **not** treating Petitioner for a psychological condition, she was treating Petitioner for chronic pain related to her lumbar spine. Again, in both previous decisions, Arbitrators Fratianni and Falcioni found that Petitioner suffered a lumbar spine condition that required medical treatment. Dr. Borchardt was part of the treatment regimen for Petitioner's condition.

Respondent also submitted a series of reports related to partial certification and non-certification of Petitioner's chiropractic treatment. Dr. Zipser from the Physicians Review Network offered a series of reports dated November 2, 2017, December 12, 2017 and November 1, 2017. Dr. Zipser indicated that only the first six chiropractic sessions were necessary. (RX 12, 13 & 14) Dr. Zipser's opinions are not credible for a number of reasons. Most significantly, it is clear that his opinion is based on his review of the IME report by Dr. McManus that indicated that Petitioner had positive Waddell findings. (RX 13 & 14) Again, Dr. McManus offered this opinion based on Dr. Singh's opinions that there were positive Waddell findings. These are the only two physicians involved in Petitioner's claim that indicate any malingering or positive Waddell signs. **Significantly, none of the many treating physicians noted any malingering or positive Waddell findings.** The physicians who treated Petitioner on multiple occasions were best positioned to note any malingering or untruthfulness and never did. **Further, both Arbitrators Fratianni and Falcioni found Petitioner to be credible.**

Although Respondent relies on the above discussed reports, they have chosen to ignore **Physician's Review Network report dated February 9, 2018 that certified Petitioner's Spinal**

Cord Stimulator implant. (PX 47) In his report, Dr. Gregory Polston, Board Certified in Anesthesiology/Pain Medicine, indicated,

> **The stimulator was necessary and appropriate and consistent with medical guidelines.** The patient has a longstanding low back and radicular component to her pain with primarily axial pain. The patient had failed conservative care, including controlled medications, nonsteroidal anti-inflammatory medications and, anticonvulsants. She had failed physical therapy and chiropractic treatment. The patient was not a surgical candidate and had pain consistent with pain that could be relieved with a spinal cord stimulator. It is also consistent with the Official Disability Guidelines for a spinal cord stimulator. **Thus, the spinal cord stimulator is reasonable, necessary, and appropriate. (PX 47)**

Despite this objectively clear Utilization Review certifying treatment, Respondent inexplicably and unreasonably refused to pay for the spinal cord stimulator.

Finally, in their Decisions, both Arbitrators Fratianni and Falcioni found that Respondent was liable for Petitioner's prospective medical treatment related to her lumbar spine. Respondent simply ignored the Commission's order.

Based on the preponderance of the credible weight of the evidence, the Arbitrator finds and concludes Respondent is liable for Petitioner's medical treatment. The Arbitrator further finds and concludes Petitioner's medical treatment has been reasonable, necessary and causally related to her work-injury.

K. THE ARBITRATOR FINDS AND CONCLUDES RESPONDENT IS LIABLE FOR PAYMENT OF PETITIONER'S TEMPORARY TOTAL DISABILITY.

L. THE ARBITRATOR FINDS AND CONCLUDES PETITIONER PROVED SHE IS PERMANENTLY AND TOTALLY DISABLED UNDER SECTION 8(F)AS A RESULT OF HER WORK ACCIDENT.

The Arbitrator incorporates all Findings of Fact into these Sections.

Given the Arbitrator's finding of causation, Respondent is liable for payment of Petitioner's temporary total disability benefits. At hearing, Petitioner claims that her temporary total disability period is from August 19, 2010 to August 21, 2012 and March 16, 2014 to November 13, 2017. From August 21, 2012 to March 16, 2014, the parties agree that Petitioner was pursuing vocational rehabilitation with Ms. Bishop and paid maintenance benefits. The main issue is if Respondent is liable for benefits after Dr. Borchardt indicated that Petitioner should no longer participate in the vocational rehabilitation program initiated by Respondent through Ms.

Bishop. Dr. Borchardt discussed her rationale for suspending Petitioner's participation in the program during her deposition testimony. Dr. Borchardt indicated that she was able to review Petitioner's FCE results from Brightmore that indicated, "Client is presently not a job match to return to her previous work as an R.N." (RX 17 at 3) Dr. Borchardt then questioned why Petitioner's vocational program focused on this and added Petitioner was not sleeping and that the process was presenting her with too much stress. Finally, Dr. Borchartdt indicated, "She was in chronic pain, there weren't treatments that were actually reducing her pain at that point in time and she couldn't sit to do this vocational rehabilitation, so no, I did not think that she could engage in that type of activity." (PX 23 at 15)

To counter this, as previously discussed, Respondent offered opinions from Dr. McManus who indicated that based on his testing, Petitioner could participate in vocational rehabilitation and that she displayed elements of malingering and secondary gain. (RX 1, 2, 3, & 4) Again, besides Dr. McManus and Dr. Singh, no other evidence substantiates this. Further, Dr. Borchardt administered like testing to Petitioner prior to Dr. McManus and indicated the test results were consistent with Petitioner's condition and related symptoms. Most significantly, however, Petitioner submitted to additional psychological testing prior to implantation of the permanent spinal cord stimulator. After the testing was completed, Dr. Rosenow determined that Ms. Eaton was an appropriate candidate for the permanent stimulator and went ahead with implantation. (PX 38) It was after this procedure, that Petitioner indicated that she had relief from the symptoms she had into her lower extremities. The fact that this procedure was not carried out for years after first being suggested by Dr. Goodman was because Respondent refused to pay for Petitioner's treatment. This is verified by Respondent's payment ledger marked as Respondent's Exhibit 22. Petitioner only received the treatment after becoming Medicare eligible after being deemed disabled. Respondent even refused payment for this after their utilization review report deemed the procedure reasonable, necessary and appropriate. (PX 47)

The evidence demonstrates that Petitioner did not reach maximum medical improvement until after implantation of the permanent spinal cord stimulator on November 13, 2017. (PX 38) The treatment prior to that date maintained Petitioner's condition but she did not get permanent relief of symptoms until after she received the stimulator. While Petitioner continued with conservative treatment including injections following the procedure, the treatment again centers on maintenance of Petitioner's symptoms. (PX 42) For example, consistent with Petitioner's

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testimony at trial, on June 18, 2018, Dr. Goodman reports that the stimulator works well for Petitioner's leg pain but that she continues to deal with low back pain. (PX 42)

Pursuant to the Act, a claimant is entitled to receive TTD benefits until maximum medical improvement is reached. *Nascote Indus. v. Indus. Comm'n*, 353 Ill. App. 3d 1067, 1072 (2004). It is clear that, despite undergoing the FCE, Petitioner did not reach MMI until implantation of the spinal cord stimulator. Given the Arbitrator's above finding and based on the greater weight of the evidence, Respondent is liable for temporary total disability benefits from August 19, 2010 to August 12, 2012 and from March 16, 2014 to November 13, 2017. Petitioner has further met her burden of proof entitling her to permanent disability benefits under the Act from November 14, 2017 to May 22, 2019.

As discussed herein above, the notation from Petitioner's hand surgeon that indicated that Petitioner was working in a bank is clearly inaccurate. Any reliance on this notation from Respondent to deny TTD is misguided, unreasonable and not based on the evidence presented. Petitioner's testimony at trial indicating she was not working in a bank at that time is confirmed by Ms. Bishop's December 10, 2012 report that documented Petitioner was doing vocational rehabilitation at that time. Ms. Bishop's reports document her ongoing meetings with Petitioner that would make it impossible for Petitioner to have been working at that time. (PX 18)

Petitioner is permanently and totally disabled based on her odd-lot status. It has been held an employee may not be completely incapacitated from working but is handicapped to the degree that she is unable to find employment in any well-known branch of the labor market. *City of Chicago v. Illinois Workers' Comp. Comm'n,* 373 Ill. App. 3d 1080, 1089 (2007). To successfully prevail on this claim, a Petitioner must show evidence which either indicates diligent searches were performed unsuccessfully to find employment or that due to Petitioner's age, skills, training, experience and education will not produce employment in a well-known branch of the labor market. Id. If such evidence can be produced, the Respondent then has the burden to show the Petitioner is employable in a stable labor market and the market exists. Id. at 1091.

Petitioner not only searched diligently for a job but did so under the guidance of a vocational rehabilitation specialist. Petitioner participated in vocational rehabilitation with Ms. Bishop who was hired by the Respondent. Not only did Petitioner participate in the program for a period of seven months, but Ms. Bishop noted in numerous reports that Petitioner was motivated and complied with assignments. (PX 18) There was no evidence indicating Petitioner lacked effort

in looking for a job during this period. The Commission has previously indicated that six months of unsuccessful job search activities was sufficient in showing a diligent job search was performed in the labor market and shifting the burden to the Respondent. *Carl Hill, Petitioner*, 05 IL. W.C. 16042 (Ill. Indus. Com'n Feb. 5, 2009).

Despite her participation and Bishop's knowledge of job placement, vocational rehabilitation only yielded Petitioner one 15-minute phone interview. Out of the numerous contacts and applications to employers, Petitioner never had an in-person interview or a job offer of any kind. Following this process, Petitioner continued and ultimately had the placement of a permanent spinal cord stimulator. Pagella testified that this only added to a potential employers' reluctance to hire Petitioner. (PX 46 at 29) This evidence is more than enough to shift the burden on Respondent to show employability in a stable labor market and that the market exists.

As a side issue regarding the vocational process, Respondent alludes that Petitioner unilaterally stopped vocational rehabilitation. (PX 46 at 41 & RX 15 at 21) This is not substantiated by the evidence submitted. Petitioner's treating physician, Dr. Borchardt indicated that Petitioner should not be involved in the process. Ms. Bishop was aware of this at the time of her deposition testimony in 2018. (RX 15 at 45)

Petitioner has also presented evidence showing that due to her age, skills, training, experience and education that employment does not exist in a well-known branch of the labor market. Petitioner relies on the opinions given by Ed Pagella, certified rehabilitation counselor. Pagella rendered his opinions regarding Petitioner during his November 12, 2018 deposition. (PX 46) At that time, Pagella testified he is a certified rehabilitation counselor and that he owns a vocational rehabilitation consulting firm, Health Connection. (PX 46 at 4) When asked to describe his business and practice, Pagella testified, "I am a vocational expert. I perform employability studies. I'm also an expert witness for the federal government as well as the railroad retirement board in determining the employability of individuals who have a wide variety of physical and/or mental limitations." (PX 46 at 6) Pagella indicated that he testifies on vocational issues in front of federal administrative law judges approximately 20 times a week and 80 times per month. (PX 46 at 7) In the realm of workers' compensation, Pagella testified that he does equal work for Petitioners and Respondents. (PX 46 at 12)

Pagella indicated that he drafted a report on behalf of Petitioner to determine her employability and relied on information including physical limitations, work history, residency,

labor market and educational history. (PX 46 at 14) To do this, he reviewed Petitioner's records from Midwest Orthopeadics, Dr. Rhode, Dr, Goodman, Northwestern Memorial Hospital, Brightmore Physical Therapy, Pain Specialists of Chicago, Vocamotive, Dr. McManus, Midwest Hand Surgery and Dr. Borchardt. (PX 46 at 16) Pagella also indicated that Petitioner is "currently receiving Social Security Disability Benefits as a Federal Administrative Law Judge has found her to be completely and totally disabled," (PX 41 at 2) In addition, Pagella was aware that Creative Case Management helped Petitioner with a job search that was unsuccessful. (PX 46 at 25) After discussing the records he reviewed and the totality of Petitioner's vocational profile including her age, her education, her work history and her physical and mental limitations, Pagella opined that Petitioner was unemployable. (PX 46 at 28)

In support of his opinion, Pagella testified he did not consider Dr. Borchardt's opinion that Petitioner should not be involved in vocational rehabilitation and, instead, focused on Petitioner's entire vocational profile. (PX 46 at 27 & 28) Pagella found it very relevant that Petitioner was involved in a job search through Creative Case Management and was still unsuccessful in finding alternative employment. (PX 46 at 28) Pagella noted Petitioner was also entering advanced age at 55, that she was found to be disabled by a federal law judge and that she had a spinal cord stimulator. (PX 46 at 19 & 29)

Pagella also reviewed a vocational assessment report from Vocamotive. (PX 46 at 28) On behalf of the Petitioner, Vocamotive also offered opinions on Petitioner's employability. Ms. Kari Stafseth, certified rehabilitation counselor, offered her opinions in a report dated January 25, 2016. (PX 26) After reviewing medical records, Petitioner's FCE and the reports from Creative Case Management authored by Bishop, Stafseth gave a number of opinions. Stafseth concluded;

- Ms. Eaton lost access to her usual and customary job of nurse.
- Ms. Eaton had put forth a reasonable effort in her previous vocational rehabilitation efforts (as was noted in Ms. Bishop's report submitted as PX 18).
- Ms. Eaton had been applying for several positions that she was not qualified for and required additional training or credentials that she did not have.
- Several of the job targets required the ability to sit for extend periods of times which exceeded the FCE restrictions.

- Petitioner was prospectively employable but that the job targets including front desk representative, concierge, security guard, cashier and retail sales associate require lifting or sitting capabilities beyond her capacity.

In conclusion, Stafseth found that she could not recommend vocational rehabilitation for Petitioner. Pagella indicated that in addition to his expertise, he also relied on Stafseth's opinions in concluding that Petitioner was unemployable. (PX 46 at 33). The Arbitrator finds these opinions credible and supported by evidence in the record and accordingly adopts them as his own.

Further, these opinions and evidence presented regarding Petitioner's age, skills, training, experience and education show employment does not exist in a well-known branch of the labor market and shifts the burden to Respondent to prove the contrary.

On the issue of employability in a stable labor market and the existence of such market, Respondent offered the opinions of Ms. Bishop via her December 5, 2018 deposition. At that time, Bishop agreed that Petitioner complied with the program and that she had not wanted to leave her job as a nurse. (RX 15 at 22 &14) Bishop testified that she drafted two updated labor market surveys dated October 9, 2016 and November 8, 2018 and it was her opinions that there was a viable labor market for Petitioner. (RX 15 at 23-27) Despite indicating that she reviewed Petitioner's FCE, Bishop again opined that the six areas she identified from the Dictionary of Occupational Titles were within nursing. (RX 15 at 34) Again, the FCE indicated that Petitioner could not work as a nurse given her restrictions. Respondent offered no evidence to dispute the findings of the FCE. Clearly, Petitioner does not qualify for the positions that Bishop indicated substantiated her opinion that there is a viable labor market for Petitioner in 2012, 2016 and 2018. Even if the FCE is disregarded, as Bishop has done, the preponderance of the credible facts of the case substantiate that Petitioner has proven she is permanently and totally disabled. Bishop confirmed as much in her deposition testimony and indicated;

- Petitioner never secured employment during the seven-month vocational rehabilitation process despite being a good candidate. (RX 15 at 33)
- Petitioner was provided professional services but did not find a job through the vocational process. (RX 15 at 33)
- Petitioner did resume training, mock interviews and followed up on job leads but did not find a job. (RX 15 at 33)
- Petitioner did not sabotage the vocational process and still did not find a job. (RX 15 at 34)

- Petitioner looked for jobs in all six categories identified in nursing that she qualified for but did not find a job. (RX 15 at 34)
- Petitioner applied for the positions identified but did not find a job. (RX 15 at 34)
- Even if an employer accommodated Petitioner's need to frequently move around, Petitioner was never offered a job. (RX 15 at 36)
- A spinal stimulator is an additional impediment to finding a job. (RX 15 at 36)
- That even if Petitioner were to find a job as of 2018, it would not be full time employment. (RX 15 at 38)
- That Petitioner is being prescribed Tramadol and Valium for her condition and would probably fail a drug test. (RX 15 at 43)
- That if Petitioner failed a drug test, it would be not be beneficial to securing employment. (RX 15 at 43)

The facts demonstrate Petitioner is permanently and totally disabled. The date of disability is the date Petitioner underwent permanent implantation of the spinal cord stimulator on November 13, 2017, when Petitioner reached MMI. Pagella reached his conclusions after that date. Even if, however, this is not deemed the date of permanent disability, the evidence demonstrates that Petitioner was permanently and totally disabled as of March 11, 2013, the date when vocational rehabilitation ceased. (RX 15 at 18) Bishop directed Petitioner's program and was well qualified to do so by review of her curriculum vitae submitted as Respondent's Exhibit 20. Despite this and Petitioner's commitment to the program, Petitioner had only one phone interview, no in person interviews and was not offered employment of any kind. Bishop documented the single phone interview in her November 7, 2012 vocational report. (PX 18) From that point forward, Petitioner's condition and limitations were unchanged. Petitioner now has a spinal cord stimulator which Pagella and Bishop agree is a further impediment to Petitioner securing employment.

The Arbitrator also places great significance, weight, credibility and reliance on Dr. Goodman's note dated January 23, 2014, where Dr. Goodman also indicates Petitioner is totally disabled. (PX 20)

Based on the weight of the preponderance of the credible evidence, the Arbitrator finds and concludes Petitioner is permanently and totally disabled under Section 8(f) of the Act. The

Arbitrator finds the date of permanent total disability to be effective on November 13, 2017, the date Petitioner reached MMI. Given this finding, the Arbitrator awards TTD benefits from August 19, 2010 to August 12, 2012, maintenance benefits from August 13, 2012 to March 11, 2013 and TTD benefits from March 12, 2013 to November 13, 2017. From November 13, 2017 to the present, the Arbitrator finds Petitioner to be permanently and totally disabled and awards benefits of **$675.91 per week for the life** of Petitioner pursuant to Section 8(f) commensurate with this ruling.

M. THE ARBITRATOR FINDS AND CONCLUDES RESPONDENT IS LIABLE FOR PENALTIES UNDER SECTIONS 19(K), 19(L) AND 16 UNDER THE ACT.

Petitioner has filed a penalties petition in this matter. Sections 19(k) and 19(l) of the Act provides for penalties and Section 16 provides for attorney fees. Under Section 19(k), the Act provides that if the Respondent's conduct has been unreasonable and vexatious, the Commission may award compensation additional to that otherwise payable under this Act equal to 50% of the amount payable at the time of the award. Respondent's payment ledger demonstrates they stopped paying bills submitted, documented in Petitioner's Exhibit 1. (RX 22) Further, throughout her testimony, Petitioner indicates that her benefits stopped along with approval of medical treatment.

Section 19(l) of the Act holds, "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." Presently, Respondent's conduct in refusing to pay Section 8(a) and 8(b) was unreasonable and vexatious.

Section 16 of the Act holds that when employer have been guilty of unreasonable or vexatious delay of payment of benefits, the Commission may award all or any part of attorney's fee and costs against such employer.

According to the Illinois Supreme Court, the intent of Sections 16, 19(k) and 19(1) of the Workers' Compensation Act is to implement the Act's purpose to expedite the compensation of industrially injured workers and to penalize an employer who unreasonably, or in bad faith, delays or withholds compensation due an employee. *Avon Products, Inc. v. Industrial Commission*, 82 111.2d 297, 412 N.E.2d 468, 45 III. Dec. 117 at 119 (1980). The Court has held that the standard to consider is "objective reasonableness" of Respondent's conduct, burden of proof, and question of fact for the Commission apply to the imposition of Section 19(k) attorneys fees and attorneys'

fees and costs under Section 16. *Board of Education of the City of Chicago v. Industrial Commission,* 93 1I1.2d 1, 442 N.E.2d 861, 66 III. Dec. 300 (1982).

Presently, Respondent refused to pay benefits to Petitioner after vocational rehabilitation ceased. The last payment was for the period from March 10, 2014 to March 16, 2014. (PX 49) From that date forward, Petitioner only received advances based on trial continuances. As discussed, the vocational process was frivolous to begin with given that Bishop refused to acknowledge the FCE that indicated Petitioner could not return to her line of work as a nurse. Despite Bishop's misguided program and Petitioner's loyalty to it, Petitioner completed 7 months of vocational rehabilitation and found no job of any kind. Despite this, Respondent refused to pay Petitioner any benefits. Respondent seems to rely on Dr. McManus' report. This report only indicated, however, that Petitioner's psychological profile did not preclude her from doing vocational rehabilitation. As discussed herein, Petitioner's treatment physician, Dr. Borchardt directed that Petitioner stop vocational rehabilitation to focus on her recovery. Prior to this time, however, Petitioner underwent this process and did not find a job. Dr. Borchardt continually discusses the impact Respondent's actions had on Petitioner's condition and her inability to address her symptoms. (PX 27)

Respondent's reliance on Dr. McManus' opinions does not preclude the award of penalties. As discussed, Dr. McManus opined that Petitioner's mental profile allowed her to continue with the vocational process. Respondent's reliance on Dr. McManus' opinion to stop paying Petitioner benefits was unreasonable. Dr. McManus' opinions were based on the vocational program directed by Bishop. This program was frivolous from the beginning given that Bishop ignored the findings of the FCE.

In addition to unreasonably refusing to pay Petitioner's benefits, Respondent refused to pay for any of Petitioner's medical treatment after January 2013. Respondent's only plausible - and available - basis for denial is Dr. Singh's April 23, 2018 report, which report is again not credible and was issued 5 years later, and almost 7 years after his prior Section 12 examination. It is unreasonable for a Respondent to base its decision not to pay benefits on the opinion of a physician (issued years after the fact) who had been previously found to lack credibility in the same case. *Scroggins v. Yellow Freight*, 04 IIC 74. This is precisely the situation at bar. Arbitrator Falcioni specifically indicated that he found Dr. Singh to lack credibility. (PX 6) Even if this Arbitrator were to find that the report gave a reasonable basis for denial (thereby

potentially avoiding penalties) this examination was not carried out until 2018, five years after benefits were denied, and continued to be died, since 2013. That half-decade delay was objectionably unreasonable.

As discussed above, the only inclination that Dr. Goodman's treatment was denied prior to this was the adjustor's letter found in Dr. Goodman's records that treatment was denied because Petitioner violated the two-doctor rule. (PX 20) Again, this is not accurate given that Dr. Goodman was in the chain of referrals.

Finally, regarding Petitioner's spinal stimulator, Respondent's utilization report indicated it was reasonable, necessary and related to her condition. Despite this, Respondent did not approve or pay for this treatment. **How could Respondent assert this denial of medical treatment was reasonable when such denial contradicted its own Utilization Review certification?**

Further, if Respondent's dispute is based on Dr. McManus, that is also is unreasonable. Dr. McManus is a board-certified Rehabilitation Psychologist and Neuropsychologist. **Therefore, Dr. MacManus is not in a position to dispute medical treatment.**

In his decision, Arbitrator Falcioni found, "Given the finding of causation, the Arbitrator further finds the treatment and testing recommended by Dr. Vohra, the epidural steroid injection, referral to Dr. Khan and the FCE, to be reasonable and necessary for treatment Petitioner's compensable work accident and awards same." (PX 6) As demonstrated by the evidence, all of the treatment prescribed to Petitioner stemmed from Dr. Vohra's referrals. Respondent was unreasonable and vexatious in ignoring Arbitrator's award of treatment.

Respondent's conduct is aptly characterized and summarized by Dr. Borchardt in her November 3, 2014 note wherein she indicated, "Sheila's pain levels have become very bad lately. She can't sleep because she can't get comfortable. The wait time for her treatments to be approved by workers compensation is inhumane, in my opinion." (PX 27) Dr. Borchardt further noted on December 10, 2014, "Sheila feels that she is controlled by workers compensation because her pain is uncontrolled and workers compensation won't approve recommended treatments." (PX 27) Notations of the hardship Petitioner endured because of the Respondent's unreasonable and vexatious conduct are described throughout Dr. Borchardt's treatment records. (PX 27)

Based on the greater weight of the evidence, the Arbitrator awards Petitioner penalties under 19(k) of the Act for Respondent's unreasonable and vexatious refusal to pay Petitioner's TTD benefits, permanent total benefits and medical treatment. The Arbitrator also awards penalties

totaling $10,000.00 under Section 19(l) of the Act as well as attorney fees under Section 16 of the Act commensurate with penalties awarded under 19(k).

CONCLUSIONS OF LAW

11WC 32885 – Bilateral carpal tunnel

C. THE ARBITRATOR FINDS AND CONCLUDES PETITIONER'S BILATERAL CARPAL TUNNEL SYNDROME AROSE OUT OF AND IN THE COURSE OF HER EMPLOYMENT WITH RESPONDENT.

F. THE ARBITRATOR FINDS AND CONCLUDES PETITIONER'S BILATERAL CARPAL TUNNEL SYNDROME IS CAUSALLY RELATED TO HER EMPLOYMENT WITH RESPONDENT.

As discussed herein above, Petitioner indicated that she noticed symptoms in her hand while working in her nursing position with Respondent. For this, she sought treatment with Dr. Karnezis who performed bilateral carpal tunnel syndrome releases on December 13, 2011. (PX 8) In his noted dated June 15, 2012, Dr. Karnezis noted,

> Work description was obtained which revealed evidence of repetitive and gripping activities to be performed at her work duties. This was specifically is part of her job requirements. This was listed under the physical demands with use of hands and fingers for push and pulls activities as well as for repetitive use of hands and fingers for push and pulls activities as well as for repetitive use of both hands for seven or more hours grasping. (PX 8)

It is unrebutted that Petitioner was a nurse with the above job duties discussed by Dr. Karnezis. Further, no other activities or hobbies are discussed in any of the evidence that would cause carpal tunnel syndrome.

It is the Commission's function, to choose between conflicting medical opinions. *International Vermiculite Co. v. Industrial Comm'n*, 77 Ill.2d 1, 4, 31 Ill.Dec. 789, 394 N.E.2d 1166, 1168 (1979); *ARA Services, Inc. v. Industrial Comm'n*, 226 Ill. App. 3d 225, 232, 168 Ill. Dec. 756, 590 N.E. 2d 78, 82 (1992). **Not only may the Commission decide which medical view is to be accepted, it may attach greater weight to the opinion of the treating physician.** *International Vermiculite Co. v. Industrial Comm'n*, 77 Ill.2d 1, 4, 31 Ill.Dec. 789, 394 N.E.2d 1166, 1168 (1979); *ARA Services, Inc. v. Industrial Comm'n*, 226 Ill. App. 3d 225, 232, 168 Ill. Dec. 756, 590 N.E. 2d 78, 82 (1992). **In this matter, after careful review, the Arbitrator places**

greater credibility, weight and reliance on the opinions of Petitioner's treating physician Dr. Karnezis over that of Respondent's Section 12 examiner.

Based on the greater weight of the evidence, the Arbitrator finds that Petitioner has proven by the preponderance of the credible evidence that her bilateral carpal tunnel conditions arose out of and in the course of her employment with Respondent and are causally related to her work activities.

J. THE ARBITRATOR FINDS AND CONCLUDES RESPONDENT IS LIABLE FOR PAYMENT OF PETITIONER'S REASONABLE AND NECESSARY MEDICAL TREATMENT.

Given the Arbitrator's finding of compensability, Respondent is liable for the reasonable and necessary medical treatment rendered for Petitioner's condition as submitted in Petitioner's exhibit 1. In his note dated June 15, 2012, Dr. Karnezis indicated that the surgeries improved Petitioner's conditions and she could return to full duty work.

L. THE ARBITRATOR FINDS AND CONCLUDES RESPONDENT IS LIABLE FOR PERMANENCY RELATED TO PETITIONER'S BIALTERAL HAND CONDITIONS.

Given the Arbitrator's finding that Petitioner suffered a compensable work accident related to her bilateral hands, Respondent is liable for permanency related to those conditions and bilateral carpal tunnel syndrome releases performed on December 13, 2011 At hearing, Petitioner testified that she continues to have weakness and permanent nerve damage in her hands that has never resolved. (T65) Based on the greater weight of the evidence, the Arbitrator finds that Petitioner suffered permanent partial disability for a total period of 66.625 weeks: the permanent partial los of use of her right hand to the extent of 17.5% thereof under Section 8(e)9, or 35.875 weeks, and the permanent partial loss of use of her left hand to the extent of 15% thereof under Section 8(e 09, or 30.75 weeks. **Petitioner's weekly PPD rate is $608.32.**

Robert M. Harris

Signature of Arbitrator Robert M. Harris

Dated: July 15, 2019

STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MICHELE DODD,

Petitioner,

vs. NO. 15 WC 32844

ROTI MEDITERRANEAN GRILL,

Respondent.

ORDER

This matter comes before the Illinois Workers' Compensation Commission on Petitioner's Motion to Adjudicate Northwestern Medical/Northwestern Memorial Hospital's Bills to Zero, under §19(h), which was heard on February 19, 2020, due notice being given, Petitioner and Respondent having been represented by counsel. Northwestern Medicine/Northwestern Memorial Hospital received due notice but was not represented at the hearing. The Commission, being advised in the premises, finds the following:

Petitioner was injured in a motor vehicle accident on July 15, 2015, and filed workers' compensation claim 15 WC 32844 against Respondent, Roti Mediterranean Grill. As a result of the accident, Petitioner underwent a cervical fusion surgery at Northwestern Medicine/Northwestern Memorial Hospital (Northwestern) on July 21, 2015. Medical charges for services rendered by Northwestern on that date totaled $5,475.00. *(PX3)*

Northwestern billed Petitioner's health insurance carrier, Blue Cross/Blue Shield (BC/BS) rather than Respondent's workers' compensation carrier. As a result, BC/BS made three payments towards the medical bills on July 29, 2019, August 19, 2019, and August 21, 2019, for a total payment of $4,660.14. *(PX3)* Thereafter, Northwestern claimed a balance due of $814.86 on account of said accident. After it was discovered bills had been submitted to the group carrier, some bills were then tendered to Respondent for payment. *(T.5)*

Petitioner and Respondent entered into a settlement agreement resolving Petitioner's workers' compensation claim for consideration of one dollar, and Petitioner agreed to reimburse Respondent in the amount of $15,000.00 to satisfy the §5(b) lien. *(RX1)* Both parties expressly waived their rights to review under §19(h) and rights under §8(a). The settlement contract, approved August 9, 2018, further stated, "This settlement includes liability for temporary total compensation and all

medical, surgical, rehabilitation, and hospital expenses incurred or to be incurred or allegedly resulting from the said accidental injury for all of which the Petitioner expressly assumes responsibility." *(RX1)* On the first page of the settlement contract, it was indicated, "Employer has not paid all medical expenses." *(RX1)* The settlement contract further stated, "Travelers will be responsible for anything owed to BCBS for treatment related to her work injury." *(RX1)*

Respondent's counsel stated at hearing that the total amount of the bill in question for services rendered on July 21, 2015, from Northwestern on account of the accident was $5,475.00. Respondent represented that per the Workers' Compensation fee schedule, the total amount owed would have been $3,014.86. *(PX4)* Respondent noted that Northwestern had received payment in excess of $4,000.00 from Petitioner's BC/BS health insurance carrier. Therefore, Northwestern had received more than if they had properly billed Respondent's workers' compensation carrier. Respondent further stated the settlement contract had closed out Respondent's medical liability.

Petitioner's attorney presented evidence that Northwestern had been advised of this hearing. *(PX1)* No representative from Northwestern appeared at this hearing.

§8(a) of the Act states, in part:

> Section 8 (a) Employer to Pay Necessary Medical Expenses.
> The amount of compensation which shall be paid to the employee for an accidental injury not resulting in death is: (a) The employer shall provide and pay the negotiated rate, if applicable, or the lesser of the health care provider's actual charges or according to a fee schedule, subject to Section 8.2, in effect at the time the service was rendered 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, even if a health care provider sells, transfers, or otherwise assigns an account receivable for procedures, treatments, or services covered under this Act. *820 ILCS 305/8(a) (West 2013)*

§8.2 of the Act states, in part:

> Section 8.2. Fee schedule.
> Except as provided for in subsection (c), for procedures, treatments, or services covered under this Act and rendered or to be rendered on and after February 1, 2006, the maximum allowable payment shall be 90% of the 80th percentile of charges and fees as determined by the Commission utilizing information provided by employers' and insurers' national databases, with a minimum of 12,000,000 Illinois line item charges and fees comprised of health care provider and hospital charges and fees as of August 1, 2004 but not earlier than August 1, 2002. These charges and fees are provider billed amounts and shall not include discounted charges. The 80th percentile is the point on an ordered data set from low to high such that 80% of the cases are below or equal to that point and at most 20% are above or equal to that point. The Commission shall adjust these historical charges and fees as of August 1, 2004 by the Consumer Price Index-U for the period

> August 1, 2004 through September 30, 2005. The Commission shall establish fee schedules for procedures, treatments, or services for hospital inpatient, hospital outpatient, emergency room and trauma, ambulatory surgical treatment centers, and professional services. These charges and fees shall be designated by geozip or any smaller geographic unit. *820 ILCS 305/8.2(a) (West 2013)*

The Commission notes that the medical bills in question had been paid by BC/BS as Northwestern submitted bills to BC/BS rather than Respondent's workers' compensation carrier. As a result, Northwestern has received more towards their medical bills than they were entitled under the fee schedule of §8.2. As such, Northwestern would not be entitled to any further claimed balance due under the Workers' Compensation Act pursuant to §8.2(e) of the Act, which provides, in pertinent part:

> Except as provided in subsections (e-5), (e-10), and (e-15), a provider shall not hold an employee liable for costs related to a non-disputed procedure, treatment, or service rendered in connection with a compensable injury. The provisions of subsections (e-5), (e-10), (e-15), and (e-20) shall not apply if an employee provides information to the provider regarding participation in a group health plan. If the employee participates in a group health plan, the provider may submit a claim for services to the group health plan. If the claim for service is covered by the group health plan, the employee's responsibility shall be limited to applicable deductibles, co-payments, or co-insurance. Except as provided under subsections (e-5), (e-10), (e-15), and (e-20), a provider shall not bill or otherwise attempt to recover from the employee the difference between the provider's charge and the amount paid by the employer or the insurer on a compensable injury, or for medical services or treatment determined by the Commission to be excessive or unnecessary. *820 ILCS 305/8.2(e) (West 2013)*

The Commission finds, however, that there is a question of jurisdiction. "The Commission is an administrative body created by legislative enactment for the purpose of administering the Act." *Trigg v. Industrial Commission*, 364 Ill. 581, 587 (1926); *Alvarado v. Industrial Commission*, 216 2d 547, 553 (2005). The 2017 Appellate Court case *Millennium Knickerbocker Hotel v. Illinois Workers' Compensation Commission*, 2017, Il App 1st 161027WC is instructive here. Petitioner and Respondent entered into a settlement contract whereby Respondent had indicated all medical bills were paid. Two and a half years later, Petitioner filed a "Motion to Enforce Contract and Penalties" alleging Respondent refused to pay outstanding medical bills pursuant to the terms of the settlement contract.

The Commission in that case entered an order granting Petitioner's motion and directing Respondent to pay the outstanding medical charges as well as penalties under §19(k) and attorney's fees under §16. The Circuit Court affirmed the Commission's order. The Appellate Court vacated the Commission's order requiring Respondent to pay Petitioner's medical expenses holding that the Commission lacks the authority to enforce a final award. Moreover, the Court found that even though the Commission had jurisdiction to address that portion of the motion requesting penalties and attorney's fees, the Petitioner abandoned the issue before the Commission thus the order awarding penalties and attorney's fees was vacated. The Appellate Court further

found that pursuant to §19(g) of the Act, the proper venue to seek enforcement of a Commission's final award was with the Circuit Court.

The Commission, while finding Northwestern has already received payment in excess of what they would have been entitled to under the Workers' Compensation Act, further finds that the terms of the settlement contract, approved August 9, 2018, divest this Commission of jurisdiction. The terms of the settlement contract expressly state that the parties waived review under §19(h) and their rights under §8(a). The settlement contract constituted a final award, and, pursuant to the holding in *Knickerbocker*, the Commission lacks jurisdiction to enforce or adjudicate the Northwestern bills in question.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Petitioner's "Motion to Adjudicate Northwestern Medical/Northwestern Memorial Hospital's Bills to Zero" under §19(h) is denied as the Commission lacks jurisdiction to provide the relief requested.

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.

JUN 17 2020

DATED:

Kathryn A. Doerries

-2/19/20
KAD/jsf
42

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

Patricia Wheatfield,

Petitioner,

vs. NO: 02 WC 58071

McDonald's,

Respondent.

20IWCC0331

DECISION AND OPINION ON §19(h) AND §8(a) PETITION

This case comes before the Commission on Petitioner's §19(h) and §8(a) Petition, alleging a material increase in his disability since the most recent arbitration decision dated 7/27/07. A hearing on the petition was held before Commissioner Thomas J. Tyrrell on 5/23/19 in Chicago, Illinois and a record was made. The Commission, having considered the entire record, denies Petitioner's Petition under §19(h) and §8(a), for the reasons set forth below.

I. HISTORY OF THE CASE

A. Arbitration:

1) §19(b) Decision of Arb. Mathis (12/18/03)

In a prior §19(b) decision, the Arbitrator found that Petitioner sustained accidental injuries arising out of and in the course of her employment on 5/7/02, that proper notice was given, that a causal connection existed between the accident and Petitioner's condition of ill-being with respect to the lumbar spine, including the need for surgical spinal decompression, that as a result Petitioner was temporarily totally disabled from 1/3/03 through 10/15/03, for a period of 40-6/7 weeks, and that she was entitled to reasonable and necessary medical expenses in the amount of $7,581.96 as well as the surgical decompression recommended by Dr. Walker Robinson pursuant to §8(a) of the Act.

The Arbitrator noted the evidence "... demonstrates that a temporal relationship exists between Petitioner's fall at work on May 7, 2002, and the onset of her left sided low back complaints. Petitioner's testimony relating to the onset of her symptoms to the fall at work is consistently corroborated by the medical records in evidence. The fall described by the Petitioner also appears to be a competent cause for an aggravation of degenerative disc disease or a herniation of a lumbar disc. There is no evidence of any prior ongoing lumbar symptoms and the only possible intervening event (a fall in June 2002) was attributed by Petitioner to her low back and left leg symptoms. Finally, Petitioner's treating neurosurgeon (Dr. Robinson), whom the Arbitrator finds to be reliable, found a causal connection exists between the fall and the condition of her low back and need for surgery." (Arb.Dec.[12/18/03], p.6).

2) Corrected Decision of Arb. White (7/27/07)

In this most recent decision, the Arbitrator noted the prior §19(b) decision had been "... affirmed by the Commission by decision issued August 3, 2004." (Arb.Dec.[7/27/07], p.3). She also noted since that prior decision "... Petitioner's symptoms have changed and various intervening events have occurred." (Id.).

In her decision, the Arbitrator found that "... Petitioner injured her low back and left leg in the accident of May 7, 2002, and that this injury aggravated the pre-existing degenerative conditions. Subsequent to the surgery of October 8, 2004, Petitioner experienced relief of the left leg pain but progressively developed pain in her right leg for which she was treated with a brace and therapy. The arbitrator finds that Petitioner's condition of ill-being in her low back and both legs are causally connected to the accident of May 7, 2002, and that treatment for these injuries is also related up until the subsequent intervening event at home on October 3, 2005." (Id., p.6).

In making this determination, the Arbitrator found that "Petitioner's credibility is defeated by her attempts to manipulate medical opinion. Petitioner has never intended to go back to work. The fall in the kitchen on the day she was to return to Respondent is too much coincidence. Petitioner's alleged fall at home on October 3, 2005 is not related directly or indirectly to the accident of May 7, 2002." (Id.).

As a result, the Arbitrator awarded medical expenses incurred up to 10/3/05 totaling $4,216.50 and denied the remaining expenses beyond that date. (Id., pp.6-7).

In addition, the Arbitrator found that "... Petitioner ceased to be temporarily totally disabled as a result of the May 7, 2002 injury on October 3, 2005" after she suffered "... an unrelated alleged fall in her kitchen." (Id., p.7). As a result, the Arbitrator found that Petitioner was entitled to TTD from 10/15/03 to 10/3/05, for a period of 102-5/7 weeks (Id.).

Finally, the Arbitrator found that Petitioner was permanently partially disabled to the extent of 50% person-as-a-whole pursuant to §8(d)2 of the Act. (Id., p.2). In support of this finding, the Arbitrator noted that "Petitioner's injury required surgery, therapy and a brace. The record contains strong suggestions that Petitioner is not as disabled as she would like the arbitrator to believe; nevertheless, she does walk with a limp and, as of October 3, 2005, had restrictions

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recommended by Nurse Marner for Dr. Robinson and Dr. VanFleet that limit her ability to find employment. Petitioner has not worked anywhere since this accident and has not applied for any job." (Id., p.7).

B. Commission on Review:

The Commission's mainframe computer shows the Commission affirmed and adopted Arb. Mathias' §19(b) decision on 8/3/04.

The Commission notes that there is no indication that a Petition for Review was filed following Arb. White's corrected decision dated 7/27/07.

On 2/6/09, Petitioner filed the present Petition for Review under §§19(h)/8(a).

On 4/2/15, Comm. DeVriendt granted the parties' joint motion to transfer venue from Urbana to Chicago.

On 10/19/16, Respondent filed a "Motion to Set case on Review Call; hearing date." This motion subsequently appeared on Comm. Tyrrell's review call on 12/8/16 at which time the case was dismissed for want of prosecution given Petitioner's failure to appear.

Petitioner filed a Motion to Reinstate on 1/12/17. Comm. Tyrrell granted the Motion to Reinstate on 1/25/17.

A hearing on Petitioner's §§19h/8a Petition was held before Com. Tyrrell on 5/23/19.

Oral arguments before the Commission were held on 4/21/20.

II. FINDINGS OF FACT

A) §§19h/8a Hearing (5/23/19)

At the commencement of the §§19(h)/8(a) hearing, Petitioner's counsel noted that his client "... resides in Vermillion County, Illinois, and it's difficult for her to travel because of her back condition, so the parties have agreed that in lieu of her testimony today, we'll present an affidavit indicating what she would testify to if she were present." (T.4). Counsel for Respondent then stated that "... there's no objections to the affidavit. As Mr. Globis [Petitioner's attorney] indicated, we believe that her testimony would be consistent with the affidavit. We do have a standing caveat to all this evidence based off of the rule of law and the underlying proceeding that basically all of these issues that are before your Honor are dispositive under the rule of law doctrine." (T.4-5).

In pertinent part, Petitioner's affidavit states that "I last testified before the Illinois Worker's Compensation [C]ommission [on] April 6 [*sic*], 2007. Since that time, I have been under the care of Dr. Gindi. I feel numbness in my right side of my back down the right leg. Doctor Gindi eventually referred me to Dr. Nardone. The doctor is with The Central Il[l]. Neuro

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Health of Advocate [*sic*], these doctors prescribed pain medication and I had surgery at Saint Joseph Hospital in Bloomington, Illinois on October 13, 2009 to my low back. My surgery was paid for by Medicare and Medicaid. After the surgery, I felt somewhat better for about three months. Then, the problems came back again which was numbness down the right side which was worse than when I testified on April 6, 2007. I use a walker due to my back condition. My right leg gives out on me at the present time and I feel pain going down the back of my right leg. The pain has increased since my last testimony of April 6 [*sic*], 2007. I have never returned to work." (PX1).

III. CONCLUSIONS OF LAW

Section 19(h) of the Act provides, in pertinent part, that

> ". . . as to accidents occurring subsequent to July 1, 1955, which are covered by any agreement or award under this Act providing for compensation in installments made as a result of such accident, such agreement may at any time within 30 months, or 60 months in the case of an award under Section 8(d)1, after such agreement or award be reviewed by the Commission at the request of either the employer or the employee on the ground that the disability of the employee has subsequently recurred, increased, diminished or ended."

In the present case, Petitioner filed the current §§19(h)/8(a) Petition on 2/6/09, or almost nineteen (19) months following Arb. White's Corrected Decision on 7/27/07. Once again, no review was filed by either party following Arb. White's Corrected Decision.

Petitioner argues that she has suffered a material increase in her disability since the last hearing on 4/16/07, and that as a result she is entitled to additional medical expenses and temporary total disability benefits as well as a finding that she is permanently and totally disabled for life pursuant to §8(f) of the Act. Respondent counters that the law of the case would apply and that therefore Petitioner would not be entitled to additional compensation in light of the Arbitrator's prior ruling as to causation.

Under the law-of-the-case doctrine, once an issue is litigated and decided, that ends the matter and the unreversed decision of a question of law or fact made during the course of the litigation settles that question for all subsequent stages of the suit. *Irizarry v. Industrial Comm'n*, 337 Ill. App. 3d 598, 606, 786 N.E.2d 218, 224, 271 Ill. Dec. 960 (2003). The doctrine is based on sound policy that after an issue has been litigated and decided, the finding or ruling should be the end of the disputed issue; an unreversed resolution of an issue of law or fact, made during the course of litigation, settles that issue for all subsequent stages of the litigation. *Id.*

"A party's failure to challenge a legal decision when it had the opportunity to do so renders that decision the law of the case for future stages of the same litigation." *People ex rel. Department of Public Health v. Wiley*, 348 Ill. App. 3d 809, 817, 810 N.E.2d 614, 621, 284 Ill. Dec. 824 (2004). A decision becomes binding for future stages of the same litigation when there is an opportunity to challenge the decision and further review is not sought. *Id.* It has also been held that the principles underlying the law-of-the-case doctrine should be applied to matters

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resolved in proceedings before the Commission. *Ming Auto Body/Ming of Decatur, Inc. v. Industrial Comm'n*, 387 Ill. App. 3d 244, 252, 899 N.E.2d 365, 374, 326 Ill. Dec. 148 (2008).

In her corrected decision, Arb. White specifically found that "... Petitioner's condition of ill-being in her low back and both legs are causally connected to the accident of May 7, 2002, and that treatment for these injuries is also related up until the subsequent intervening event at home on October 3, 2005." (Arb.Dec. [7/27/07], p.6). In making this determination, the Arbitrator found that "Petitioner's credibility is defeated by her attempts to manipulate medical opinion. Petitioner has never intended to go back to work. The fall in the kitchen on the day she was to return to Respondent is too much coincident. Petitioner's alleged fall at home on October 3, 2005 is not related directly or indirectly to the accident of May 7, 2002." (Id.). In addition, the Arbitrator found that "... Petitioner ceased to be temporarily totally disabled as a result of the May 7, 2002 injury on October 3, 2005" after she suffered "... an unrelated alleged fall in her kitchen." (Id., p.7).

Thus, the Arbitrator clearly found that Petitioner's condition of ill-being was no longer causally related to the work-related accident following an unrelated, intervening event that occurred at Petitioner's home on 10/3/05. Since neither party filed a review of Arb. White's decision, the findings relative to the issues raised at that time, particularly on the question of ongoing causation, are considered settled for all subsequent stages. As a result, Petitioner is prohibited from relitigating the issue of causation as part of her Petition under §§19(h)/8(a) of the Act.

Accordingly, Petitioner's Petition under §19(h) and §8(a) is hereby denied based on the law of the case.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's Petition under §19(h) and §8(a) is hereby denied.

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

DATED: JUN 17 2020
o: 4/21/20
TJT/pmo
51

Thomas J. Tyrrell

Kathryn A. Doerries

Maria E. Portela

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)
Correct scrivener's errors only	☐ PTD/Fatal denied
☐ Modify Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ALEXANDER A. GIGLIO,

Petitioner,

vs. NO: 18 WC 12067

ILLLINOIS STATE POLICE,
STATE OF ILLINOIS,

Respondent.

20IWCC0334

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, temporary total disability, medical expenses, 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, other than correction of scrivener's errors.

The Commission, herein, corrects a scrivener's error in the Arbitrator's decision in Section (G), the correct accident date should be noted as February 14, 2018.

The Commission corrects a scrivener's error in Section (J), second paragraph, the sentence is herein corrected to read, "The Petitioner was seen at the Emergency Room at DuPage Medical Group on February 17, 2018."

The Commission corrects the scrivener's error in Section (K), specifically the TTD dates in the first sentence of the first paragraph. The Commission notes that the TTD awarded in the Order section of the Arbitrator's Decision, February 21, 2018 through May 9, 2018, was correct and corrects the scrivener's error in the Memorandum of Decision of Arbitrator to be consistent with the dates cited therein. The sentence is corrected to read, "The Arbitrator finds that the petitioner was restricted from work from February 21, 2018, to May 9, 2018, at which time he was able to return to the Academy."

20IWCC0334

IT IS THEREFORE ORDERED BY THE COMMISSION that the Corrected Decision of the Arbitrator filed December 10, 2019 is hereby affirmed and adopted, other than the corrections of the scrivener's errors noted above.

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

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

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

DATED: JUN 17 2020
o-6/9/20
KAD/jsf

Kathryn A. Doerries

Maria E. Portela

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

GIGLIO, ALEXANDER Case# **18WC012067**
Employee/Petitioner

STATE OF ILLINOIS-ISP
Employer/Respondent

On 12/10/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.52% 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:

1497 MORICI FIGLIOLI & ASSOC
KENNETH LUBINSKI
150 N MICHIGAN AVE SUITE 1100
CHICAGO, IL 60601

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

6236 ASSISTANT ATTORNEY GENERAL
KATIE KOYNE
500 S SECOND ST
SPRINGFIELD, IL 62706

2202 ILLINOIS STATE POLICE
801 S 7TH ST
SPRINGFIELD, IL 62794

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 10 2019

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

STATE OF ILLINOIS)
)SS.
COUNTY OF SANGAMON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
CORRECTED ARBITRATION DECISION

Alexander Giglio,
Employee/Petitioner

v.

State of Illinois—ISP,
Employer/Respondent

Case # **18** WC **012067**

Consolidated cases: _____

20IWCC0334

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Seal**, Arbitrator of the Commission, in the city of **Springfield**, on **September 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. ☒ 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 **February 14, 2018**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $ **32,075.68**; the average weekly wage was $**616.84**.

On the date of accident, Petitioner was **22** 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 $**N/A** for TTD, $**N/A** for TPD, $**N/A** for maintenance, and $**N/A** for other benefits, for a total credit of $**N/A**.

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

ORDER

The Arbitrator finds that the medical treatment that the petitioner received is causally related to the work accident he sustained on February 14, 2018, and that the medical bills that were submitted as petitioner's Exhibit A constitute reasonable and necessary medical treatment pursuant to Section 8(a) of the Act.
The treatment rendered by Dr. Stender and the DuPage Medical Group was reasonably required to relieve the effects of the injury. The petitioner was seen at the Emergency Room at DuPage Medical Group on September 17, 2018. He was prescribed physical therapy and told to follow up with his primary care provider. On February 19, 2018, he was seen by Internal Medicine at DuPage Medical Group and was referred to an orthopedic surgeon, Dr. Zachary Stender, who the petitioner saw on February 21, 2018. Dr. Stender initiated conservative treatment which included a course of physical therapy and a Medrol Doespak, and also provided off-work restrictions. The petitioner underwent the course of physical therapy and continued to follow up with Dr. Stender until May 9, 2018, at which time the petitioner was discharged. The petitioner testified that after the completion of the course of physical therapy his pain resolved. The Arbitrator therefore finds that this course of treatment is reasonable and was required to provide relief from the effects of the February 14, 2018, work accident.
The petitioner's Exhibit A contains the medical bills that the petitioner incurred for treatment at DuPage Medical Group. Each of those bills lists the amount of the charge and the amount paid. The total amount of the bills contained in Exhibit A is $6,534.00.

With respect to the bills from DuPage Medical Group, the Arbitrator finds that the bills constitute reasonable and necessary medical treatment pursuant to Section 8(a) of the Act. As noted above, the petitioner's treating physicians referred the petitioner to physical therapy, which the petitioner testified was effective in providing relief for his injuries. petitioner's Exhibit A consists of the bills from DuPage Medical Group and shows that the unpaid balance is $6,534.00. Based on the above, the Arbitrator awards the petitioner the medical expenses outlined in petitioner's Exhibit A in the amount of the outstanding balance of $6,534.00 pursuant to the medical fee schedule in Section 8.2 of the Act.

The Arbitrator finds that the petitioner was restricted from work from February 21, 2018, to May 9, 2018, for a period of 11 weeks. This finding is based upon the testimony of the petitioner which the Arbitrator finds credible. This finding is also based on the medical records. Based on this, the Arbitrator finds that the petitioner is entitled to 11 weeks of temporary total disability benefits at a rate of $411.18 per week.

The Arbitrator awards the petitioner the sum of $5,551.50 representing $370.10 per week for a period of 15 weeks as provided in section 8(d) (2) of the Act, because the injury sustained caused serious and permanent injuries resulting in 3% 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.

Signature of Arbitrator

December 10, 2019
Date

DEC 10 2019

MEMORANDUM OF DECISION OF ARBITRATOR

Findings of Fact

The petitioner testified that he is 24 years old, single, with no dependents. He is currently employed as an Illinois State Trooper. His job duties as a State Trooper are to patrol the interstate highways in the Chicago area.

The petitioner graduated in June of 2016, with a B.A. in criminal justice and sociology. Shortly after graduating from college, he applied to the Illinois State Police. He passed a series of tests and was then hired as an "At Will Cadet."

At Will Cadets have to attend a six-month training session at the Illinois State Police Academy located in Springfield, IL. The petitioner testified that his salary as an At-Will Cadet was $1336.50 every two weeks. He produced a pay stub to support this testimony. (Pet. Ex. C) This is consistent with Respondent's Exhibit 6 which lists the petitioner's pay rate at $2,673 per month. (Res. Ex. 6).

The petitioner arrived at the Academy on Sunday, February 11, 2018. The classes, which started on Monday, last from 5:30 am to approximately 6:00 pm, Monday through Friday. During the course of each day, the cadets undergo one hour of Physical Training ("PT"). It consists of various exercises including push-ups, running, sit-ups, pull-ups, and burpees. The petitioner testified that PT is intense. The cadets are told by the instructors to move quicker and faster. The cadets cannot stop during PT but are told to keep going.

The accident occurred on Wednesday February 14, 2018, during Physical Training ("PT"). Trooper Allotey was in charge of PT on the day of the accident. On the date of the accident, prior to the accident, the petitioner had undergone 45-50 minutes of PT. While he was performing a Burpee exercise, the petitioner felt a sharp pain in his upper back and on the left side of his neck, radiating into his shoulders. Due to the pain, the petitioner stopped performing the exercises.

Sgt. Yencko, who was the cadet training supervisor, was observing the cadets during P.T. at that time of the accident and saw the petitioner stop performing the exercises. When Sgt. Yencko saw the petitioner stop. Sgt. Yencko proceeded to pull the petitioner in front of the class to finish the work out and to make an example of him. Sgt. Yencko got into the petitioner's face and shouted at the petitioner to keep going. The petitioner had to perform more Burpee exercises while standing in front of the class. The petitioner did not tell Sgt. Yencko that he was hurt because he wanted to finish the Academy. The petitioner continued to attend the Academy the rest of that week and also continued to attend PT. He testified that he was still in pain during the remainder of the week.

The petitioner testified that on Friday, February 16, 2018, when he was in his car on his way home from the Academy, his shoulder was unbearably painful, he realized that the pain was not going away, and that he would need to seek medical treatment. The petitioner described the pain as left sided neck pain, radiating into shoulders, left arm, and left elbow.

On Saturday, February 17, 2018, the petitioner went to DuPage Medical Group ("DMG") Immediate Care in Tinley Park. (Pet. Ex. B). The petitioner reported that over the past few weeks he has had progressively worsening neck pain and stiffness radiating into his shoulders. He reported that it happened sometime at the Police Academy. A diagnosis of neck strain and cervical spasm was rendered.

The petitioner testified that on Saturday, February 17, 2018, he reported the accident to Trooper Juergensen via text message. In the message, the petitioner told Trooper Juergensen that he was hurt and had to go to the doctor. The petitioner then returned to the Academy on February 18, 2018, to fill out paperwork in relation to the injury and his medical treatment. On that day, he met with Sgt. Drats. The petitioner was discharged from the Academy and told that he could return in the next class.

The petitioner was not able to return to the Academy due to his injuries. Instead he had to attend the next session, which began in June 23, 2018. During that period of time, from the date that he left the academy on February 16, 2018, up to the date that he returned in July of 2018, the petitioner was unemployed. He did not receive any TTD payments.

On February 21, 2018, the petitioner was seen by Dr. Stender at DuPage Medical Group. (Pet. Ex. B). On that date, the petitioner reported left sided neck pain for 1-2 weeks, that he cannot recall a specific event but that he was doing heavy training at police academy. The petitioner stated that the pain radiates down his left arm. The diagnosis was neck strain with cervical radiculopathy and possible cervical disc herniation. A Medrol Dosepak was prescribed along with a course of physical therapy. The petitioner underwent physical therapy at DMG starting on March 2, 2018. (Pet Ex. B).

On April 9, 2018, the petitioner retuned to Dr. Stender. (Pet Ex. B). He reported that he was 40-50% better, no longer had pain in left arm, but still had trapezial pain. The diagnosis was neck strain. On April 23, 2018, the petitioner was seen by Dr. Stender for a follow up. (Pet Ex. B). He reported increased pain in the trapezial region after sitting in a car of 8 hours. The diagnosis was again neck strain.

The petitioner's last session of physical therapy was on May 1, 2018, at DuPage Physical Therapy. The diagnosis on that date was cervical radiculopathy. It was recommended that the petitioner continue physical therapy for an additional 16 visits; however, the petitioner testified that he was feeling better and did not undergo the additional treatment.

On May 9, 2018, the petitioner was discharged by Dr. Stender with a home exercise program. The diagnosis on that date was neck strain. Dr. Stender returned the petitioner to work full duty with no restrictions.

The petitioner testified that he continues to experience left sided neck pain and upper back pain approximately once per week. When he experiences that pain, it is a sharp pain. He takes over-the-counter medication and does home exercises to alleviate the pain. The pain lasts for approximately 20 minutes.

Sgt. Yencko testified at the Arbitration hearing. He testified that the Academy is a military style academy. There is rule that a cadet does not speak unless spoken to. The cadets are not to talk back to the instructors. Sgt. Yencko testified that the Academy is tough. He testified that the cadets take pride in attending the Academy. For many of the cadets, attending the Academy is their life-long dream.

Sgt. Yencko oversees the training at the Academy. He will on occasion observe the PT sessions and is a superior to the PT instructors. Sgt. Yencko testified that the cadets cannot stop during PT. If a cadet stops, there are consequences. If Sgt. Yencko sees someone stop during the exercises, he will verbally encourage the cadet in front of the class to continue to perform the exercises. Sgt. Yencko explained that an officer needs to be able to physically restrain people and the purpose of PT to get the cadets into physical shape to be able to perform those duties.

The Respondent offered the following exhibits into evidence

- Respondent's Exhibit 1 is the IL Form 45. The Form 45 is dated February 20, 2018. The report was completed by Samantha Carmona and states that the petitioner felt muscle soreness during the week and it later worsened. (Res Ex. 1). There was no testimony at trial by Carmona.
- Respondent's Exhibit 3 is the Supervisor's Report of Injury or Illness, completed by Office McDonald. Trooper McDonald did not testify at the hearing. It is reported that during the first week of physical training, the petitioner suffered muscle soreness. (Res. Ex. 3). There was no testimony at trial by Trooper McDonald.
- Respondent's Exhibit 9 consists of numerous documents including Office Memorandums.
- Respondent's Exhibits 11 and 12 consist of the Illinois State Police Academy Cadet Files.

Conclusions of Law

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

The Arbitrator finds that the petitioner sustained an accident that arose out of and in the course of his employment with the Illinois State Police that resulted in injuries to his neck and upper back. This finding is based upon the testimony of the petitioner which the Arbitrator finds credible and consistent with the medical records presented in this case.

The petitioner's credible and unrebutted testimony establishes that he sustained an accident that arose out of and in the course of his employment in that he suffered an injury to his neck and upper back while participating in a session of physical training ("PT") at the Illinois State Police Academy.

The petitioner testified that the accident occurred on February 14, 2018, at the Illinois State Police Academy, which is clearly a task he was assigned to perform as an At-Will Cadet with the Illinois State Police. He testified that he felt a pain while performing a Burpee exercise, that he stopped performing the exercise, and was immediately told by Sgt. Yencko to go to the front of the class and finish the exercises. The Arbitrator finds the petitioner's testimony credible as to why he did not immediately report his injury. The petitioner stated that he wanted to finish the Academy, that becoming an Illinois State Police Officer was his goal upon graduation from college, and that the Academy's rules were to not speak to the instructors unless spoken to. This Academy culture was confirmed by Sgt. Yencko who testified that the Academy is a military-style academy, that cadets are not to speak unless spoken to, that there is clearly defined hierarchy between the cadets and instructors, and that if he observed a cadet slacking off during PT, he would verbally encourage the cadet to complete the exercises.

The medical records also support a finding that the petitioner sustained an accident that arose out of and in the course of his employment with the Illinois State Police. When the petitioner first sought treatment at DuPage Medical Group ("DMG") on February 17, 2018, even though the record incorrectly states that the pain had increased over the past few weeks, the record clearly states that the pain originated during training at the police academy. The academy

started on February 11, 2018, so it is impossible for it to have occurred a few weeks prior to this visit.

Other medical records support this finding. A Progress Note dated February 19, 2018, states that the petitioner had pain for five days and that he feels it started at the academy while doing intense PT. The record dated February 21, 2018 states that the petitioner had neck pain for one week and that he believes he injured himself while training at the police academy. The physical therapy record dated March 5, 2018, states that the pain began 2.5 weeks ago. Two and a half weeks prior to this date was February 14, 2018. No other origin of the pain is noted. It is irrelevant that the time frame of the development of the pain is listed in the initial record is a few weeks because the pain nevertheless is identified as occurring during the training at the police academy. As noted, the academy started on February 11, 2018.

The Respondent's documents support a finding that the petitioner sustained an accident that arose out of and in the course of his employment with the Illinois State Police. In Respondent's Exhibit 2, the Employee's Notice of Injury, under the section labeled "what duty were you performing at time of injury," the petitioner wrote "P.T." (Res. Ex. 2). Under additional details, the petitioner states that he believed he was suffering from muscle soreness during the week and woke up on Saturday morning with a sharp pain in his neck and upper back. This form is dated February 18, 2018. In the document titled, "Injury Form 1," the petitioner states that he was suffering from muscle soreness during PT training, and that notice was given to Trooper Juergensen on February 18, 2018. (Res. Ex. 5).

The Arbitrator has carefully reviewed and considered all medical evidence along with all the testimony offered by the parties. Based upon the above facts, the Arbitrator finds that the petitioner sustained an injury that arose out of and in the course of his employment with the Illinois State Police.

F. <u>Is the petitioner's current condition of ill-being causally related to the injury?</u>

The Arbitrator finds that the petitioner's current condition of ill-being is causally related to the work accident he sustained on February 14, 2018. This finding is based upon the petitioner's testimony, which the Arbitrator finds to be credible, and on the medical records submitted.

Causal connection can be established by a chain of events. A chain of events which demonstrates a previous condition of good health, an accident, and a subsequent injury resulting in disability may be sufficient circumstantial evidence to prove a causal nexus between the accident and the employee' injury. *International Harvester v. Industrial Commission*, 93 III.2d 59, 63-64 (1982). Causal connection between work duties and an injured condition may be established by a chain of events including claimant's ability to perform duties before the date of an accident and inability to perform those same duties following the date of accident. *Darling v. Industrial Commission,* 176 III.App.3d 186, 530 N.E.2d 1135 (1988).

The chain of events in this case demonstrates that the petitioner had no prior problems or injuries to his neck and upper back, he then sustained an accident and resulting injury on February 14, 2018, which resulted in a period of disability. This set of facts sufficiently proves a causal nexus between the accident and the petitioner's injury. This finding is based upon the testimony of the petitioner which the Arbitrator finds credible and consistent with the medical records presented in this case.

The petitioner credibly testified that he did not have left sided neck pain, radiating into shoulders, left arm pain, and left elbow pain prior to the accident. As noted above, the petitioner credibly testified to the injury he sustained at work. He testified that he felt a sharp pain in his upper back and on the left side of his neck, radiating into his shoulders when he was performing a Burpee exercise on February 18, 2018. He testified that he immediately stopped performing the exercises. He also testified he was then called in front of the class by Sgt Yencko who made the petitioner complete the PT exercises. In this case, the petitioner was able to fully participate in the Academy before the accident. It was not until after the accident, that he was placed on work restrictions and had to withdraw from the Academy.

The medical records further support a finding that the petitioner's pain started after the accident on February 14, 2018. As noted, the petitioner sought medical treatment at DuPage Medical Group on his first day off from the Academy, which was February 17, 2018. The medical records consistently give a history that the petitioner's pain started during PT. The record dated February 17, 2018 states that the injury happened at the Police Academy. (Pet. Ex. B). The record dated February 21, 2018, states that he was injured while doing heavy training at the police academy. The records submitted at Arbitration contain no prior complaints of pain that the petitioner experienced to his neck pain, shoulders, left arm, and left elbow. Further, the history provided in the medical records clearly establish that the accident occurred during physical training at the Academy.

The respondent's documents further support a finding that the petitioner's current condition of ill-being is causally related to the work accident he sustained on February 14, 2018. The document signed by petitioner on February 11, 2018, which was his first day at the Academy indicates that he did not have any injuries prior to attending the Academy. There is no credible testimony or evidence to contradict this.

Furthermore, the petitioner testified that he continues to experience pain in his neck and upper back. He testified that he experiences left sided neck pain and upper back pain approximately once per week. He said that when he experiences that pain, it is a sharp pain and that he takes over-the-counter medication and performs home exercises to alleviate the pain. The pain lasts for approximately 20 minutes. There is no evidence that the petitioner sustained any subsequent injuries or accidents.

The Arbitrator has carefully reviewed and considered all medical evidence along with all testimony. The Arbitrator concludes a causal connection exists between the petitioner's current condition of ill-being and the work accident he sustained on February 14, 2018.

G. <u>What were petitioner's earnings?</u>

The petitioner was injured during his first week at the Academy, therefore, he did not work 52 weeks prior to the date of accident. According to Section 10 of the Act, where by reason of the shortness of the time during which the employee has been in the employment of his employer or of the casual nature or terms of the employment, it is impractical to compute the average weekly wages as above defined, regard shall be had to the average weekly amount which during the 52 weeks previous to the injury, illness or disablement was being or would have been earned by a person in the same grade employed at the same work for each of such 52 weeks for the same number of hours per week by the same employer

The petitioner submitted a pay stub dated August 15, 2018. (Pet. Ex. C). The petitioner testified that this is from his second time in the Academy and that he was paid the same amount

during the first time as he was during the second time. The pay stub indicates gross earnings of $1336.50, which is the amount the petitioner received twice per month. The respondent's Exhibit 6 lists the petitioner's base pay as $2,673.00 per month which is consistent with the petitioner's pay stub. (Res. Ex. 6). Based on the above, the Arbitrator finds that the petitioner's average weekly wage at the time of his accident on February 15, 2018, was 616.84.

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

The Arbitrator finds that the medical treatment that the petitioner received is causally related to the work accident he sustained on February 14, 2018, and that the medical bills that were submitted as petitioner's Exhibit A constitute reasonable and necessary medical treatment pursuant to Section 8(a) of the Act.

The treatment rendered by Dr. Stender and the DuPage Medical Group was reasonably required to relieve the effects of the injury. The petitioner was seen at the Emergency Room at DuPage Medical Group on September 17, 2018. He was prescribed physical therapy and told to follow up with his primary care provider. On February 19, 2018, he was seen by Internal Medicine at DuPage Medical Group and was referred to an orthopedic surgeon, Dr. Zachary Stender, who the petitioner saw on February 21, 2018. Dr. Stender initiated conservative treatment which included a course of physical therapy and a Medrol Doespak, and also provided off-work restrictions. The petitioner underwent the course of physical therapy and continued to follow up with Dr. Stender until May 9, 2018, at which time the petitioner was discharged. The petitioner testified that after the completion of the course of physical therapy his pain resolved. The Arbitrator therefore finds that this course of treatment is reasonable and was required to provide relief from the effects of the February 14, 2018, work accident.

The petitioner's Exhibit A contains the medical bills that the petitioner incurred for treatment at DuPage Medical Group. Each of those bills lists the amount of the charge and the amount paid. The total amount of the bills contained in Exhibit A is $6,534.00.

With respect to the bills from DuPage Medical Group, the Arbitrator finds that the bills constitute reasonable and necessary medical treatment pursuant to Section 8(a) of the Act. As noted above, the petitioner's treating physicians referred the petitioner to physical therapy, which the petitioner testified was effective in providing relief for his injuries. petitioner's Exhibit A consists of the bills from DuPage Medical Group and shows that the unpaid balance is $6,534.00. Based on the above, the Arbitrator awards the petitioner the medical expenses outlined in petitioner's Exhibit A in the amount of the outstanding balance of $6,534.00 pursuant to the medical fee schedule in Section 8.2 of the Act.

K. **What amount of compensation is due for temporary total disability?**

The Arbitrator finds that the petitioner was restricted from work from February 19, 2018, to June 23, 2018, at which time he was able to return to the Academy. This finding is based upon the testimony of the petitioner which the Arbitrator finds credible and on the medical records.

The petitioner testified that in the Academy, he had to undergo daily PT which consisted of various exercises including push-ups, running, sit-ups, pull-ups, and Burpees. On February 21, 2018, Dr. Stender instructed the petitioner to "be off of police academy work for one month to allow him to rest and rehabilitate." The petitioner was not released to full duty until May 9, 2018.

The petitioner testified that he was not able to return to the Academy due to his injuries and had to withdraw. Instead, because of his injuries, he had to attend the next session of the Academy, which did not begin until June 23, 2018.

The Arbitrator finds that the petitioner was restricted from work from February 21, 2018, to May 9, 2018, for a period of 11 weeks. This finding is based upon the testimony of the petitioner which the Arbitrator finds credible. This finding is also based on the medical records. Based on this, the Arbitrator finds that the petitioner is entitled to 11 weeks of temporary total disability benefits at a rate of $411.18 per week.

L. <u>What is the nature and extent of the injury?</u>

The Arbitrator finds that the petitioner has sustained loss of use of the "person as a whole" under Section 8(d)2 as a result of the neck and upper back injury he sustained on February 14, 2018. This finding is based on the petitioner's testimony and on the medical records.

Pursuant to Section 8.1(b) of the Act, the following criteria and factors must be weighed in determining the level of permanent partial disability, for accidental injuries occurring on or after September 1, 2011;

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

(b) Also, the Commission shall base its determination on the following factors:
   - (i) The reported level of impairment;
   - (ii) The occupation of the injured employee;
   - (iii) The age of the employee at the time of the injury;
   - (iv) The employee's future earning capacity; and
   - (v) Evidence of disability corroborated by medical records.

<u>With regard to (i) of Section 8.1(b) of the Act;</u>

The Arbitrator notes that no AMA Impairment Rating pursuant to the 6th Edition of the Guides to the Evaluation of Permanent Impairment was submitted by either party in this case. Therefore, this factor has not been considered by the Arbitrator.

<u>With regard to (ii) of Section 8.1(b) of the Act;</u>

The petitioner's current occupation is that of an Illinois State Trooper. Both the petitioner and Sgt. Yencko testified that this is a physically demanding job as an Illinois State Trooper needs to be able to physically restrain individuals. Sgt. Yencko testified that the purpose of PT to get the cadets into physical shape to be able to perform the job duties of an Illinois State Trooper. The petitioner testified that he continues to experience neck and upper back pain approximately once per week. When he experiences that pain, it is a sharp pain, he has to stop what he is doing, he takes over-the-counter medication and does home exercises to alleviate the pain. Therefore, this neck and upper back injury has an impact on the petitioner's ability to perform his job duties as an Illinois State Trooper. The Arbitrator assigns significant weight to this factor.

With regard to (iii) of Section 8.1(b) of the Act;

The age of the petitioner at the time of this work accident was 24 years old. The Arbitrator considers the petitioner to be a younger individual who will remain in the workforce for a significant period of time. As a result, this injury may have some impact upon him as he continues to work toward retirement. The Arbitrator assigns some weight to this factor.

With regard to (iv) of Section 8.1(b) of the Act;

The petitioner's future earnings do not appear to be diminished in any way by this injury. The petitioner testified that he currently performs the job duties of an Illinois State Trooper. Therefore, the Arbitrator assigns no weight to this factor.

With regard to (v) of Section 8.1(b) of the Act;

The petitioner has demonstrated evidence of his disability which is corroborated by the medical records. At the hearing, the petitioner testified that he injured his neck and upper back on February 14, 2018. He further testified that he continues to experience left sided neck pain and upper back pain approximately once per week. When he experiences that pain, it is a sharp pain. He takes over-the-counter medication and does home exercises to alleviate the pain. The pain last for approximately 20 minutes. The petitioner testified that he has not suffered similar injuries prior to the accident.

The records from DuPage Medical contain documentation that the petitioner was diagnosed with neck strain and cervical spasm with cervical radiculopathy and possible cervical disc herniation as a result of the February 14, 2018, accident. The medical records also document that the petitioner reported left arm pain, and trapezial pain following that accident. There is no evidence contained in the medical records that the petitioner was injured prior to February 14, 2018. Likewise, there is no evidence in the medical records that the petitioner suffered an injury or accident subsequent to February 14, 2018. The Arbitrator therefore assigns significant weight to this factor.

The determination of an appropriate award of permanent partial disability under the Act utilizes all five factors as stated above and no single factor is the sole determinant in this analysis. Moreover, under Section 19(c) of the Act, prior Commission decisions may be used as precedent

in determining awards for permanent partial disability. Accordingly, the Arbitrator has considered all five factors enumerated above and awards the petitioner the sum of $5,551.50 representing $370.10 per week for a period of 15 weeks, as provided in section 8(d) (2) of the Act, because the injury sustained caused serious and permanent injuries resulting in 3% loss of use of the person as a whole.

STATE OF ILLINOIS)
) SS:
COUNTY OF KANE)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Julio C. Gaytan,

Petitioner,

vs. NO: 11 WC 09980

T.J. Fabricators, Inc.,

20IWCC0332

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 reinstatement, and being advised of the facts and law, remands this matter to the Arbitrator with instructions, as set forth below.

In a prior Order dated 6/7/17, Commissioner Tyrrell dismissed Petitioner's Motion to Reinstate filed before the Commission on Review on 1/27/17, given that a previously filed Motion to Reinstate (filed 11/9/16) was still pending at arbitration. The parties were then ordered to present the prior motion to the assigned Arbitrator for further consideration.

On 11/17/17, the Arbitrator denied Petitioner's Motion to Reinstate by checking off "denied" at the bottom of the Notice of Motion and Order form presented by the parties on that date. No record was made at that time and no separate order was issued.

Petitioner subsequently filed the present Petition for Review before the Commission on 12/7/17 disputing the Arbitrator's denial of his Motion to Reinstate.

Based on the above, the Commission finds that it is unable to adequately evaluate the Arbitrator's denial of Petitioner's Motion to Reinstate absent a hearing on the record and/or a written order setting forth the basis for his ruling.

20IWCC0332

Therefore, the Commission dismisses Petitioner's present Petition for Review and orders that the case be remanded to the Arbitrator to once again consider Petitioner's previously filed Motion to Reinstate (originally filed 11/9/16) and to provide a basis for said holding, either on the record or in the form of a written order setting forth as much. The parties are also advised that once a decision is issued by the Arbitrator following this remand order, any subsequent appeal would require the filing of a new Petition for Review.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's Petition for Review is hereby dismissed and the matter is remanded to the Arbitrator with instructions to provide a basis for his holding as to Petitioner's Motion to Reinstate by holding a hearing on the record and/or setting forth his rationale in a written order.

IT IS FURTHER ORDERED BY THE COMMISSION that the parties properly present this remand order to the Arbitrator in order to effectuate this process.

The Commission further notes that since this order is interlocutory and not final and appealable, the need for the filing of a Notice of Intent to File for Review in Circuit Court would not be applicable.

DATED: JUN 17 2020

o-4/21/20
TJT/pmo
51

Thomas J. Tyrrell

Kathryn A. Doerries

Maria E. Portela

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Melissa Causey,

Petitioner,

vs.

NO: 18 WC 9605

20IWCC0333

Amazon,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, temporary total disability, 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: JUN 17 2020
TJT:yl
o 6/9/20
51

Thomas J. Tyrrell

Deborah L. Simpson

Kathryn A. Doerries

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)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Melissa Causey
Employee/Petitioner

Case # 18 WC 09605

v.

Consolidated cases: n/a

Amazon
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 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. [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, 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 COOK	)	☐ 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 &
09WC 30457

ECHO JOINT AGREEMENT,and THE RATE ADJUSTMENT FUND,

20IWCC0335

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petitions for Review having been filed by the Petitioner and Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses,temporary total disability,temporary partial disability,permanent total disability, and penalties and fees, and being advised of the facts and law, modifies the Decision of the Arbitrator in case number 09 WC 3047 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 3046.

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 173.6 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 17.1 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

20IWCC0335

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 17 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
Employee/Petitioner

Case# **09WC030456**

09WC030457

ECHO JOINT AGREEMENT
Employer/Respondent

20IWCC0335

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
DAVID X KOSIN
134 N LASALLE ST SUITE 1340
CHICAGO, IL 60602

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

20 IWCC0335

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

Catherine M. Jacobs
Employee/Petitioner

v.

ECHO Joint Agreement
Employer/Respondent

Case # **09** WC **30456**

Consolidated cases: **09 WC 30457**

An *Application for Adjustment 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.

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. [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?
[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 **3/19/2009**, 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 not*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**38,770.29 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.

ORDER

THE ARBITRATOR FINDS THAT PETITIONER HAS NOT SUSTAINED ANY PERMANENT PARTIAL DISABILITY TO HER CHEST OR RIBS AS A RESULT OF THE MARCH 19, 2009 ACCIDENT.

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

ATTACHMENT TO ARBITRATION DECISION

Catherine M. Jacobs

v. Case # **09 WC 30456**

 # 09 WC 30457

ECHO Joint Agreement

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 30456. In both the original and Amended Applications, Petitioner alleged that on March 19, 2009, she sustained an accident while working for Echo Joint Agreement ("Respondent") when she was struck by a mentally challenged student and injured her "chest/rib cage" as a result.

Respondent has disputed that Petitioner's current condition of ill-being is causally related to the injury of March 19, 2009. Case #09 WC 30457 was consolidated with case #09 WC 30456. Petitioner proceeded with a long course of treatment for injuries that resulted from the accident of March 23, 2009 (case #09 WC 30457).

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.

FINDINGS OF FACT:

In March 2009, Petitioner, Catherine M. Jacobs, was a 45-year-old Special Education Teacher for Respondent, ECHO Joint Agreement. (T. 23, 26) Petitioner testified that prior to her 2 stipulated, work-related injuries on March 19, 2009 and March 23, 2009, she was "[c]ompletely fine, healthy" and had never had any problem with her low back, legs or torso and had not suffered from any chronic pain condition. (T. 23-24) Petitioner testified that she was active and engaged in walking 5-7 nights a week, motorcycle riding, boating in the summer, and competitive volleyball twice a week for 9 months of the year. She had no restrictions in her ability to sit, drive a vehicle, stand or walk. (T. 26)

Petitioner taught at The Academy for Learning in Dolton, Illinois (AFL). (T.28) Petitioner's duties as a Special Education Teacher for Respondent were to attend to the special needs of students whose IQ scores were below 70. (T.27) All of her students were children or

young adults who had behavioral challenges. On a daily basis, these students could be throwing desks, chairs or books, and could hit other students or teachers. (T. 29-30)

Petitioner's job description required her to be able to "participate in lifting of students" and "participate in physical restraint of students". (Px. 26) Petitioner's students would range in age from 13-22 and could weigh up to 300 pounds. (T. 29-30) Petitioner testified that in March 2009, she was 5'6" and weighed 128 lbs. (T. 26)

It is uncontested that on Friday, March 19, 2009 (case #09 WC 30456), a student named Kevin hit Petitioner underneath her rib cage on the left side. (T.41) Kevin was 18 years old, 5'10" and 150 pounds, and was Petitioner's lowest functioning student. (T.39) After Kevin struck her, Petitioner brought him to the Dean's Office to write up a Behavioral Referral Sheet in which she described what he had done. (T.42)

Petitioner testified that she did not seek medical care for this injury on the day it occurred, and did not seek medical care the next day, which was a Friday. (T. 42-43) Petitioner testified that over the weekend she experienced soreness underneath her breast on her left side. On the morning of Monday, March 23, 2009, Petitioner mentioned this injury to her Aide who called in the School Nurse. Petitioner assumed that the School Nurse wrote up the injury since that is the policy. (T. 43-44)

Petitioner did not seek medical care for the injury sustained in this case, #09 WC 30456, until after her work injury of March 23, 2009, which is the subject of the consolidated matter now pending as case #09 WC 30457.

CONCLUSIONS OF LAW: 20IWCC0335

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

The Arbitrator finds that timely notice of the accident was given to Respondent. First, Respondent does not dispute the fact of the accident. Second, Petitioner offered unrebutted testimony that on March 19, 2009, after bringing the offending student to the Dean's Office, she completed a Behavioral Referral Sheet in which she documented that Kevin struck her. Third, it is further unrebutted that on the morning of March 23, 2009, prior to her subsequent work injury of that date, Petitioner told her Aide about the incident and the School Nurse was called in.

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

The Arbitrator finds that Petitioner's left-sided ribs/chest pain resolved in 2015 and therefore there is no current condition of ill-being of her chest or ribs.

When Petitioner first treated in the Emergency Department at MacNeal Hospital on March 23, 2009, she stated that at 10:00 that morning, a special needs student punched her in the chest, pushed her down and her lower back landed on a cart as did her right buttock. The ED staff member recorded that she complained, *inter alia*, of rib pain. Upon examination, the physician found "[s]ome tenderness of the left ant. ribs ~ 6~10." (Px. 1)

On March 25, 2009, when Primary Care Physician Matthew Hsieh, M.D., examined Petitioner, he noted, *inter alia*, chest wall tenderness without ecchymosis over anterior left lower ribs. (Px. 2(A), p. 285)

On June 1, 2009, when Julie M. Wehner, M.D., examined Petitioner on behalf of Respondent, she noted that Petitioner complained, *inter alia*, of some pain underneath the bra area of her chest. (Rx. 3, pp. 11-12)

Marie Kirincic, M.D., testified on April 23, 2010 that when she treated Petitioner on February 15, 2010, Petitioner complained of tightness of the muscle in the left chest area, the pectoralis. (Px. 23, pp. 74, 77) Dr. Kirincic also testified at that time that Petitioner had developed CRPS of the torso. (Px. 23, p. 107)

On March 15, 2015, Howard S. Konowitz, M.D., examined Petitioner on behalf of Respondent. In reviewing his report of that date, he noted that Petitioner previously marked her ribs as an area of pain but did not do so on this date. Dr. Konowitz concluded that Petitioner's rib pain had disappeared. (Rx. 8, pp. 47-48)

In letters dated February 12, 2016 and August 4, 2016, and authored by Timothy R. Lubenow, M.D., Petitioner's treating physician, he makes no mention of any complaints of pain or other symptoms to Petitioner's chest or ribs. (Px. 24, Dep. Ex. 8 and 9)

On January 10, 2018, Petitioner's boyfriend, William Izzo, testified: "from her first injury she *had* pains in her chest." [Emphasis added.] (Tr. 248)

Petitioner testified on the same day that Mr. Izzo testified. At that time, when Petitioner testified as to her current complaints, she made no mention of any pain or other symptoms in her chest or ribs. (Tr. 178-182)

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

Based upon the Arbitrator's Decision in the consolidated matter of 09 WC 30457, all medical bills presented relate to treatment necessitated by the accident of March 23, 2009 and are hereby denied in this matter. Any credits are applicable to benefits awarded under 09 WC 30457.

K. What temporary benefits are in dispute?

Based upon the Arbitrator's Decision in the consolidated matter of 09 WC 30457, all temporary benefits requested relate to temporary benefits necessitated by the accident of March 23, 2009 and are hereby denied in this matter. Any credits are applicable to benefits awarded under 09 WC 30457.

M. Should penalties or fees be imposed upon Respondent?

For the above stated reasons, all penalties are denied.

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

Based on the Arbitrator's findings on causation as to the March 19, 2009 accident, the Arbitrator finds that Petitioner's chest/ribs injury resolved in 2015 and therefore, finds she has sustained no permanent partial disability to this area of her body.

Brian T. Cronin

Arbitrator

3-6-2019

Date

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

JACOBS, CATHERINE M
Employee/Petitioner

Case# **09WC030457**

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 ISALY
140 S DEARBORN ST 6TH FL
CHICAGO, IL 60603

20 IWCC0335

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

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

LINDA ACEBO,

Petitioner,

vs.

20IWCC0336

NO: 12 WC 3229

KM WHEELAND,

Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission further finds that no psychiatrist or psychologist rendered an opinion specifically relating Petitioner's anxiety or depression to her November 22, 2010 accident. A recitation of symptoms and complaints in a medical record is not equivalent to a causation opinion. We also note that, although Dr. Rioja did causally relate Petitioner's anxiety and depression to her accident, she is not a psychiatrist or psychologist. Likewise, to the extent that Dr. Robbins' testimony can be viewed as providing a causation opinion with regards to the anxiety or depression, we find it unpersuasive since he is not a psychiatrist or psychologist.

We also correct several scrivener's errors. First, the Arbitrator wrote, "Petitioner continued to work for Respondent until January 1, 2011, when the restaurant was taken over by new owners and Petitioner's employment was terminated, (T. 19-20)." *Dec. 2.* We hereby correct the decision to reflect that Petitioner was actually terminated a year later, on January 6, 2012, when a new owner took over. *T.20; Px13 at 126 (1/6/15 Athletico record); Px16 (9/24/12 Dr. Lofland record).*

20IWCC0336

The decision, in multiple places, also incorrectly refers to Petitioner's date of accident as "October 22, 2010" even though the Arbitrator accurately found that Petitioner's accident occurred on November 22, 2010. These errors, on pages 16, 18, 19, 20, and 21, are hereby corrected to reflect the accurate accident date.

Finally, the Arbitrator wrote, "Petitioner acknowledges that her right eye vision loss, occipital neuritis and right shoulder conditions is not causally related to her work injury of November 22, 2010." *Dec. 15.* Although Petitioner's physician, Dr. Robbins, opined that Petitioner's right eye condition was not related, Petitioner never actually admitted that the right eye vison loss and occipital neuritis were not related. Petitioner only admitted that her right shoulder condition was unrelated. *T.49.* We hereby correct the decision to accurately reflect this.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 13, 2018, is hereby affirmed and adopted with the clarification noted above.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $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: JUN 17 2020

Maria Elena Portela

Maria E. Portela

Thomas J. Tyrrell

Kathryn A. Doerries

O: 4/21/20
49

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

ACEBO, LINDA
Employee/Petitioner

Case# **12WC003229**

20IWCC0336

KM WHEELAND
Employer/Respondent

On 9/13/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.26% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0328 LEWIS & DAVIDSON LTD
ANN-LOUISE KLEPER
ONE N FRANKLIN ST SUITE 1850
CHICAGO, IL 60606

0210 GANAN & SHAPIRO PC
JULIA A MURPHY
120 N LASALLE ST SUITE 1750
CHICAGO, IL 60602-2492

20 IWCC0336

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)

Linda Acebo
Employee/Petitioner

v.

KM Wheeland
Employer/Respondent

Case # **12** WC **3229**

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 **Chicago**, on **June 13, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] Is Petitioner entitled to any prospective medical care?
L. [x] What temporary benefits are in dispute?
[x] 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 choice of medical providers under Section 8(a) of the Act?**

FINDINGS

On the date of accident, **November 22, 2010**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$34,639.02**; the average weekly wage was **$666.14**.

On the date of accident, Petitioner was **36** years of age, ***single*** with **2** dependent children.

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

ORDER

The Arbitrator finds that the **left shoulder adhesive capsulitis and post-traumatic stress disorder is causally related** to her work accident of November 22, 2010 but the **occipital neuritis, occipital neuralgia, loss of vision, migraines, myofascial pain syndrome, cervical facet syndrome, cervical radicular pain, right shoulder pain, anxiety and/or depression is not causally connected** to her work injury of November 22, 2010, as set forth in the Conclusions of Law attached herein.

Respondent **is liable for the medical bills** associated with the diagnoses and treatment of the left shoulder capsulitis which includes the following: (1) treatment provided by Dr. Wolin including the FCE as delineated in PX 21; (2) treatment received from Stroger Hospital as delineated in PX 18; (3) treatment provided by Dr. Drake as delineated in PX 20; (4) services provided by Hawthorn Works Medical Imaging for the 2/7/2014 date of service as delineated in PX 9; (5) services provided for the left shoulder by Athletico as delineated in PX 14; (6) services provide by Dr. Chekka for the left shoulder on 1/30/2014, 2/13/2014 and 2/24/2014 as delineated in PX 15; (7) services provided by Dr. Rioja for the left shoulder on 1/27/2014 as delineated in PX 8; (8) treatment provided at MacNeal Hospital involving the left shoulder on 11/25/2013 as delineated in PX 4; and (9) treatment provided by Dr. Lofland of North Shore Integrative Healthcare, as set forth in the Conclusions of Law attached herein.

Petitioner's request for **prospective medical care is denied**, as set forth in the Conclusions of Law attached herein.

Petitioner's request for **TTD benefits and TPD benefits is denied**, as set forth in the Conclusions of Law attached herein.

The issue of whether Petitioner exceeded her choice of physicians pursuant to Section 8(a) of the Act is moot and needs not be addressed, as set forth in the Conclusions of Law attached herein.

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

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

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

Signature of Arbitrator

9/12/2018
Date

SEP 13 2018

20IWCC0336

PROCEDURAL HISTORY

This case was tried on June 13, 2018 pursuant to Section 19(b) of the Act. The disputed issues involve whether Petitioner's current condition of ill-being is causally connected to her injury, whether Respondent is liable for unpaid medical bills, whether Petitioner is entitled to 280 4/7 weeks of TTD benefits and 12 3/7 weeks of TPD benefits, whether Petitioner is entitled to prospective medical care consisting of radiofrequency neurotomy, physical therapy and Botox injections and whether Petitioner exceeded her choice of physicians pursuant to Section 8(a) of the Act.

FINDINGS OF FACT

On November 22, 2010, Linda Acebo (hereinafter referred to as "Petitioner", was employed as a general manager by KM Wheeland (hereinafter referred to as "Respondent"), the owner and operator of a McDonald's restaurant. Petitioner was 36 years old and her job duties included handling inventory, dealing with customer complaints, overseeing managers and making daily bank deposits. (T. 10)

Petitioner testified that On November 22, 2010, while making a daily bank deposit, a man grabbed the deposit bag she was carrying in her left hand resulting in a struggle over the bag until the robber struck her on the left side of her head. After the incident, Petitioner was taken to the emergency room at LaGrange Park Hospital. Petitioner testified that she reported head pain, left sided neck pain and left arm pain while at the emergency room. (T. 11, 12).

The LaGrange Memorial Hospital medical records show Petitioner's complaints consisted of mild left shoulder pain, neck pain and tenderness on the midline of the trachea. Petitioner reported being punched in the face during the robbery. The examination found no markings or indication of trauma, redness or busing on the face and head. X-rays of the cervical spine and left shoulder were normal. Petitioner was diagnosed with a neck contusion. (PX 1).

On November 23, 2010, Petitioner followed up at Midwest Health Works. Petitioner complained of pain over her left arm and left side of the head. Petitioner described the pain

level as 8 out of 10. Petitioner provide a history of being assaulted by someone trying to snatch a bag that she resisted letting go of until she was struck on the left side of her head. Petitioner reported falling to the ground. The examination did not find any evidence of bruising or swelling on the face and head. Petitioner reported tenderness over the left temporal region but no evidence of edema or soft tissue swelling was found. Petitioner was assessed with a cervical strain and contusion of the head. (PX 2).

On December 2, 2010, Petitioner continued to Midwest Health Works. Petitioner reported to feeling 90% better and that she was still experiencing minimal tightness in the neck. Petitioner said that she was not experiencing any headache. Petitioner's left shoulder had full range of motion without pain and she had no tenderness of the cervical spine with no radicular complaints. Petitioner was discharged from care and released to work full duty. (PX 2).

Petitioner testified that she returned to work and was able to perform her job duties including making bank deposits. Petitioner continued to work for Respondent until January 1, 2011, when the restaurant was taken over by new owners and Petitioner's employment was terminated. (T. 19-20).

On August 8, 2011, Petitioner presented to Dr. Arturo Lema, her primary care physician. Petitioner reported that "on and off for one week" she was seeing lights, losing sight in her right eye, feeling dizzy and experiencing headaches. Dr. Lima diagnosed migraines and referred Petitioner to an optometrist and to a neurologist. (PX 3).

On August 10, 2011, Petitioner went to the emergency room at MacNeal Hospital complaining of experiencing a headache for the past 5 days and seeing bright white dots out of her right eye. Petitioner reported no known history of trauma. During the examination, Petitioner complained of sinus, face and scalp tenderness. Petitioner's neurological examination was normal. A CT scan of the head was performed showing no acute intercranial findings. Petitioner was diagnosed with a urinary tract infection, headache and tension. (PX 4).

On August 16, 2011, Petitioner presented herself to Dr. Lacayo, an optometrist with Chicago Eye Consultant. Petitioner reported experiencing headaches, light sensitivity and seeing white light for past two weeks. (PX 6).

On October 19, 2011, presented herself to Dr. Ligia Rioja, of Neurologic Care Associates, complaining of neck pain and headaches. Petitioner reported neck pain and headaches for a year after being hit on the left side of the head and neck during a robbery. Dr. Rioja noted that Petitioner reported experiencing blurring of her right sided vision and severe left-sided headaches over the past month. Dr. Rioja noted that one headache lasted five days and caused Petitioner to go to the emergency room. In his records, Dr. Rioja wrote. "*I do think that she has post traumatic migraine type of headaches. Although it is unusual that it has become more frequent the last few months.*" Dr. Rioja performed an examination which noted left cervical paraspinal spasms, weakness of the left arm and sensory deficit of the left arm. Dr. Rioja assessed neck pain which, he said, started after Petitioner's trauma. Dr. Rioja ordered a MRI of the cervical spine. (PX 9).

On December 21, 2011, Petitioner was examined by Dr. Helge Frank, a neurologist, pursuant to Section 12 of the Act. Petitioner reported a history of being grabbed by the back of her clothing, on her upper body, and being thrown to the ground in a forward position and being struck in the left side of the head while making a bank deposit. Petitioner also reported during the altercation she kicked the perpetrator knocking off his hat and cell phone. Petitioner's neurological examination was normal. Dr. Helge Frank diagnosed post-closed head injury with no clear-cut evidence of cerebral concussion, post-traumatic cervical and left shoulder strain without evidence of radiculopathy, myelopathy or neuropathy and classic migraine of visual obscurations. Dr. Helge Frank opined that Petitioner's migraines were not caused by the work incident of November 22, 2010. Dr. Helge Frank further opined that Petitioner could work full duty. (RX 2).

The MRI of the brain taken on January 30, 2012 at MacNeal Hospital was unremarkable but for a single non-specific punctuate focus of white matter signal abnormality

in the subcortical right frontal lobe. The cervical MRI showed no significant abnormalities but for a minor left neural foraminal stenosis at C6-C7. (PX 19, PX 4).

On February 27, 2012, Petitioner returned to Dr. Rioja complaining migraines. Dr. Rioja noted that Petitioner continued to report blurred right eye vision and right eye pain. Dr. Rioja indicated the typical precipitation factors of the headaches include emotional stress and lack of sleep. Dr. Rioja assessed common migraines and referred Petitioner back to the ophthalmologist. (PX7).

On March 2, 2012, Petitioner returned to Dr. Lacayo of the Chicago Eye Consultants. At that visit, Petitioner reported seeing everything white and being unable to focus for six months. Petitioner was found to have best corrected vision in the right eye of 20/50 and referred back to her neurologist. (PX 6).

On April 18, 2012, Petitioner returned to Dr. Rioja. At that visit, Petitioner reported that she was doing well other than headaches. Petitioner told Dr. Rioja that her headaches started after the robbery. Petitioner also told Dr. Rioja that prior to the robbery, she did not have headaches or vision problems. Dr. Rioja reviewed the cervical spine MRI which showed no abnormalities except mild C6-7 foraminal stenosis and he also reviewed the MRI of the brain which showed only a punctate lesion in the right cortical area. Dr. Rioja assessed classic migraine which, he said, may be posttraumatic. An MRA was performed which was normal. Dr. Rioja referred Petitioner to Dr. Bernard, of the University of Chicago, for a second opinion. (PX 7).

On June 21, 2012, Petitioner was seen by Dr. Bernard. At that visit, Petitioner reported immediately developing headaches after sustaining a head injury during a robbery on November 22, 2010. Petitioner reported being struck with a fist to the left side of the head and falling to the ground. Dr. Bernard assessed post-traumatic headache, on the left, and optic neuritis, on the right. Dr. Bernard recommend physical therapy and ordered repeating the brain MRI. (PX 10). Petitioner attended physical therapy at Athletico. (PX 10).

On August 1, 2012, Petitioner returned to Dr. Rioja reported that physical therapy was helping her headaches, vision problems and neck pain. Dr. Rioja noted that Petitioner was complaining of tenderness of the neck and mid-thoracic spine. Petitioner was also complaining of tingling in her legs and arms and symptoms in the face. Petitioner reported mood changes as well. Dr. Rioja diagnosed myofascial pain syndrome, most likely chronic, and recommended additional physical therapy and ordered MRIs of the brain and cervical spine. The MRI studies were unremarkable. (PX 7).

On August 24, 2012, while attending physical therapy, Petitioner reported difficulties lying flat during the cervical MRI which caused increased left anterior neck pain, a burning sensation from her neck into her left upper arm, slight facial trembling and a choking sensation. Petitioner was advised to go to the emergency room (T.23-24, PX13).

Petitioner went to the emergency room at MacNeal Hospital. Petitioner was given hydrocodone, Vicodin and a hard neck collar told to follow up with Dr. Rioja (T.24-25, PX4).

On August 28, 2012, Petitioner returned to Dr. Rioja complaining of neck pain, numbness and weakness in her left arm. Dr. Rioja noted that Petitioner's left-sided neck pain was exacerbated. The examination showed a decrease in sensation without any specific nerve root or sensory levels. Dr. Rioja noted that Petitioner might have referred type of paresthesias from myofascial pain-type syndrome. Petitioner was also complaining of headaches, anxiety, depression and feelings that she is unable to breathe. Dr. Rioja recommended a CT angiogram and told Petitioner to go to the emergency room at the University of Chicago (T. 25-26, PX7).

Petitioner went to the emergency room at the University of Chicago Hospital. Petitioner had a CT angiography of the brain was found to be normal. Petitioner was proscribed pain medications and told to follow up with her neurologist (PX 10).

On September 4, 2012, Petitioner returned to Dr. Rioja reporting her left-sided neck pain improved and the numbness of the arm resolved. Dr. Rioja noted that Petitioner continues to have some psychological effects from the assault which may be post-traumatic. Dr. Rioja

referred Petitioner to a psychologist. Dr. Rioja assessed myofascial pain syndrome and referred Petitioner to a pain clinic for trigger point and epidural steroid injections. (PX 7).

On September 24, 2012, Petitioner saw Dr. Lofland, a clinical psychologist at Northshore Integrative Healthcare. Petitioner reported that she had been working until January 6, 2012 when her employment was terminated because of new ownership which could not pay her as much as the prior owners. Petitioner reported pain following an assault on November 22, 2010. Petitioner said that during the assault she pushed the man away and struggled with him over the deposits until the man struck her on the left side back of her head. Petitioner reported having difficulty moving her arm, terrible headaches which she took Advil until August 2011 when the headaches became more severe, would not go away and she started seeing "white" in her eye. Dr. Lofland found that Petitioner's profiles were consistent with chronic pain sufferers in need of treatment for stress, anxiety, depression and physical conditions. Dr. Lofland recommended cognitive behavioral therapy including pain coping techniques, stress reduction and relaxation training. (PX 16).

On September 25, 2012, Petitioner presented to Dr. Kiran Chekka of Premier Pain Specialist. Petitioner complained of left-sided headaches and left-sided neck pain radiating into the left upper extremity. Petitioner said her pain started after being mugged in November of 2010 when her left arm was pulled, and she was punched on the left side of the head, close to the neck. Petitioner told Dr. Chekka that for the year following the incident she experienced mild to moderate headaches she managed with ibuprofen until August of 2011. Petitioner reported left-sided neck pain radiating down her entire left upper extremity into the thumb that she was able to tolerate the pain until three weeks ago, when she experienced a problem during a MRI. Dr. Chekka diagnosed myofascial pain syndrome, cervical pain, cervicalgia, cervical radicular pain, mild cervical facet syndrome and daily tension-type headaches. Dr. Chekka recommended trigger point injections into the left paracervical and trapezius musculature. (PX 15).

On October 1,2018 and October 8, 2018. Petitioner received cognitive behavior therapy to address her stress levels, anxiety and depression with Dr. Lofland. Petitioner did not return to Dr. Lofland because only two appointments were approved by worker's compensation. (T. 29, PX 16).

On October 3, 2012, Petitioner followed up Dr. Rioja for left-sided neck pain and upper extremity pain. Petitioner reported that she feels as if she is "lying or there are ghosts flying over her" and that she continues to experience right eye blurriness and headaches. Petitioner also reported that her left arm as become numb and that she feels a popping or clicking in all of her joints including in her left jaw. Dr. Rioja noted spasms in the left paraspinal and trapezius muscles. Dr. Rioja assessed myofascial pain syndrome and recommended trigger point injections. Dr. Rioja indicated, in his records, that Petitioner's left-sided neck and arm pain were related to the myofascial pain syndrome, which is posttraumatic from the November of 2010 assault. Dr. Rioja also indicated that Petitioner suffers from posttraumatic stress disorder which, he said, was related to Petitioner's anxiety and depression. (PX 7).

On October 23, 2012, Dr. Chekka administered trigger point injections. On November 13, 2012, after receiving the injections, Petitioner returned to Dr. Chekka reporting that she did not experience relief from the injections. Dr. Chekka assessed occipital neuralgia, cervicogenic headaches, cervical facet syndrome and myofascial pain syndrome. Dr. Chekka recommended cervical epidural steroid injections and occipital nerve blocks for the neuralgia symptoms. (PX 15).

On November 28, 2012, Petitioner returned to Dr. Rioja reporting the trigger point injections increased her pain levels. Dr. Rioja assessed myofascial pain syndrome, posttraumatic stress disorder and occipital neuralgia which, he said, could be related to the occipital neuralgia or cervical facet syndrome. (PX 7).

On December 19, 2012, Petitioner returned to Dr. Chekka noted that Petitioner does not have any marked or clear-cut symptoms into her upper extremities. Dr. Chekka diagnosed radicular pain syndrome. Dr. Chekka deferred further interventional therapies because, he

noted, Petitioner's condition improved with medical management. Dr. Chekka recommended physical therapy which Petitioner received at ATI. (PX 15).

On February 6, 2013, Petitioner returned to Dr. Chekka noted that Petitioner's condition regressed after physical therapy. Petitioner reported pain into the left upper extremity radiating into the elbow and down into the first three digits. Dr. Chekka recommended a left paramedian C6-7 interlaminar epidural steroid injection under fluoroscopic guidance which was performed on February 28, 2013. (PX 15).

On March 2013, Petitioner returned to Dr. Rioja complaining of neck and leg pain. Petitioner reported that her lower extremity pain occurred after the cervical steroid injections. Dr. Rioja noted the left-sided neck pain was located more anterior at the sternocleidomastoid region. (PX 7).

On March 21, 2013, Dr. Chekka administered another cervical epidural steroid injection and occipital nerve blocks. Dr. Chekka provided Petitioner a TENS unit for home use. On April 11, 2013, Petitioner returned to Dr. Chekka reporting no headaches for several days and when the headaches returned they were less severe. Dr. Chekka recommended repeating the occipital nerve blocks and trigger point injections. (PX 15).

On April 5, 2013, at the request of her attorney, Petitioner saw Dr. Lawrence Robbins, of Robbins Headache Clinic. Petitioner disclosed that her sister also suffers from migraines. (PX 19). Petitioner provided a history of being punched on the left side of her head and falling to the ground on her right side and, since the incident, she has been experienced moderate left-sided head and neck pain until August 8, 2011 when, at that time, Petitioner started to experience sudden severe left-sided headaches, right-sided optic neuritis, and neck pain. The neurologic exam was normal. Dr. Robbins wrote, in his report to Petitioner's attorney, which was admitted into evidence without objection, that Petitioner's current condition is almost completely due to the attack on November 22, 2010 and that she is legitimately disabled due to the severity of her 24/7 pain. Dr. Robbins recommended Botox injections. (PX 27).

On May 8, 2013, Petitioner returned to Dr. Chekka on May 8, 2013, at which time Petitioner reported that he pain was reduced by 80% but she was still experiencing minimal pain. Dr. Chekka did not recommend the Botox injections because Petitioner was responding to her current treatment. (PX 15).

On June 6, 2013, Petitioner returned to Dr. Chekka reporting that her radicular symptoms resolved. Dr. Chekka noted the occipital nerve blocks resulted in an excellent analgesic response to the posterior headaches and classic occipital neuralgia. Dr. Chekka recommended discontinuing epidural steroid injections and continuing with the occipital nerve blocks to treat the posterior occipitogenic headaches. Nerve blocks were administered on June 12, 2013 and on July 3, 2013. Dr. Chekka also administered additional trigger point injections. (PX 15 -p.39-44).

On July 25, 2013, Petitioner returned to Dr. Chekka reporting initial relief from the nerve blocks, but, the symptoms returned. Petitioner reported headaches for 10-12 hour per day associated with significant photophobia and visual changes. Dr. Chekka described Petitioner's headache pattern as multifactorily mixed with both occipital neuralgia pattern and chronic migraine-type patterns. Dr. Chekka recommended a trial of Botox injections. (PX 15).

On August 29, 2013, Petitioner returned to Dr. Rioja complaining of left-sided neck pain which now radiates down the left arm. Petitioner told Dr. Rioja that her left arm was "pulled back" during the assault but she did not concentrate on the pain because of the headaches. Dr. Rioja assessed shoulder joint pain and referred Petitioner to an orthopedic surgeon. (PX 7).

On October 15, 2013, Petitioner returned to Dr. Robbins reporting improvement with a change in her medication (PX 19). On November 25, 2013, Petitioner went to the emergency room, at MacNeal Hospital, complaining of severe left shoulder pain. Petitioner reported chronic pain from a work injury with no new trauma. An examination showed a decreased range of motion in the left upper extremity. Petitioner was advised to follow up with an

orthopedic surgeon and obtain an MRI. Petitioner testified that she went to Stroger Hospital because she did not have insurance. (T37-38, PX4).

On November 15, 2013, later that day, Petitioner sought treatment at Stroger Hospital. X-rays taken of the left shoulder were negative. Petitioner was given pain medication and discharged. Petitioner was diagnosed with left shoulder pain and possible rotator cuff syndrome and proscribed physical therapy and a MRI. (PX 17).

On January 21, 2014, Petitioner returned to Dr. Rioja complaining that her left shoulder feels stuck. Dr. Rioja noted a decreased range of motion of the left shoulder with abduction. Dr. Rioja assessed joint pain of the shoulder region. Dr. Rioja took Petitioner off work because of severe pain and migraines. (PX 8).

On January 30, 2014, Petitioner returned to Dr. Chekka reporting increased shoulder pain which, she believes, is related to her injury. Dr. Chekka recommended a MRI and continue with physical therapy. (PX 15).

On February 5, 2014, Petitioner returned to Dr. Robbins to receive her first Botox injection. (PX 19).

On February 7, 2014, Petitioner underwent an MRI of the left shoulder at Hawthorne Works Medical Imaging which was suggestive of adhesive capsulitis with no evidence of a tear (PX9).

On February 13, 2014, Petitioner returned to Dr. Chekka who administered an intra-articular glenohumeral injection of the left shoulder under ultrasound guidance. Dr. Chekka's diagnosed arthritis and shoulder pain. (PX 15, PX 40).

On February 27, 2014, Petitioner returned to Dr. Chekka reporting 40% relief of pain after the injection. Dr. Chekka referred Petitioner to Dr. Drake, of Core Orthopedics and Sports Medicine, for further evaluation of the left shoulder. (PX 15).

On March 4, 2014, Petitioner presented to Dr. Gregory Drake complaining of left shoulder pain and stiffness. Petitioner reported the onset of her symptoms occurred on November 22, 2010 when she was robbed while making a bank deposit. Petitioner said she

was punched in the face and her left arm was violently tugged many times. Petitioner also told Dr. Drake that during the attack that she pulled the individual's hoodie and managed to get his cellphone. Petitioner said that her left shoulder stiffness was related to her work injury because it became more painful and stiff around December of last year. Dr. Drake assessed tendinitis/bursitis of the left shoulder and adhesive capsulitis and recommended a CT scan of the chest and a left shoulder manipulation under anesthesia. (PX 20).

On April 25, 2014, Petitioner underwent an MRI of the left shoulder at Stroger Hospital. The MRI demonstrated a small but deep partial articular surface tear involving the distal supraspinatus tendon and mild acromioclavicular osteoarthritic changes with possible capsulitis. On June 26, 2014, Petitioner saw Dr. Garapati, at Stroger Hospital, who prescribed anti-inflammatory drugs, administered a left shoulder cortical steroid injection and proscribed physical therapy. (PX 17).

On April 29, 2014, at the request of her attorney, Petitioner was evaluated by Dr. Preston Wolin, of the Center for Athletic Medicine, Ltd. Dr. Wolin authored a report dated April 29, 2014, which was admitted into evidence without objection. Petitioner reported during an attempted robbery an attacker grabbed her right arm and tugged it forcibly. Petitioner said she experienced left neck and shoulder pain within 5 minutes of the attack and she continues to experience pain in her left shoulder. Petitioner also said that she has been treated for headaches and vision changes. Dr. Wolin diagnosed post-traumatic adhesive capsulitis which, he said, was causally related to the work episode. Dr. Wolin noted that Petitioner's primary treatment had been related to the neck and headaches but a portion of Petitioner's her neck pain could be related to her shoulder. Dr. Wolin recommended arthroscopic pericapsular release surgery because the release surgery offers the opportunity to view the intra-articular structures. Dr. Wolin opined that Petitioner should be off work due to her neck, shoulder and headaches. (PX 21).

On October 10, 9, 2014, Petitioner was examined by Dr. Brian Cole pursuant to Section 12 of the Act. Petitioner reported that she was making a bank deposit, which was abnormal

task for her to perform but the owner was out of town, when a perpetrator struck her in the neck and shoulder a few times while he was pulling at the money bag. Dr. Cole noted that Petitioner was 90% improved on December 2, 2010 and did not seek additional medical treatment until being scene at the MacNeal Hospital emergency room on August 10, 2011. Dr. Cole opined, based upon the facts provided, it appears that Petitioner maintained some sequelae of posttraumatic adhesive capsulitis. Dr. Cole opined it was plausible that the shoulder tightness and pain was, at lease, indirectly, downstream sequelae of the November 22, 2010 trauma. Dr. Cole found the left shoulder capsular release and manipulation surgery and subsequent physical therapy reasonable. Dr. Cole further opined that Petitioner could work without restrictions of no over-the-shoulder work of more than 5 pounds. (RX1).

On January 5, 2015, surgery was performed at Weiss Hospital. The post-surgical diagnosis was capsulitis and bicep tendon a tear. Dr. Wolin performed complex debridement and biceps tenotomy. (PX 21-appendix to records). Petitioner attended physical therapy from January 6, 2015 through June 23, 2015. (PX 13).

On June 25, 2015, Petitioner underwent a FCE at ATI, and on July 22, 2015, Dr. Wolin released Petitioner to return to work pursuant to the FCE recommendations. (T. 46, PX 21).

On August 6, 2015, Petitioner was reevaluated by Dr. Cole, pursuant to Section 12 of the Act, at which time, Dr. Cole opined that Petitioner was at MMI for her shoulder complaints and he further opined that Petitioner could return to work full-duty. (RX 1).

On October 19, 2015, Petitioner started treating with Dr. Machabanski, a psychologist. Petitioner was referred to Dr. Machabanski by Dr. Robbins. (T. 46). Petitioner was treated for depression and issues involving self-esteem. On June 4, 2018, Petitioner was released from care. (T. 47, PX. 22).

On March 7, 2016, Petitioner was evaluated by Dr. Lawrence Frank for neck pain, at the request of her attorney. (T. 47). Petitioner reported she was carrying a deposit bag, in her left hand, when an assailant grabbed a bag and repetitively jerked the bag behind her back and

to her side. Petitioner also reported being pushed and punched in the left side of her head. Dr. Lawrence Frank opined her condition was related to her injury of November 22, 2010 based upon the Patient's history and "severity of her injury and attack". Dr. Lawrence Frank recommended diagnostic bilateral cervical medial branch block injections diagnostically to address the facet joints. Dr. Lawrence Frank believed Petitioner could work light duty. On cross-examination Dr. Lawrence Frank acknowledged that he did not review the FCE or review any diagnostic films. Dr. Lawrence Frank further acknowledged that his opinions were based upon one examination and Petitioner's functionality on the date of his evaluation. (PX. 28).

On August 25, 2016, Petitioner started treating with Dr. Seymore for her right shoulder condition. (T. 48). Dr. Ho, one of his partners, performed a manipulation of the right shoulder under anesthesia October 11, 2016. Petitioner does not contend the treatment is related to her November 2010 accident (T.48-49, PX23).

On October 4, 2016, Petitioner was examined by Dr. Kenneth Candido, an anesthesiologist specializing in both acute and chronic pain management, pursuant to Section 12 of the Act. (RX. 3). Petitioner reported being struck in the head and grabbed in the back during a robbery. Dr. Candido found that Petitioner's pain complaints and history did not correlate with his examination. Dr. Candido performed Jamar Testing, for strength, which found that Petitioner had greater strength on her left side than her right side. Dr. Candido said Petitioner's findings were the opposite of what he had expected. Dr. Candido opined that Petitioner's left shoulder issue was related to her work incident but her condition resolved by October 4, 2016 and Petitioner reached MMI on June 25, 2015, the date of the FCE, and additional pain management treatment was not warranted. Dr. Candido further disagreed with the need for bilateral cervical branch injections noting that Petitioner did not have pain to the palpitation over the cervical facet joint and no decease in range of motion. Dr. Candido further opined that Petitioner's headaches, depression, anxiety and right shoulder conditions were not related to her accident. Dr. Candido also disagreed with the need for Botox injections noting that the FDA has not approved Botox injections for general headaches when there is no focal

point for the headaches. Dr. Candido acknowledged he could not render an opinion regarding post-traumatic stress disorder because he is not a psychiatrist. (RX 3).

Petitioner testified she obtained new employment with Windy City Ribs on January 15, 2018. (T. 49). Petitioner testified that as of March 31, 2018 she stopped working for Windy City Ribs but not due to any physical limitation. Petitioner testified that she is currently capable for returning to work. (T. 51, 69-70).

Petitioner testified that she still suffers from headaches several times a week and her left shoulder still hurts. Petitioner testified that she continues to experience problems with her vision, neck and anxiety, which she controls with medication. (T.54). Petitioner testified she would like to pursue treatment with Dr. Lawrence Frank and Dr. Robbins. (T. 47, 70). Petitioner testified that believes the nerve blocks will fix her vision issues. (T. 72).

The Arbitrator does not find the testimony of the Petitioner to be credible.

CONCLUSIONS OF LAW

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

To obtain compensation under the Act, a claimant bears the burden of showing by a preponderance of the evidence, he suffered a disabling injury which arose out of, and in the course of his employment. *Baggett v. Industrial Commission*, 201, Ill 2d. 187, 266 Ill. Dec. 836, 775 N.E. 2d 908 (2002). The "arising out of" component is primarily concerned with causal connection. To satisfy this requirement it must be shown that the injury had its origin in some risk connected with or incidental to the employment to create a causal connection between the employment and the accidental injury. *Caterpillar Tractor Co. vs. Industrial Commission*, 129 Ill. 2d, 52, 133 Ill. Dec. 454, 541 N. E. 2d. 665 (1989). Accidental injury need not be the sole causative factor, not even the primary causative factor, as long as it was a causative factor in resulting condition of ill-being. *Rock Road Construction Co. v. Industrial Commission*, 37, Ill. 2d. 123, 227 N.E. 2d. 65 (1967).

WITH RESPECT TO ISSUE (F) WHETHER PETITIONER'S CURRENT CONDITION OF ILL-BEING IS CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

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 her current condition of ill-being is, in part, causally connected to her work injury of November 22, 2010, as set forth more fully below.

The Petitioner has proven that her left shoulder adhesive capsulitis and post-traumatic stress disorder is causally related to her work accident of November 22, 2010. The Arbitrator finds that Petitioner failed to prove that her current conditions consisting of occipital neuritis, occipital neuralgia, loss of vision, migraines, myofascial pain syndrome, cervical facet syndrome, cervical radicular pain, right shoulder pain, anxiety and/or depression is causally connected to her work injury of November 22, 2010. Petitioner acknowledges that her right eye vision loss, occipital neuritis and right shoulder conditions is not related to her work injury of November 22, 2010.

On the date of the incident, Petitioner was treated at LaGrange Memorial Hospital and diagnosed with a neck contusion. Petitioner reported tenderness on the midline of the left side of Petitioner's trachea. Petitioner was examined and no markings of trauma to Petitioner's face, redness or bruising were noted. Dr. Lema's examination found no evidence of bruising, edema or soft tissue swelling about Petitioner's face and head. On December 2, 2010, Petitioner told Dr. Lema that she was not experiencing any headaches. At that visit, Petitioner reported that she was 90% better. Dr. Lema noted that Petitioner did complain of some residual issues involving her left shoulder. (RX 2). The Arbitrator finds the medical records from LaGrange Memorial Hospital and Dr. Lema, of Midwest Health Works, indicate that Petitioner sustained a minor injury and that she was not experiencing headaches or any cervical symptoms when she was released from medical care on December 2, 2010. Petitioner returned

to full duty and did not undergo any medical treatment until she started to experience vision issues, in her right eye, which accompanied headaches on or around August 8, 2011.

Petitioner testified that she had been experiencing headaches since the November 22, 2010 incident which she was able to control until August of 2011. Petitioner provided a similar history to several of her doctors. The Arbitrator finds Petitioner's testimony to be inconsistent with her original treatment records. On August 8, 2011, Petitioner told Dr. Lema, that she was experiencing headaches "on and off for one week". Petitioner also told Dr. Lema the headaches were associated with loss of sight in her right eye, seeing lights, and feeling dizzy. (PX 3). On August 10, 2011, Petitioner was treated at MacNeal Hospital emergency room. At that time, Petitioner said that for the past five days she had been experiencing a headache concurrently with seeing bright white dotes out of her right yet. Petitioner's neurologic exam was normal, and the CT scan of the head was also normal. Petitioner was diagnosed with a diagnosed with a urinary tract infection, headache and tension. While at the hospital, Petitioner did not report any cervical issues. (PX 4). On August 16, 2011, Petitioner saw Dr. Lacayo, an optometrist with Chicago Eye Consultant. At that time, Petitioner reported headaches and light sensitivity and seeing white lights for the past two weeks. (PX 6). The Arbitrator finds that, based upon the initial treatment records, Petitioner's headaches began on or about the first week August and her headaches developed concurrently with Petitioner's right eye vision issues. The Arbitrator does not find Petitioner's testimony credible as it relates to the onset of her headaches occurring immediately after her work incident of October 22, 2010.

The Arbitrator further finds that Petitioner also provided inconsistent descriptions of the October 22, 2010 incident to various doctors which were inconsistent with Petitioner's examinations taken on and immediately after the October 22, 2010 incident. Petitioner told Dr. Cole, who performed a Section 12 examination after left shoulder adhesive capsulitis surgery had been recommended, that during the robber she was struck in the neck and left shoulder a few times. (RX 1). Petitioner told Dr. Helge Frank, a neurologist who performed a Section 12

examination, that she was grabbed by the back of her clothing and thrown to the ground in a forward positon while being struck in the left side of the head. Petitioner further said that she kicked the robber knocking his hat off and dislodging his cell phone. (RX 2). Petitioner told Dr. Chekka that her left arm was pulled, and she was punched on the left side of the head near the area of her neck. (PX 15). Petitioner told Dr. Lofland, a psychologist, that she was punched in the back of the head. (PX 7). Petitioner told Dr. Drake, an orthopedic physician Petitioner was referred for a left shoulder evaluation, she was punched in the face and her left arm was violently tugged many time. Petitioner also told Dr. Drake she grabbed the robber's hoodie. (PX 20). Petitioner told Dr. Lawrence Frank, who examined Petitioner as the request of her attorney, that the robber repetitively jerked the bag from behind her and to her side and she was also pushed and punched in the head. (PX 28).

The Arbitrator finds that Petitioner's description of the incident varied depending on the doctor and the purpose of the visit. The Arbitrator further finds the various versions Petitioner provided to the treating physicians to be inconsistent with the results of the examinations taken on and near of the date of the incident. At LaGrange Memorial Hospital Petitioner complained of mild left shoulder pain and had no markings of trauma such as redness or busing on the face and head. (PX 1). On November 23, 2010, Petitioner was examined at Midwest health Works no evidence of bruising or swelling on the face and head was noted. When Petitioner was released from care, on December 2, 2010, she was not experiencing headaches and the tenderness she had in the temporal region resolved and she was not experiencing any tenderness over her cervical spine. (PX 2). Dr. Candido found that Petitioner's pain complaints and her history did not correlate with her examination. (RX 3).

The Arbitrator does not find the opinions of Drs. Rioja, Bernard, Chekka, Robbins Drake, Lawrence Frank to be persuasive because their opinions are based upon, in part, a history provided by Petitioner which is inaccurate. 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 (1st Dist. 2000); Internal inconsistencies in a claimant's testimony, as well as conflicts between the claimant's testimony and medical records, may be taken to indicated unreliability. *Gilbert v. Martin & Bayley/Hucks,* 08 IL.W.C. 004187 (Ill. Indus. Comm'n 2010).

The Arbitrator finds the opinions of Drs. Helge Frank, Cole and Candido persuasive. Dr. Cole opined that the left shoulder adhesive capsulitis was a sequela of the November 22, 2010 incident. (RX 1). Dr. Helge Frank opined Petitioner's migraines were not related to the incident of November 22, 2010. (RX 2). Dr. Candido, who specializes in acute and chronic pain management, opined that Petitioner's headaches, depression, current cervical conditions were not related to the November 22, 2010 incident. (RX 3).

The Arbitrator does find the opinions of Dr. Lofland persuasive. Dr. Lofland found that Petitioner suffered post-traumatic stress disorder as a result of the October 22, 2010 incident. Dr. Lofland recommended cognitive behavior therapy to lower Petitioner's stress levels, anxiety and depression. Dr. Lofland also found that Petitioner also suffering from anxiety and depression. The Arbitrator finds that Petitioner failed to prove her anxiety and depression was related to the incident of October 22, 2010. Petitioner subsequently treated with Dr. Machabanski for depression and anxiety. The Arbitrator notes that Dr. Machabanski did not treat Petitioner for her post-traumatic stress disorder. Dr. Machabanski treated Petitioner's anxiety and depression.

WITH RESPECT TO ISSUE (J) WHETHER THE MEDICAL SERVICES PROVIDED REASONABLE AND NECESSARY AND WHETHER RESPONDENT HAS PAIN FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, THE ARBITRATOR FINDS AS FOLLOWS:

For treatment of an employee's workplace injury to be compensable under the worker's compensation laws, Petitioner must establish the treatment is necessitated by the work injury and not some other cause or condition. *Hansel & Gretel Day Care Center v. Industrial Comm'n,* (1991) 215 Ill.App.3d 284, 574 N.E. 2d. 1244. An employee is entitled to recover

reasonable medical expenses that are causally related to the accident that are determined to be required to diagnose, relieve or cure the effects of her injury pursuant to Section 8(a) of the Act. The employee bears the burden of proving the treatment was necessary and the expenses for the incurred care were reasonable. *City of Chicago v. IWCC*, 409 Ill. App. 3d. 258, 267 (1st Dist., 2011).

On April 25, 2014, Dr. Wolin diagnosed post-traumatic adhesive capsulitis and recommend arthroscopic release surgery. Dr. Cole, who performed a Section 12 examination, opined that it was possible Petitioner's adhesive capsulitis could be the indirect sequela of the November 22, 2010 incident and he agreed the surgery and subsequent physical therapy were reasonable. (RX 1). As stated above the Arbitrator found Petitioner's left shoulder adhesive capsulitis condition to be caused by her work injury of October 22, 2010. As such the Arbitrator finds that Respondent is liable for the medical bills associated with the diagnoses and treatment of the left shoulder capsulitis which includes the following: (1) treatment provided by Dr. Wolin including the FCE as delineated in PX 21; (2) treatment received from Stroger Hospital as delineated in PX 18; (3) treatment provided by Dr. Drake as delineated in PX 20; (4) services provided by Hawthorn Works Medical Imaging for the 2/7/2014 date of service as delineated in PX 9; (5) services provided for the left shoulder by Athletico as delineated in PX 14; (6) services provide by Dr. Chekka for the left shoulder on 1/30/2014, 2/13/2014 and 2/24/2014 as delineated in PX 15; (7) services provided by Dr. Rioja for the left shoulder on 1/27/2014 as delineated in PX 8; (8) treatment provided at MacNeal Hospital involving the left shoulder on 11/25/2013 as delineated in PX 4; and (9) treatment provided by Dr. Lofland of North Shore Integrative Healthcare.

As stated above the Arbitrator finds that Respondent is liable to pay for the medical expenses related to the diagnoses and treatment of Petitioner's left shoulder adhesive capsulitis and post-traumatic stress disorder conditions pursuant to Sections 8.2 and 8(a) of the Act, subject to the fee schedule. Respondent shall be provided a credit for medical benefits that have been paid and Respondent shall hold Petitioner harmless form any claims by any

providers of services for which Respondent is receiving a credit or any credit under Sections 8(j). The Arbitrator denies the remainder of Petitioner's medical expenses, as Petitioner failed to prove the condition of ill-being were causally related to her work incident of October 22, 2010.

WITH RESPECT TO ISSUE (K) PROSPECTIVE MEDICAL CARE, THE ARBITRATOR FINDS AS FOLLOW:

Petitioner is requesting prospective medical care consisting of Botox injections and cervical branch injections. The Botox injections are intended to treat Petitioner's headaches, occipital neuralgia and/or occipital neuritis while the cervical branch injections are intended to treat Petitioner's cervical facet syndrome and/or myofascial pain syndrome. The prospective medical care Petitioner seeks is for conditions not found to be causally related to her work accident and, as such, Petitioner's request for prospective medical care is denied. For treatment of an employee's workplace injury to be compensable the Petitioner must establish the treatment is necessitated by the work injury and not some other cause or condition. *Hansel & Gretel Day Care Center v. Industrial Comm'n*, (1991) 215 Ill. App. 3d 284, 574 N.E. 2d 1244.

WITH RESPECT TO ISSUE (L) WHAT AMOUNT OF COMPENSATION IS DUE FOR TTD AND TPD BENEFITS, THE ARBITRATOR FINDS AS FOLLOW:

Petitioner is seeking TTD benefits from November 12, 2012 to January 15, 2018 and April 1, 2018 through the dated of the hearing, June 13, 2018. Petitioner is also seeking TPD benefits from January 15, 2018 through March 31, 2018. The Parties stipulate that Petitioner was paid TTD benefits from April 29, 2014 through August 6, 2015, while she was off work for her left shoulder surgery.

Petitioner is seeking TTD and TPD benefits for the conditions found not to be causally related to her work incident of October 22, 2010 which include occipital neuritis, occipital neuralgia, loss of vision, migraines, myofascial pain syndrome, cervical facet syndrome, cervical radicular pain, anxiety and/or depression. The Arbitrator finds that Petitioner failed to

prove that she was eligible to receive the additional TTD benefits and/or TPD benefits as it relates to those conditions found to be causally related to her October 22, 2010 work incident. As such, Petitioner's request for TTD benefits and TPD benefits is denied.

WITH RESPECT TO ISSUE (O) CHOICE OF PHYSICIANS, THE ARBITRATOR FINDS AS FOLLOWS:

Respondent claims that Petitioner exceeded her choice of physicians pursuant to Section 8(a) of the Act. In light of the Arbitrator's finding that various conditions which Petitioner received treatment was not causally related to her work accident of October 22, 2010, the issue is moot and needs not to be addressed.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DENNIS SLONIKER,

Petitioner,

20IWCC0337

vs. NO: 11 WC 14983

ASPEN CONSTRUCTION SYSTEMS,

Respondent.

DECISION AND OPINION ON §19(h) PETITION

This matter comes before the Commission on Respondent's §19(h) Petition, filed on August 15, 2017 and heard before Commissioner Lamborn on November 9, 2018, alleging that Petitioner's disability has diminished or ended; specifically, that Petitioner's annular tear at L4-5 has resolved since the previous arbitration hearing, which was held on July 23, 2013.

To summarize the history of this case, Petitioner sustained a lumbar injury at work on February 22, 2010. After a hearing pursuant to §19(b) of the Act on August 11, 2011, Arbitrator Akemann issued a decision, dated October 25, 2011, finding causation and awarding temporary total disability benefits, medical expenses and a prospective functional capacity evaluation. This decision was not reviewed by either party. On July 23, 2013, a second arbitration hearing was held before Arbitrator Lee. His decision, dated October 21, 2013, awarded additional medical expenses, maintenance benefits and wage differential benefits under §8(d)1 of the Act. Respondent reviewed this decision, which the Commission affirmed and adopted on January 29, 2015. Respondent filed the current §19(h) Petition on August 15, 2017, and it was heard before Commissioner Lamborn on November 9, 2018.

On July 2, 2018, Petitioner filed a "Motion to Bar Testimony of [Dr. Mather, et al] and to Dismiss Respondent's 19(h) Petition, and Objection to Introduction of Reports from [Dr. Mather, et al]." This motion was voluntarily withdrawn prior to Dr. Mather's deposition, with Petitioner reserving the right to refile at a later date. This motion was refiled at the §19(h) hearing on

November 9, 2018. *T.83-84.*

Respondent's Section 19(h) Motion

Respondent's Section 19(h) motion argues that Petitioner's disability has materially diminished or ended and requests that Petitioner's wage differential award under Section 8(d)1 be terminated and converted into a person-as-a-whole award under Section 8(d)2. The Arbitration decision, issued on October 25, 2011, found that Petitioner sustained a work-related low back injury on February 22, 2010. That decision stated, Dr. Keehn "found an annular tear and displacement of the disc at L4-5. Additionally, he diagnosed lumbosacral facet joint pain and degeneration of the lumbar spine." *Dec. 10/25/11 at 6.* However, in the Conclusions section, the Arbitrator found "petitioner's axial low back pain from the annular tear at the L4-5 disc was caused by the lifting accident with respondent on [2/22/10]. The Arbitrator, therefore, adopts the opinion of Dr. Keehn, the Petitioner's treating physician." *Dec. at 8.*

The events that led to Respondent filing this Section 19(h) motion began on October 6, 2016, when Dr. Keehn's nurse practitioner, Lindsay Vanselow, wrote that Petitioner's updated MRI performed on September 29, 2016, "again reveals degenerative disc disease at L4-5. However, **the annular tear has resolved. New findings at L5-S1** include mild bilateral neural foraminal narrowing secondary to a broad based disc bulge as well as moderate facet arthropathy. Has not had ESI since 2011 and it was an L4-5 interlaminar injection. **He now has MRI findings at L5-S1 which correlate with his painful areas.**" *(Emphases added.)*

Respondent argues that if the L4-5 annular tear that was found to be causally related no longer exists then Petitioner's condition, by definition, must have "diminished or ended." Furthermore, if Petitioner has new findings at L5-S1, which correlate with his painful areas, then his symptoms are no longer related to the L4-5 level. In contrast, Petitioner argues that the Arbitrator's decision incorporated more than just the L4-5 annular tear.

Although a significant amount of testimony was focused on whether the exact source of Petitioner's current symptoms are attributable to L4-5 or L5-S1 and whether it is due to an annular tear, degenerative disc disease, facet joint disease, or some other condition, it is unnecessary for us to make such distinctions at this time. We note that this is not a petition under Section 8(a) by Petitioner for medical treatment related to L5-S1. It is also not a Section 19(h) petition by Petitioner alleging a material increase in disability related to L5-S1. The matter before us, pursuant to Respondent's Section 19(h) petition is whether Respondent has proven that Petitioner's disability related to the L4-5 annular tear has materially diminished or ended. We find that Respondent has failed to so prove and reach this conclusion without having to decide whether Petitioner's L5-S1 condition is or remains causally related to his work accident.

Testimony of Dr. Douglas Keehn

We initially note that the premise of Respondent's argument was disavowed by Dr. Keehn during his October 22, 2018 deposition testimony when he disputed the statement of his nurse practitioner that the annular tear had resolved. He explained that the changes in

Petitioner's diagnoses over time were due to a change in how they were coded in October 2015 as well as variations in providers' interpretations of Petitioner's conditions since Dr. Keehn had been through "about four different nurse practitioners." *Px3 at 14, 22-26.* Regarding the October 6, 2016 visit note, Dr. Keehn then testified:

> With all due respect to my very outstanding nurse practitioner, her judgment and everything are exceptional. She was fairly new, I believe only working with us for about six months at this point, and she wrote the assessment portion of this.
>
> The -- Given that, saying that the annular tear has resolved is not necessarily accurate, and this is why. You cannot actually see an annular tear itself on MRI. What you see is what's called a high-intensity zone, which is a small white dot of contrast that you will see in the posterior aspect of the disc that is suggestive of an annular tear. Sometimes those are red herrings and mean nothing, sometimes they are clinically significant annular tears.
>
> The only way to actually document whether an annular tear is present is throughout discography, which is taking a needle, putting it into the mid-portion of the disc [...] and inject contrast and see where does the contrast go. *Id. at 37-38.*

Dr. Keehn testified that Petitioner did, however, "have other findings of disc degeneration on [the MRI] and so that absolutely remains consistent with his clinical presentation which has been essentially consistent throughout his treatment with us." *Id. at 38.* Dr. Keehn opined that Petitioner's MRI findings were consistent with his initial diagnosis and are still related to the original work accident in 2010. *Id. at 42.*

Dr. Keehn testified that he did see, on the MRI, a bright white signal that was nearing the outer annulus of the L4-5 level. *Id.* He explained that the outer third of the disc has "lots and lots of nerve endings in it. So if you have a tear in the doughnut portion of the disc, and the - that inflammatory nuclear material touches with the nerves in the outer portion of the disc, it hurts, and that is the substrate for discogenic back pain." *Id. at 43.* Dr. Keehn testified, "while I do not see a frank high-intensity zone, I certainly do see signal that does extend into the outer third of that disc and that would certainly be consistent with a remaining annular tear and discogenic back pain." *Id. at 44.* Dr. Keehn reiterated that a discogram would be required to "make that diagnosis precisely" but, since Petitioner is not a candidate for surgery, it is probably unnecessary to do a discogram because "his films still support a diagnosis of discogenic back pain at the level of L4-5 and possibly L5-S1 as well." *Id.*

Dr. Keehn then gave the following testimony:

Q: Okay. So do you have an opinion within a reasonable degree of medical certainty whether or not his condition – or whether there's been a material change in his condition at this time, at the time of the review?
A: I have no evidence to suggest that there has not been a change in his anatomic condition and his clinical condition remains stable.
Q: And related to the work accident?
A: Yes. *Id.*

Apparently, realizing that Dr. Keehn gave a confusing answer, he was asked more directly:

Q: So you're saying you don't believe there's been a material change?
A: I do not feel that there has been a material change anatomically in the patient's condition.
Q: Does Mr. Sloniker continue to need the same restrictions for work activity?
A: I believe so. Yes. *Id. at 45.*

Dr. Keehn testified that Petitioner's diagnosis at L4-5 remains degenerative disc disease and discogenic back pain related to the original work accident. *Id. at 47.* His direct examination concluded with the following:

Q: ... Comparing Mr. Sloniker's current condition to the condition that he [sic] diagnosed and as presented by Mr. Sloniker at the [7/23/13] trial, has there been a material change in that diagnosed condition or a material improvement in that diagnosed condition that would allow Mr. Sloniker to resume other than his current work activity that he's doing as a carpet estimator with Coyle Carpets?
A: No, there has been no substantial material change, and I do not feel that he would be able to return to full-time duty as a construction foreman with no restrictions. I don't think that's reasonable for this patient at this time.
Q: Has that opinion changed or has it altered in any way by the findings on MRI dated [9/29/16]?
A: No. *Id. at 63-64.*

On cross-examination, Dr. Keehn testified that it is more challenging from an objective standpoint to determine discogenic back pain because "typically the patients don't have neurological dysfunction associated with it [... and] sometimes the only findings that you have are tenderness to palpation and limitations in the range of motion." *Id. at 79.*

Regarding the annular tear at L4-5, Dr. Keehn testified that a high-intensity zone had been seen on Petitioner's 2010 MRI, which was consistent with an annular tear of the disc that was also confirmed by the discogram in 2010. *Id. at 89.* Although he did not see a high-intensity zone on the 2016 MRI, he could not say that the annular tear has resolved because, "When I reviewed his films, I still saw signal in the outer third of the annulus, meaning that I still saw there was leakage of that nuclear material in the outer third of the disc where it is not supposed to be." *Id. at 90-91.* He again explained that "while it is not a frank high-intensity zone, I could still see that there was contrast in the outer portion of the disc, and he had still other findings that were consistent with degenerative disc disease." *Id. at 91.*

Dr. Keehn testified that an annular tear is a type of degenerative disc disease, which is "an umbrella term." *Id.* Significantly, Dr. Keehn noted that the area where he saw the contrast in the 2016 MRI is in the same, posterior aspect of the disc, where the high-intensity zone was in 2010. *Id.*

Dr. Keehn felt that it was possible but "unlikely" that Petitioner's current complaints

could be the result of findings at the L5-S1 level. *Id. at 97.* He testified that discogenic pain and facet mediated pain are two different things but there are "not really" complaints that are specific to facet mediated pain that would not overlap with discogenic pain and it would be "difficult to tell" if Petitioner's ongoing complaints are facet mediated as opposed to discogenic back pain. *Id. at 102-03.*

Dr. Keehn testified that it is a "difficult leap" to state that L5-S1 is the generator of Petitioner's current, ongoing complaints. *Id. at 107.* He continued:

> I think it's entirely possible that he could have multi-factorial discomfort. From what I gathered was that he had some relief of his leg pain but his back pain persisted despite the epidural steroid injections. *Id.*

Dr. Keehn admitted that Petitioner's back pain could be coming from the degenerative disc disease at either L4-5 or L5-S1 or both. *Id.* He opined that the L5-S1 level "certainly could be contributing, but I think that the [degenerative disc disease at the] L4-5 level is likely to be contributing as well." *Id. at 109.* He then added, "If not solely." *Id.*

Dr. Keehn stated that he did not believe one could say with any certainty that the annular tear discovered in 2010 was no longer a contributor to Petitioner's current complaints. Id. He testified that Petitioner "certainly has degenerative changes within the L4-5 level, and I feel that his back pain has been reasonably consistent and so…I have no reason not to think that that is still contributing to his back pain." *Id. at 109-110.*

On redirect examination, Dr. Keehn testified that there has not been a substantive change in Petitioner's condition overall since he testified at the previous trial in July 2013. *Id. at 113.* He was then asked:

> Q: And if there - if the annular tear at L4-5 has resolved, is not there, would that indicate that there's been a material change in his condition?
>
> A: One thing that I have to look at is how does the patient respond over time and really what's their functional status. And you know, the imaging is just a part of it. Cases like this can be challenging because the patients by definition of having discogenic back pain, there aren't objective findings always that we can – that you can put your hat on and so you follow the patients over time.
>
> I've…cared for this patient for a very long period of time and his – and his presentation has always been consistent. He's been extremely compliant with his…regimen. I think we've done a reasonable job of helping him to function.
>
> It's my charge as a physician to provide therapies that may help him to function better. But, you know, he continues to struggle with…this event that's been life changing for him. *Id. 113-14.*

On recross examination, Dr. Keehn testified that, although it is possible that something has changed:

> …his clinical condition hasn't changed. He had great relief from two epidural steroid

injections of his leg pain. His back pain did persist through that time. And, really, reviewing his records from his most recent visits, his leg pain is not a substantial contributor to his pain complaints at this point. It really is mostly axial back pain. And that has been consistent throughout.

So...because his clinical picture has not really changed dramatically, the fact that his imaging has had some changes to it, I can't even say that the L5-S1 level wasn't somehow injured in his initial event and this is just natural progression of the disease that you would see for somebody who underwent or who had a traumatic annular tear ten years ago.

The degeneration you see at L5-S1 for him is much more than I would appreciate for someone of his...age...and size. I mean Dennis does a good job of doing all the right things. He's not overweight. He gets regular exercise. He doesn't smoke. Those are all things that we recommend to our patients to prevent degenerative disc disease. I think he's made very good effort to do that and works within his restrictions.

Testimony of Dr. Steven Mather

The Commission notes that Dr. Mather did not review Petitioner's 2009 or 2010 MRI films. He only reviewed the 2016 MRI. Dr. Mather's opinion about the annular tear having resolved also seems to be based, in large part, on his review of Dr. Keehn's records. At his deposition on May 5, 2018, Dr. Mather testified:

Q: And what did Dr. Keehn indicate with regard to the annular tear at the L4-5 level?
A: That it had resolved.
Q: And what does that mean to you?
A: That the ligament had healed. The ligament that makes up the disc has healed like an ankle sprain. *Rx10 at 23.*

Dr. Mather was asked if there was still an annular tear at L4-5 based on his own review of the September 29, 2016 MRI and he answered:

> I don't think to any significant degree. Annular tears come in very different forms. You can spot them in different ways on the MRI, but you can also see if they've healed to a significant degree. So they're always going to leave some little remnant left, but nothing significant. *Id. at 24.*

The Commission notes that, on one hand, Dr. Mather believed the annular tear resolved because that's what Dr. Keehn indicated. On the other hand, Dr. Mather opined that "they're always going to leave some little remnant left, but nothing significant." Therefore, the logical inference is that there *is* something still on the MRI at L4-5 but Dr. Mather does not believe it is "significant."

Dr. Mather opined that Petitioner does not currently suffer from axial low back pain due to aggravation of an annular tear at the L4-5 level because "all I saw [on the 9/29/16 MRI] was simple dehydration of the disc. I didn't see any significant annular tear. Anything that was

there, had basically healed. Any of the effects from the 2010 and...the initial MRI, were no longer present on the 2016 MRI." *Id. at 31.*

We question how Dr. Mather can confidently say the "effects" from the 2010 MRI were no longer present when he never compared the films himself. Regardless, Dr. Mather gave some confusing testimony, summarized as follows:

- Petitioner's MRI showed that he had degenerative disc disease at the L4-5 level. *Id. at 32.*
- Based on Dr. Mather's review of the records, Petitioner exhibited signs of degenerative disc disease since the accident of February 2010. *Id.*
- Degenerative disc disease is a progressive condition. *Id. at 34.*
- Petitioner's annular tear, which is a form of degenerative disc disease, had healed. *Id.*
- Petitioner had spondylosis, which is the next grade worse than disc degeneration or annular tear, already by his 2010 MRI. *Id.*
- Degenerative disc disease "always progresses" and "there's no stopping" it. *Id.*

In other words, Dr. Mather's opinion was that Petitioner had symptomatic degenerative disc disease going back to 2010. The annular tear Petitioner had is a form of degenerative disc disease, which always progresses, yet the annular tear that Petitioner had was healed as of 2016.

We find it enlightening how Dr. Mather explained the basis of his opinion that Petitioner could return to work:

> My opinion is that Mr. Sloniker may have not been credible with his reports of pain because he was not credible with what – when he told me he started having pain.
>
> Since I had very little to support his complaints of pain on physical exam – that's number one. Number two, he didn't tell me the truth about when his pain started. Number three, there were no focal findings on exam. Number four, he didn't have any neurologic impairment. Number five, I didn't see on the MRI any significant annular tears still present in 2016. I didn't really see anything that would restrict him from going back to work.

Although Dr. Mather stated five bases for his opinion, these can be distilled into three reasons: physical exam findings (#1, #3, and #4); Petitioner's credibility (#2); and the 2016 MRI findings (#5).

Regarding Petitioner's exam findings, Dr. Mather stated, following his exam and review of records, he felt that Petitioner had a lumbar strain and degenerative disc disease. *Rx10 at 14.* His exam showed normal strength, reflexes and sensation. Petitioner's straight-leg-raising test was negative and his only positive finding was pain with range of motion. *Id. at 11.* Petitioner did not exhibit any Waddell signs. *Id. at 12.* However, later, Dr. Mather stated:

> His findings appeared to be out of proportion to one that normally one would see with painful degenerative disc disease. So I did not feel his pain complaints aligned with degenerative disc disease.

He really had nothing focal on exam to indicate that he had a restrictive condition. *Id. at 41.*

The Commission questions Dr. Mather's conclusion that Petitioner's only positive finding of having pain with range of motion was "out of proportion" for degenerative disc disease. Petitioner exhibited no Waddell signs. Dr. Mather admitted that Dr. Keehn's records also showed no real focal findings other than back pain with range of motion. *Id. at 72, 74.* Petitioner's treating physician, Dr. Keehn, testified that with discogenic pain, sometimes the only findings are tenderness to palpation and limitations in range of motion. *Px3 at 81.* The Commission finds, based on the evidence, that Petitioner's symptoms are proportionate and consistent with degenerative disc disease. We note that Petitioner has not been adjudicated to be permanently totally disabled. He continues to work but is under restrictions that don't allow him to return to his previous job.

On cross-examination, Dr. Mather testified:

Q: Okay. So after the review of the records, the exam, and the history, you reached a diagnosis that Mr. Sloniker sustained a lumbar strain from the [2/22/10] work accident, correct?
A: Yes.
Q: And that he had lumbar degenerative disease, but that was not related to the [2/22/10] work accident, correct?
A: Correct. *Id. at 74.*

Dr. Mather opined that Petitioner has "simple lumbar degenerative disc disease, as anyone his age is going to have. He had a lumbar strain. When I saw the MRI, all I saw was disc desiccation at L4, 5, disc degeneration LS-S1. I didn't see any injury." *Id. at 75.*

The Commission finds that Dr. Mather's opinion contradicts the law of the case in two respects. First, he believes that Petitioner only sustained a lumbar strain in the 2010 accident, while the Arbitrator's decision found that Petitioner sustained an L4-5 annular tear. Second, Dr. Mather attributes Petitioner's "simple lumbar degenerative disease" to Petitioner's age, while the Arbitrator's decision makes clear that Petitioner's work injury was a contributing factor to that L4-5 degenerative condition (i.e., annular tear). Therefore, when Dr. Mather opines that, on the 2016 MRI, all he sees is "disc desiccation" and no injury, that seems to be because he refuses to accept the Arbitrator's finding that Petitioner *did* sustain an injury and that Petitioner's degenerative L4-5 condition *was* related to that injury. As evidence of this, when Dr. Mather opined that Petitioner's "axial back pain" had objectively resolved, he admitted that he was referring to the low back strain that he diagnosed. *Rx10. at 83.* However, we know from the Arbitrator's decision that Petitioner sustained more than just a lumbar strain. We find Dr. Mather's opinion unpersuasive because it ignores the law of the case.

Regarding Petitioner's credibility, Dr. Mather seems to have based all of his opinions through a lens that Petitioner was not credible, because Petitioner supposedly claimed that he had no prior back treatment and that his back was "perfect" prior to his work injury. *Rx10 at 14-15, 58, 68.* Petitioner was asked about this and testified:

Q: Dr. Mather indicates that you told him you had never had any prior back treatment and that your back was, quote, perfect before your work accident. Did you tell him that?
A: No.
Q: Did he ask you if you were working at the time of your work accident?
A: Yes, he did.
Q: And what did you tell him?
A: I said I was working.
Q: All right. Full duty, no restrictions?
A: Yes.
Q: Okay. But you specifically remember talking about your prior MRI, your prior injections, your treatment, and all the ongoing complaints you had before the work accident, right?
A: Yes. *T.61.*

The Commission notes that the original Arbitration decision clearly discusses Petitioner's pre-accident lumbar symptoms and treatment including MRI and injections. There was absolutely nothing for Petitioner to hide and it seems unlikely that Petitioner would have claimed, to Dr. Mather, that his back was "perfect" prior to his work accident knowing that Dr. Mather had access to all of his medical records. The Commission finds that Dr. Mather's opinion regarding Petitioner's lack of credibility is unpersuasive.

Another aspect of Dr. Mather's perception that Petitioner lacked credibility is related to whether Petitioner was taking fentanyl prior to December 2016. We point out that Dr. Mather is wrong in his claim that Petitioner did not take fentanyl prior to December 2016. The Illinois report that Dr. Mather referenced only goes back twelve months. However, Dr. Keehn's treating records indicate that Petitioner was being prescribed fentanyl for years. This is also supported by toxicology reports that indicate the presence of fentanyl in Petitioner's system and Wisconsin Query reports indicating that Petitioner had been having his fentanyl prescriptions filled long before December 2016. *Px4.*

Petitioner's Testimony

We find Petitioner's testimony credible that, since his trial in 2013, his pain complaints have never gone away other than temporarily following one of the injections, after which the pain returned "like it was at the time of the original injury." *T.50-51.* Petitioner testified that there has not been any improvement in his condition over the last 5 years from the date that he testified in 2013 until now. *T.57.* He has good days and bad days. On a good day, his pain score would be a 2 or 3 out of 10. *T.58.*

Petitioner continues to work, within the restrictions given by Dr. Keehn, at Coyle Carpet as a field measurer which involves traveling to customers' homes, measuring the floor area with a laser measure, and creating a drawing of the installation. *T.13-15, 46, 57.*

CONCLUSION

Respondent argues that "it is clear from a review of the testimony of both Dr. Keehn and Dr. Mather that the annular tear that was present at the L4-L5 level as exhibited on Petitioner's MRI scan of March 15, 2010, has resolved." *R-brief at 22.* The Commission finds this assertion to be far from "clear." Dr. Keehn opined that there was no longer the *same* high-intensity signal at L4-5 on the 2016 MRI, but a signal did still exist in the same place. He also testified that one cannot say that the annular tear is no longer present because a discography would be necessary to determine that.

Respondent admits that Petitioner still suffers from "axial low back pain" but argues that this is consistent with "either degenerative disc disease at the L4-L5 level, or degenerative disc disease with a broad-based disc bulge and narrowing of the bilateral neuroforamina at the L5-S1 level or is due to facet mediated pain." *R-brief at 23.* In other words, even though Petitioner is still having low back symptoms, it must be coming from anything but the L4-5 annular tear.

Without addressing whether the original Arbitration decision may have been written too narrowly, we find the opinion of Dr. Keehn more persuasive than that of Dr. Mather regarding Petitioner's current L4-5 condition. We note that Dr. Keehn's deposition was taken on October 22, 2018, five months after Dr. Mather's was taken on May 10, 2018. Therefore, Dr. Mather did not specifically refute Dr. Keehn's testimony that, on the 2016 MRI at the L4-5 level, there *was* still a "signal that does extend into the outer third of that disc and that would certainly be consistent with a remaining annular tear and discogenic back pain." *Px3 at 44.* Furthermore, Dr. Mather based his opinion, in part, on the finding by Dr. Keehn that Petitioner's L4-5 annular tear had resolved. Dr. Mather was unaware that Dr. Keehn had repudiated this finding, which had been made by his nurse practitioner.

Based on the persuasive opinion of Dr. Keehn, the Commission finds that Respondent failed to prove that Petitioner's L4-5 annular tear has resolved completely (i.e., returned back to its pre-injury state) and that Petitioner's disability related thereto has "ended."

A more difficult question is whether the annular tear has "diminished" and, if so, does that translate into a material diminishment of Petitioner's disability such that his wage-differential benefits should be terminated? The Commission is persuaded by Dr. Keehn's testimony that one cannot tell if the annular tear has resolved without doing another discography. We note that Petitioner's initial post-accident MRI on March 15, 2010 did not specifically mention an annular tear at L4-5. It stated:

> At L4-5, desiccation of the disc with shallow broad-based disc bulging noted. Mild bilateral facet arthropathy. Foramen and canal are patent.

The annular tear was not discovered until the April 12, 2010 discogram. Therefore, since it was only evident under pressure, it is not surprising that the L4-5 annular tear might be interpreted as "resolved" on the 2016 MRI. Yet, even the September 29, 2016 radiologist's interpretation included "annular disc bulge" at L4-5. Dr. Mather would have the Commission believe that all

20IWCC0337

of Petitioner's problems are degenerative and pre-existing. However, the law of the case is that Petitioner sustained an L4-5 annular tear injury at work. Petitioner's most recent MRI indicates that there is still an annular bulge at that level. Dr. Keehn opined that there is still a bright signal at that level even though it is not the same as before. The Commission finds that Dr. Mather's opinion is insufficient to prove that Petitioner's L4-5 annular tear has "diminished."

Furthermore, even if Petitioner's anatomic condition of the L4-5 annular tear has diminished, that would not necessarily equate to a finding that Petitioner's *disability* from the L4-5 condition has materially diminished. In other words, even if the L4-5 annular tear is anatomically "less" than it was before, that does not mean that his pain is lessened or that he is now somehow able to return to his previous job.

Based on the totality of the evidence, we find that Respondent failed to prove that Petitioner's disability has materially diminished or ended and hereby deny its Section 19(h) motion. We also deny Petitioner's "Motion to Bar Testimony...."

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent's Petition under §19(h) is hereby denied.

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

DATED: JUN 17 2020

Maria E. Portela

Thomas J. Tyrrell

Kathryn A. Doerries

SE/
O: 4/21/20
49

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

CONNIE MUELLER,

Petitioner,

20IWCC0338

vs.

NO: 13 WC 5603

UNITED STATIONERS,

Respondent.

DECISION AND OPINION ON REVIEW

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

On September 9, 2019, Petitioner filed a "Motion for Adjustment of Credit to Prevent Windfall or Double Recovery or in the Alternative for Leave to Supplement the Statement of Exceptions and Supporting Brief." This motion was heard by Commissioner Parker on November 12, 2019, and a record was made.

The Commission hereby grants Petitioner's motion and hereby modifies the Findings section of the decision to reflect that Respondent shall be given a credit of "$0.00 for other benefits, for a total credit of $0.00," as stipulated to by the parties.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $277.33 per week for a period of 109-3/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

20IWCC0338

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $253.00 per week for a period of 175 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the 35% loss of use of the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner reasonable and necessary medical services for treatment of Petitioner's left and right shoulder conditions, as identified in Petitioner's Exhibit 5, for medical expenses under §8(a) of the Act subject to the fee schedule in §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent 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 17 2020

Maria Elena Portela
Maria E. Portela

Thomas J. Tyrrell
Thomas J. Tyrrell

Kathryn A. Doerries
Kathryn A. Doerries

SE/
O: 5/5/20
49

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MUELLER, CONNIE
Employee/Petitioner

Case# **13WC005603**

20IWCC0338

UNITED STATIONERS
Employer/Respondent

On 6/26/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.12% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2412 BEATTY & MOTIL
WILLIAM S BEATTY
78 S MAIN ST PO BOX 730
GLEN CARBON, IL 62034

1109 GAROFALO SCHREIBER HART ETAL
CRAIG SCARPELLI
55 W WACKER DR 10TH FL
CHICAGO, IL 60601

20IWCC0338

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

Connie Mueller
Employee/Petitioner

v.

United Stationers
Employer/Respondent

Case # 13 WC 05603

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 William R. Gallagher, Arbitrator of the Commission, in the city of Collinsville, on May 19, 2017. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On August 15, 2012, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $21,632.00; the average weekly wage was $416.00.

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

Petitioner has received all reasonable and necessary medical services.

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

Respondent shall be given a credit of $0.00 for TTD, $0.00 for TPD, $0.00 for maintenance, and $16,430.38 for other benefits, for a total credit of $16,430.38.

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 treatment for Petitioner's left and right shoulder conditions 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 pay Petitioner temporary total disability benefits of $277.33 per week for 109 3/7 weeks commencing October 15, 2012, through November 21, 2014, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $253.00 per week for 175 weeks because the injury sustained caused the 35% loss of use of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

William R. Gallagher, Arbitrator

June 20, 2017
Date

JUN 26 2017

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged she sustained a repetitive trauma injury arising out of and in the course of her employment for Respondent. The Application alleged a date of accident (manifestation) of August 15, 2012, and that Petitioner sustained "Repetitive Trauma" to her "Left and Right Shoulders, Multiple Body Parts" (Arbitrator's Exhibit 2). Respondent disputed liability on the basis of accident and causal relationship (Arbitrator's Exhibit 1).

Petitioner began working for Respondent on September 20, 2006, and worked as a janitor. Prior to being employed by Respondent, Petitioner worked for Basler Electric Company for 19 years on an assembly line. Petitioner used a soldering iron on various electronic circuit boards. For another three years, Petitioner had her own housecleaning business.

Petitioner testified in detail about her job duties as a janitor. Petitioner's work day typically started at 5:00 or 5:30 AM. In the mornings, Petitioner emptied trash, mopped floors and carried a large bucket filled with water and soap. In order to mop the floors, Petitioner had to first pick up large runner type rugs on the floor. Petitioner lifted the rugs and placed them on a counter. She was uncertain how much the rugs weighed, but stated that they were heavy. Prior to mopping, Petitioner also picked up chairs and placed them on the table. When she finished mopping, Petitioner returned the chairs to their position on the floor. Petitioner estimated there were approximately 60 chairs. The mopping process included a lot of forceful "pushing" to remove marks on the floor. When filling/emptying the bucket, Petitioner had to lift it in/out of a sink. Petitioner did not know how much the bucket weighed, but she did state that it was heavy.

Petitioner's job also required she empty trash cans. She would empty small trash into large rolling trash containers. Once the large rolling trash container was full, Petitioner would roll it to the trash compactor and then empty the contents of the rolling trash container into the trash compactor. The compactor was at about Petitioner's chest level.

Petitioner testified she also serviced/maintained a large tea machine. Petitioner would lift the machine, drain it and then refill it to make a new batch of tea. Petitioner also serviced/maintained approximately six large water coolers during the summer months. The coolers were located throughout the plant. The coolers were transported on a cart, the Petitioner had to lift them on/off the cart.

Petitioner would also use a floor buffer and would clean offices. She also had to clean an outdoor smoking area.

Petitioner testified that the various lifting tasks she performed periodically involved lifting at or above the shoulder level. This included lifting the rugs and water coolers.

Petitioner testified that sometime in June, 2012, she began to have symptoms in her left shoulder. Petitioner then began to use her right arm more and she began to have right shoulder symptoms as well. Petitioner stated she had no prior shoulder injuries; however, Petitioner said she had

previously had neck surgery consisting of disc surgery and a fusion at C6-C7. Petitioner initially thought that her shoulder symptoms were related to her prior neck surgery.

At trial, Petitioner testified she was initially seen by a chiropractor (the name of the chiropractor was not stated); however, no chiropractic records were tendered into evidence. Petitioner stated that the chiropractor then referred her to Dr. Timothy Farley, an orthopedic surgeon, but the earliest record of Dr. Farley that was tendered into evidence was dated October 1, 2012.

Petitioner was evaluated by Dr. Robert Bernardi, a neurosurgeon, on September 25, 2012. Dr. Bernardi noted the fact that Petitioner had a C6-C7 discectomy and fusion performed in 1990 and did well afterward. In regard to her left shoulder, Petitioner advised she had left shoulder symptoms several months ago, but did not recall any trauma. About three months prior, Petitioner began to have right shoulder symptoms. Dr. Bernardi examined Petitioner and reviewed an MRI of the cervical spine that was performed on September 18, 2012. Dr. Bernardi opined that the MRI revealed the fusion at C6-C7, some degenerative disc disease and stenosis at C4-C5 and C5-C6. He opined that Petitioner's shoulder symptoms were not related to her neck. He recommended evaluation by an orthopedic surgeon (Petitioner's Exhibit 1).

Petitioner was seen by Todd Schmidt, a Physician Assistant in Dr. Farley's office on October 1, 2012. At that time, Petitioner complained of bilateral shoulder pain, left greater than right. He opined Petitioner had left shoulder adhesive capsulitis and right shoulder early AC capsulitis. Bilateral MRIs/arthrograms were recommended (Petitioner's Exhibit 2).

Petitioner was again seen by PA Schmidt on October 5, 2012, and he reviewed the results of the MRIs/arthrograms with her (the radiologist's report was not tendered into evidence). The MRI/arthrogram of the left shoulder revealed a rotator cuff tear and the MRI/arthrogram of the right shoulder revealed tendinosis but no obvious tear. Arthroscopic surgery on the left shoulder was recommended (Petitioner's Exhibit 2).

Petitioner was subsequently seen by Dr. William Sedgwick, an orthopedic surgeon, on October 10, 2012. Dr. Sedgwick examined Petitioner and reviewed the MRIs/arthrograms. Dr. Sedgwick opined that the MRI/arthrogram of the left shoulder revealed a full thickness rotator cuff tear and the MRI/arthrogram of the right shoulder revealed a 50% thickness partial rotator cuff tear. He recommended surgery on the left shoulder (Petitioner's Exhibit 3; Deposition Exhibit 2).

Dr. Sedgwick performed left shoulder surgery on October 15, 2012. The procedure consisted of a mini open left rotator cuff repair and acromioplasty. Dr. Sedgwick also administered a steroid injection to the right shoulder for capsulitis (Petitioner's Exhibit 3; Deposition Exhibit 2).

Subsequent to surgery, Petitioner continued to be treated by Dr. Sedgwick who ordered physical therapy. Petitioner was seen on a regular basis by Dr. Sedgwick from October 19, 2012, through July 30, 2013. Petitioner's progress was slow and she continued to have stiffness and a decreased range of motion of the left shoulder. When Dr. Sedgwick saw Petitioner on July 30, 2013, he continued to authorize her to remain off work, recommended she continued home exercises and that he would see her in approximately three months (Petitioner's Exhibit 3; Deposition Exhibit 2).

Dr. Sedgwick subsequently saw Petitioner on October 30, 2013. At that time, Petitioner continued to have pain in both shoulders and stiffness in the left shoulder. On examination, the range of motion of both shoulders was limited. Dr. Sedgwick opined that further medical treatment was appropriate. In regard to the left shoulder, Dr. Sedgwick recommended another MRI to assess the healing of the rotator cuff followed by manipulation and a capsular release. In regard to the right shoulder, Dr. Sedgwick recommended arthroscopic rotator cuff debridement or repair. He continued to authorize Petitioner to remain off work (Petitioner's Exhibit 2; Deposition Exhibit 3).

On October 29, 2013, Petitioner was seen by Dr. Rachel Feinberg, a pain management physician. Dr. Feinberg evaluated Petitioner for pain symptoms in reference to the neck, low back, hands, knees as well as both shoulders. Dr. Feinberg ordered an MRI/arthrogram of Petitioner's left shoulder which was performed on January 16, 2014. The study suggested the presence of a posterior labrum tear of indeterminate age and a small component of a full thickness tear of the supraspinatus (Petitioner's Exhibit 4; Deposition Exhibit 2).

At the direction of Respondent, Petitioner was examined by Dr. George Paletta, an orthopedic surgeon, on December 2, 2013. In connection with his examination of Petitioner, Dr. Paletta reviewed medical records provided to him by Respondent as well as job descriptions prepared by both Petitioner and Respondent. Dr. Paletta opined Petitioner had residual post-op adhesive capsulitis of the left shoulder, post rotator cuff repair and rotator cuff tendinopathy and impingement syndrome of the right shoulder. Dr. Paletta could not determine if the left rotator cuff repair was healed and recommended Petitioner undergo either an MRI/arthrogram or ultrasound to determine the integrity of the rotator cuff repair (Respondent's Exhibit 2; Deposition Exhibit 2).

In regard to causality, Dr. Paletta stated that he could not say with a reasonable degree of medical certainty that Petitioner's work activities were either a causative or contributing factor to her shoulder conditions. He based this opinion on the fact that Petitioner did not specifically relate the onset of her shoulder symptoms to a work-related injury or specific activity. Further, he stated Petitioner did not make any statement of experiencing an exacerbation or worsening of her symptoms as being associated with specific work activities (Respondent's Exhibit 2; Deposition Exhibit 2).

Dr. Paletta opined Petitioner had work/activity restrictions of no repetitive overhead activity or overhead lifting. He also stated Petitioner had a 25 pound lift, push/pull limit from floor to chest. Further, Dr. Paletta stated Petitioner was not at MMI in regard to her left shoulder, but was at MMI in regard to her right shoulder (Respondent's Exhibit 2; Deposition Exhibit 2).

Dr. Feinberg continued to treat Petitioner for her pain symptoms, primarily with injections and medication. As aforestated, Dr. Feinberg's treatment was not limited to the left and right shoulders. Dr. Feinberg treated Petitioner through April, 2016 (Petitioner's Exhibit 4; Deposition Exhibits 2 and 3).

Petitioner was seen by Dr. Sedgwick on February 7, 2014. He apparently reviewed the most recent MRI and opined it revealed leakage of fluid off the anterior portion of the repaired rotator cuff. Dr. Sedgwick advised Petitioner that she should undergo anesthesia with manipulation and anterior capsular release (Petitioner's Exhibit 3; Deposition Exhibit 3).

On March 24, 2014, Dr. Sedgwick performed surgery which consisted of an arthroscopic anterior capsular release and shoulder manipulation and arthroscopic debridement of the humeral head and subacromial space. Following surgery, Dr. Sedgwick continued to treat Petitioner and ordered physical therapy (Petitioner's Exhibit 3; Deposition Exhibit 3).

Petitioner was subsequently seen by Dr. Sedgwick on March 31, 2014, May 6, 2014, July 7, 2014, and September 10, 2014. Dr. Sedgwick noted that Petitioner's symptoms improved; however, in his note of September 10, 2014, he stated that Petitioner's attempt to return to work to an occupation that required a lot of physical work would be extremely difficult for her (Petitioner's Exhibit 2; Deposition Exhibits 3 and 5).

Dr. Sedgwick subsequently saw Petitioner on November 21, 2014. At that time, Dr. Sedgwick discussed Petitioner's job duties with her and determined that there was not a specific injury, but that the symptoms came on gradually. He noted that many of Petitioner's job duties required overhead lifting. He informed Petitioner that her working in a position that required repetitive lifting, pushing or pulling, would aggravate her shoulder symptoms. He did not schedule any further appointments (Petitioner's Exhibit 2; Deposition Exhibit 5).

Dr. Sedgwick was deposed on July 1, 2015, and his deposition testimony was received into evidence at trial. In regard to his diagnosis and treatment of Petitioner's shoulder conditions, Dr. Sedgwick's testimony was consistent with his medical records. In regard to causality, Dr. Sedgwick was provided with a job description which had been prepared by Petitioner. Based upon the assumption that the job description was accurate, Dr. Sedgwick testified that Petitioner's shoulder conditions were caused, contributed to or aggravated by Petitioner's work activities (Petitioner's Exhibit 3; pp 15-16, Deposition Exhibit 4). At trial, Petitioner's testimony in regard to her job duties was consistent with the aforementioned job description that she prepared.

Dr. Sedgwick also testified that Petitioner was off work the entire time he treated her. In regard to restrictions, Dr. Sedgwick stated that Petitioner could not perform work involving repetitive lifting, pushing or pulling with either arm (Petitioner's Exhibit 3; p 12).

On cross-examination, Dr. Sedgwick agreed that Petitioner had more symptoms in her left shoulder even though she was right hand dominant. He also stated that Petitioner was at MMI as of this last visit with her on November 21, 2014 (Petitioner's Exhibit 3; pp 18-19).

Dr. Paletta was deposed on January 21, 2016, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Paletta's testimony was consistent with his medical report and he reaffirmed the opinions contained therein. In regard to causality, Dr. Paletta testified that he could not, within a reasonable degree of medical certainty, state that Petitioner's work activities either caused or contributed to the shoulder conditions. He based this opinion on

the fact that Petitioner did not sustain a specific work injury nor did she specifically relate any exacerbation or worsening of her symptoms with her work activities (Respondent's Exhibit 2; p 29).

In regard to restrictions, Dr. Paletta testified Petitioner did not require any restrictions in regard to her right shoulder. In regard to her left shoulder, Dr. Paletta stated that Petitioner should not perform repetitious overhead activities or lifting overhead. He also imposed a 25 pound lift limit from floor to chest (Respondent's Exhibit 2; pp 30-31).

Dr. Feinberg was deposed on June 1, 2016, and her deposition testimony was received into evidence at trial. In regard to her treatment of Petitioner's shoulder conditions, Dr. Feinberg's testimony was consistent with her medical records. In regard to causality, Dr. Feinberg also reviewed the job description prepared by Petitioner. Based upon that job description, Dr. Feinberg testified that Petitioner's repetitive performance of her job duties could have caused or contributed to the conditions in Petitioner's shoulders. In regard to restrictions as they related to Petitioner's shoulder conditions, Dr. Feinberg stated that Petitioner had a 10 pound lifting restriction, no overhead, pushing, pulling or lifting and no repetitive pushing (Petitioner's Exhibit 4; pp 11-14).

Respondent tendered into evidence the job description prepared by Respondent that was reviewed by Dr. Paletta. The job description was consistent with the job description prepared by Petitioner; however, the job description prepared by Petitioner contained much more detailed information especially regarding the overhead use of her arms.

At trial, Petitioner testified that she has not worked since September 15, 2012. She stated her shoulders still get painful, especially her left shoulder. Petitioner is still able to use her arms, but only for a few hours. Petitioner generally avoids lifting anything that weighs more than five pounds.

Petitioner testified that subsequent to her sustaining the work injury, she had a number of other health problems that were not work-related. Petitioner had four strokes, the earliest of which occurred approximately two years ago. Petitioner had to receive therapy to walk again. Fortunately, Petitioner's speech was not affected.

Conclusions of Law

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

The Arbitrator concludes that Petitioner sustained a repetitive trauma injury to her left and right shoulders arising out of and in the course of her employment for Respondent that manifested itself on August 15, 2012.

In support of this conclusion the Arbitrator notes the following:

Petitioner testified in detail about her job duties, many of which were repetitive and required overhead use of her arms. Petitioner's testimony regarding same was unrebutted.

Petitioner also prepared a detailed job description which was consistent with her testimony at trial. Further, while the job description prepared by Petitioner was more detailed than the one prepared by Respondent, they were consistent.

Petitioner's primary treating physicians, Dr. Sedgwick and Dr. Feinberg, both reviewed the job description prepared by Petitioner and opined that Petitioner's repetitive job duties could have caused or contributed to her shoulder conditions.

Given Petitioner's unrebutted testimony regarding the repetitive nature of her job duties, and the opinions of Dr. Sedgwick and Dr. Feinberg, the Arbitrator is not persuaded by the opinion of Respondent's Section 12 examiner, Dr. Paletta, there was not a causal relationship between Petitioner's work activities and the shoulder conditions.

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 for her left and right shoulder conditions was reasonable and necessary and that Respondent is liable for payment of the medical bills incurred therewith.

Respondent shall pay reasonable and necessary medical services for treatment for Petitioner's left and right shoulder conditions as identified in Petitioner's Exhibit 5, 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 temporary total disability benefits of 109 3/7 weeks commencing October 15, 2012, through November 21, 2014.

In support of this conclusion the Arbitrator notes the following:

Petitioner was being treated by Dr. Sedgwick during the aforestated period of time and he authorized her to be off work. Dr. Sedgwick opined Petitioner was at MMI as of November 21, 2014.

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

The Arbitrator concludes Petitioner has sustained permanent partial disability to the extent of 35% loss of use of the person as a whole.

In support of this conclusion the Arbitrator notes the following:

Neither Petitioner nor Respondent tendered an AMA impairment rating. The Arbitrator gives this factor no weight.

Petitioner's occupation was a janitor. As aforestated, Petitioner's testimony in regard to her work duties was unrebutted. Petitioner's primary treating physicians, Dr. Sedgwick and Dr. Feinberg, as well as Respondent's Section 12 examiner, Dr. Paletta, all imposed work restrictions that would not permit Petitioner to return to work to her job as a janitor. The Arbitrator gives this factor significant weight.

Petitioner was 55 years old at the time of the accident. While Petitioner has other health conditions that contributed to her overall disability, she will have to live with the effects of the work-related injury for the remainder of natural life. The Arbitrator gives this factor moderate weight.

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

Petitioner sustained injuries to both the left and right shoulders. The medical records clearly indicated that the left shoulder was more severely injured than the right. Two surgical procedures were performed on the left shoulder by Dr. Sedgwick. Permanent work restrictions have been imposed by Petitioner's primary treating physicians, Dr. Sedgwick and Dr. Feinberg, as well as by Respondent's Section 12 Examiner, Dr. Paletta. Petitioner's current complaints/symptoms were consistent with the injury she sustained.

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF CHAMPAIGN)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

RANDALL JUDSON,
Petitioner,

vs. No: 11 WC 37566

STATE OF ILLINOIS – DEPARTMENT OF TRANSPORTATION,
Respondent

ORDER

This matter comes before the Commission on Petitioner's petition for penalties pursuant to §19(l) of the Act. A hearing was held before Commissioner Simpson on March 13, 2020 in Urbana, the parties were represented by counsel, and a record was taken.

An Arbitration decision in this matter was issued on July 25, 2012. In the decision, the Arbitrator awarded Petitioner medical expenses incurred to date, 80.625 weeks of PPD representing loss of 37.5% of Petitioner's left leg, and ordered "Respondent to reimburse Medicare/MSPRC for amounts due and owing in this matter consistent with the notification from MSPRC dated June 6, 2012 with attachments appended thereto. The respondent shall hold the Petitioner harmless with respect to reimbursement due and owing to MSPRC." Neither party sought review of the Decision of the Arbitrator.

Petitioner submitted correspondence from MSPRC dated June 6, 2012, with which was attached the original documentation dated May 10, 2010 outlining about $20,000 in medical payments made on Petitioner's behalf. The original document has the heading in bold, capital type "**THIS IS NOT A BILL. DO NOT SEND PAYMENT AT THIS TIME.**" Petitioner submitted a similar correspondence from MSPRC dated February 8, 2019, titled "**CONDITIONAL PAYMENT NOTICE**" which includes the same notice not to send payment. The letter also includes language asking that no payment be sent because the amount might not be final to avoid possible overpayment or underpayment. Petitioner forwarded this correspondence to Respondent. Even with the aforementioned language Respondent sent it to the third party administrator which issued a draft for the amount specified. Thereafter, on March 14, 2019, MSPRC sent Petitioner correspondence which was deemed a final request for payment in an amount less than that noted in the February 8th letter. Respondent reissued a check in the new amount on March 21, 2019.

Petitioner argues that he sent Respondent demand letters on August 2, 2012 and August 14, 2012, seeking advise on when payments for the awards would be issued. Respondent replied that it sent payment for the PPD award on August 16, 2012. In addition, Respondent asserted that it paid medical bills which it received after the award was entered. Finally, Respondent noted that it did not receive any notification from MSPRC or Petitioner from 2012 to 2019. Petitioner did not dispute any of these assertions. Nevertheless, Petitioner argues that he is entitled to penalties for unreasonable delay in payment of reimbursement to MSPRC because the delay was in violation of the Arbitrator's order and federal law.

The Commission does not find that any delay in reimbursing MSPRC to be unreasonable. First, Petitioner's letters in August 2012 do not really constitute a demand for payment of reimbursement to MSPRC. Rather, they were simply routine follow up letters after the finality of the Arbitrator's order asking when payment of the award could be expected. Clearly, Respondent was neither late nor recalcitrant to reimburse MSPRC at that time. Second, Respondent paid the PPD award immediately upon the query from Petitioner's lawyer showing overall good faith. Third, Respondent simply followed the instructions from MSPRC to not pay because the calculations might not yet be final. Therefore, any delay in reimbursement was the result of the actions of MSPRC and not Respondent. Finally, Petitioner has not established that he suffered any prejudice from any alleged delay in reimbursement to MSPRC. Therefore, Petitioner's petition for penalties pursuant to §19(l) is denied.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Petitioner's petition for penalties pursuant to §19(l) of the Act is denied.

DATED: JUN 19 2020

Deborah L. Simpson

Barbara N. Flores

Marc Parker

DLS/dw
R-3/13/20
46

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Maricela Silva,
Petitioner,

vs.

Team Concept Printing,
Respondent.

20IWCC0339

NO: 15 WC 24934

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, bills, temporary disability and permanent disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 30, 2019, is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $39,400.00. 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: o5/21/20
DLS/rm
046

JUN 19 2020

Deborah L. Simpson

Barbara N. Flores

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION

NOTICE OF ARBITRATOR DECISION

CORRECTED

20IWCC0339

SILVA, MARICELA
Employee/Petitioner

Case# **15WC024934**

TEAM CONCEPT PRINTING
Employer/Respondent

On 7/30/2019, 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 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:

6238 LAW OFFICE OF LAURA A CHILDS
650 WARRENVILLE RD
SUITE 100
LISLE, IL 60148

2837 LAW OFFICES JOSEPH MARCINIAK
BRENT HALBLEIB
200 W MADISON ST SUITE 500
CHICAGO, IL 60606

20IWCC0339

20IWCC0339

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
CORRECTED ARBITRATION DECISION

Maricela Silva
Employee/Petitioner
v.
Team Concept Printing
Employer/Respondent

Case # **15** WC **24934**

An *Application for Adjustment 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 M. Ory**, Arbitrator of the Commission, in the city of **Wheaton**, on **November 16, 2018.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **January 26, 2015,** Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$29,205.00**; the average weekly wage was **$603.41**

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

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

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

To date, Respondent has paid **$0** in TTD and/or for maintenance benefits, and is entitled to a credit for any and all amounts paid.

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

Respondent is entitled to a credit of **$8,254.55 (for medical expense only)** under Section 8(j) of the Act.

ORDER

Medical Benefits

Respondent shall pay the sum of **$31,529.95** for medical bills in accordance with the fee schedule, §8 and §8.2 of the Act, with credit to be given for any payments made through the group insurance pursuant to §8 j of the Act.

Temporary Total Disability

Respondent shall pay temporary total disability benefits from **July 29, 2015 to October 11, 2015,** which is **10-5/7 weeks** at the rate of **$402.27 per week.**

Permanent Disability

Petitioner is entitled to **32.25** weeks' permanent partial disability, at **$362.05** per week, as petitioner's permanent disability has resulted in **15% loss of use of the right leg under §8 (e) 12 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.

Christine M Ory

Signature of Arbitrator

July 30, 2019

Date

JUL 30 2019

20 IWCC0339

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Maricela Silva	)
Petitioner,	)
vs.	) **No. 15 WC 24934**
Team Concept Printing	)
Respondent.	)
	)

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

This matter proceeded to hearing in Wheaton on November 16, 2018. The parties agree that on January 26, 2015, 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 and that petitioner gave timely notice of the claimed accident. The parties agree petitioner earned $29,205.00 in the year predating the accident and that her average weekly wage, calculated pursuant to §10, was $603.41.

At issue in this hearing is as follows:

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

STATEMENT OF FACTS

The Petitioner does not speak English; her native language is Spanish. She testified with the assistance of Anabel Mendoza, a certified interpreter, qualified to translate Spanish to English and English to Spanish. After being duly qualified and accepted by both parties, Ms. Anabel Mendoza served as an interpreter for the petitioner.

Petitioner, Maricela Silva, Testimony

Petitioner, now 56 years old, was hired by respondent in 2001. She worked at respondent's location on Tower Boulevard in Carol Stream. She quit her employment with respondent in March, 2016. In January, 2015 she was working in quality control and packing. Her shift was from 5:00 A.M. to 1:00 P.M.

On January 26, 2015, she arrived at work at 4:45 AM. She parked in the back of the building as instructed. Her supervisor, Arturo, had instructed her to enter in the back as that is where the employees had to park due to the fact that the main entry in the front was closed at that time; it did not open until 7 AM.

Petitioner identified photos identified as Petitioner's Exhibits 1A through 1E. Petitioner's Exhibit 1E depicted the only door open at the time petitioner arrived. Petitioner testified it had snowed about one half inch, but it was not snowing at the time. As she got to sidewalk, her right leg slipped and she fell. She hit her right knee and fell onto her elbow. The right knee was hurting a lot. She walked inside and did not tell anyone, even though her knee was hurting a lot and she was walking crippled. She started to work. A man saw her walking crippled and asked what happened. Bob, the supervisor arrived at 7 AM. Mike Stone also arrived at that time and she told him what had happened. She said she slipped and hurt knee and couldn't work. He told me to ice it. Petitioner agreed to wait until the next day to go to the clinic as she thought it wasn't serious.

She testified the area was icy with snow on top. By the end of her shift that day, the sidewalk had been salted and cleared. The following day, she completed the report identified as Petitioner's Exhibit 2. The top part was in her handwriting; the rest was filled in by Mike Stone. She asked to got to the clinic. She was sent by Stone to Occupational Health in Bloomingdale. She followed up twice with Occupational Health. At the last visit, she was given a paper to obtain a MRI. The date of accident listed in the body of the record from Occupational Health as January 27, 2015, is incorrect.

She confirmed she received a denial letter from Hartford (PX.4). After that, she saw her primary care physician, Dr. Hurst, which was on February 20, 2015. Dr. Hurst recommended she see orthopedic surgeon, Dr. Julio Gonzalez. She saw Dr. Gonzalez on February 23, 2015. She had pain and swelling; Dr. Gonzalez recommended an MRI, brace and anti-inflammatory. She did not return to Dr. Gonzalez until June, 2015 due to insurance issues. She saw Dr. Gonzalez on June 23, 2015. She had an MRI on July 2, 2015. She then saw Dr. Kevin Walsh, who recommended surgery, which he performed at Central DuPage Hospital on July 29, 2015.

Petitioner testified the doctors at Occupational Health recommended alternate sitting and standing. She agreed she did her normal job on January 27, 2015.

Petitioner testified that her knee continues to hurt and gets swollen. She has a hard time walking. She has to put ice on and take a pill for pain.

On cross examination, she denied she told the doctors at Cadence Occupational Health that she had bruised her knee three days before when she struck her bed.

Petitioner confirmed Stone signed the form in her presents on the same day.

She is currently self-employed cleaning offices three to four hours per day, four days a week. She testified that approximately once a week she takes a pain pill.

She testified she did not park in front before January 26, 2015 accident. However, after she returned to work in October, 2015, as she was on a different shift that started at 7 AM, she came in the front. She confirmed the only door open at 5 A M was in the rear lot.

Michael Stone Testimony

Michael Stone, production manager for respondent for the last six or seven years, was called by respondent to testify. He had been employed by respondent for 12 years. On January 26, 2015, he was employed as respondent's finishing manager; responsible for ten employees.

He confirmed petitioner reported injury and he completed the paper work. He confirmed the report of injury was completed by petitioner; he only signed and dated the form.

He confirmed he used to come in the back when working as the finishing manager. He agreed the front service door, identified as Respondent's Exhibit 5, was not open until 6 A.M.

He thought the front and back door were on a simultaneous system whereby both would open at the same time. Stone agreed that if they tried to enter through the front door before 6 A.M., then you had to knock on the door to let be let in.

William Schweinberg Testimony

William Schweinberg, employed by respondent since July 3, 2004, testified in behalf of respondent. In January, 2005 was a press operator. He confirmed he had to be to work by 5 A.M. On cross-examination, he agreed they were instructed not to park in the front.

Joan Segon Testimony

Joan Segon, employed by respondent for eighteen years as executive assistant human resource manager; which is the same positon she held in January, 2015. She did not fill out forms. She provided the photos identified as Respondent's Exhibits 5 through 17.

Photos (PX.1)

PX.1A and PX.1B depicts respondent's main entrance.

PX.1C depicts the entrance to another business. Petitioner testified she parked her vehicle to enter the service entrance.

PX.1D depicts respondent's garage door that was not open when petitioner arrived.

PX.1E Petitioner identified the spot with an "X" as the location where she fell on January 26, 2015.

Occupational Injury/Illness Report (PX.2 and RX.4)

Petitioner completed the report of her accident on January 27, 2015 indicating she fell on January 26, 2015 at 4:50 P.M. on the sidewalk that was icy and covered in snow.

Cadence Occupational Health Visit Summary for Employer Reports (PX.3)

Petitioner was seen on January 27, 2015, February 3, 2015 and February 10, 2015 for a contusion to right knee after slipping on sidewalk at work on February 26, 2015. A MRI was ordered.

Hartford February 17, 2015 Denial Letter (PX.4)

The respondent's insurance carrier advised petitioner on February 17, 2015 that her claim was denied as it was determined her accident did not arise out of and in the course of her employment.

DuPage Medical Group Records (PX.5)

The records include treatment for shoulder and cervical problems in addition to treatment to her right knee.

The treatment to her right knee included February 20, 2015 X-rays as ordered by Dr. Hurst, February 23, 2015 visit with Dr. Julio Gonzalez, who ordered a MRI. Petitioner did not return for further treatment until June 23, 2015 with Dr. Gonzalez; at which time an MRI was again ordered.

She was then referred to Dr. Kevin Walsh on July 15, 2015 for surgery after the MRI showed a torn medial meniscus. Surgery was scheduled for July 29, 2015 at Central DuPage Hospital. She had an August 4, 2015 post-op visit with Dr. Walsh. He released petitioner to return

to work on August 13, 2015, with restrictions. If the restrictions were not accommodated, petitioner was to remain off work.

At the August 25, 2015 visit, petitioner continued to complain of pain. Dr. Walsh reported petitioner had a complex tear of the anterior horn of the lateral meniscus with minimal degenerative changes. Formal physical therapy was ordered. Dr. Walsh believed petitioner could return to work in mid-September, 2015. As of November 3, 2015 Dr. Walsh reported she had good motion and strength, with no effusion or instability in the right knee.

Dr. Kevin Walsh Disability Note (PX.6)

Dr. Walsh had petitioner off from July 29, 2015 to August 10, 2015.

Northwestern Medical Records (PX.7)

Petitioner underwent right knee arthroscopy with partial lateral meniscectomy for degenerative tear, anterior horn of the lateral meniscus.

Dr. Kevin Walsh Disability Note (PX.8)

Dr. Walsh released petitioner to return to work on October 12, 2015 without restrictions.

Athletico Physical Therapy Records and Bills (PX.9)

Petitioner received physical therapy to her right knee from August 27, 2015 to October 16, 2015.

Medical Bills (PX.10)

Petitioner submitted medical bills (the DuPage Medical bills not included in the list were those unrelated to the work injury to the right knee)

$12,301.00 Athletico Physical Therapy (08/27/ 2015 to 10/16/2015.)
$3,014.00 DuPage Medical Group/Dr. Walsh (07/29/2015-surgery)
$157.00 DuPage Medical Group/Dr. Walsh (11/03/2015-right knee follow up)
$1,573.00 DuPage Medical Group (07/02/2015-MRI right knee)
$12,531.09 Northwest Medicine/Central DuPage Hospital (07/29/2015)
$927.00 Medac Anesthesia Partners (Anesthesia 07/29/2015)
$1,026.86 Northwestern Med. Occ Health /Cadence (01/27/2015-02/10/2015)

Petitioner's Out of Pocket Expenses (PX.11)

Petitioner claims a total of $100.00 out of pocket expenses.

Petitioner's Attorneys' Claimed Expenses (PX.12)

Petitioner's attorney claims $227.04 in expenses.

Translation Services Costs (PX.13)

Costs for translation services.

Respondent's Lease for Building (PX.14)

Respondent's lease with building owner called for respondent to maintain the property, including snow removal.

Cadence Occupational Health Records (RX.1)

These records are all inclusive of the treatment to petitioner on January 27, 2015, February 3, 2015 and February 10, 2015 visits, not just the Visit Summary for Employer Reports identified as Petitioner's Exhibit 3, these records include mention of the fact that petitioner's right knee showed a bruise on February 3, 2015 that she reported was from striking it on her bed.

Arial Photo of Respondent's Property (RX.2)

Petitioner identified the location of her fall with an "X" in the lower right side of the building as the location of where she fell.

Lease Covenants Agreements (RX.3)

This is contained in Petitioner's Exhibit 14.

Photo of Front Service Door (RX.5)

This was identified as respondent's front service door.

Photos of Respondent's Building (RX.6-17)

These photos are of various angles of respondent's building; both inside and out. Petitioner identified Respondent's Exhibit 8 as the door she entered on January 26, 2015.

CONCLUSIONS OF LAW

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

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

The spot where petitioner claimed to have fallen on January 26, 2015 was leased and maintained by respondent, which included snow removal. There was a dispute as to whether petitioner could or should have entered respondent's premises through the front door, or whether she had to enter in the back, where she fell. The evidence indicates the front door was locked at the time petitioner arrived at work. There was evidence petitioner was instructed to park in the rear. The fact remains, petitioner was on respondent's premises when she slipped and fell. Therefore, the Arbitrator finds petitioner was in the course of her employment at the time of her fall.

As to whether the accident arose out of petitioner's employment with respondent, the unrefuted testimony was that petitioner slipped on respondent's snow covered icy sidewalk. This is an area, according to the lease, that respondent was to maintain; which included snow removal. This was not a natural accumulation, as the snow covered ice. Therefore, the Arbitrator finds petitioner was exposed to a risk greater than the general public and that her accident arose out of her employment with respondent.

Based upon the foregoing, the Arbitrator finds petitioner sustained injuries to her right knee that arose out of and in the course of her employment with respondent on January 26, 2015.

F. With respect to the issue of whether the petitioner's condition of ill-being is related to the injury, the Arbitrator makes the following conclusions of law:

The records of Northwestern Medicine/CDH confirm petitioner complained of right knee pain of five years' duration on January 14, 2014, which was diagnosed as a baker's cyst. She received no further treatment to her right knee until January 27, 2015, the day after her work accident.

As of January 27, 2015, all treatment received from Cadence Occupational Health and from DuPage Medical Group, which included Dr. Hurst, Dr. Gonzalez and Dr. Walsh to her right knee all related back to the work accident of January 26, 2015. Dr. Walsh reported petitioner had a complex tear of the anterior horn of the lateral meniscus with minimal degenerative changes for which petitioner underwent arthroscopic surgery.

Based upon petitioner's testimony and the medical records, the Arbitrator finds petitioner's condition of a complex tear of the anterior horn of the lateral meniscus was caused by the work accident of January 26, 2015.

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

Respondent did not put forth any defense to the reasonableness or necessity of the medical treatment. The Arbitrator, having determined petitioner's work accident arose out of and in the course of her employment with respondent and determined there was a causal connection of petitioner's condition of her right knee to the work accident, awards the following bills in accordance with the fee schedule, as well as in accordance with §8 and §8.2 of the Act, with credit to be given for any payments made pursuant to §8 j of the Act:

$12,301.00 Athletico Physical Therapy (08/27/ 2015 to 10/16/2015.)
$3,014.00 DuPage Medical Group/Dr. Walsh (07/29/2015-surgery)
$157.00 DuPage Medical Group/Dr. Walsh (11/03/2015-right knee follow up)
$1,573.00 DuPage Medical Group (07/02/2015-MRI right knee)
$12,531.09 Northwest Medicine/Central DuPage Hospital
$927.00 Medac Anesthesia Partners (Anesthesia 07/29/2015)
$1,026.86 Northwestern Med. Occ Health /Cadence (01/27/2015-02/10/2015)

K. With respect to the Arbitrator's decision with regard to temporary total and temporary partial disability, the Arbitrator makes the following conclusions of law:

The evidence supports a finding that petitioner was disabled from July 29, 2015 to October 11, 2015, and awards temporary total disability for this period, which is 10-5/7 weeks at the rate of $402.27 per week.

L. In support of the Arbitrator's decision with regard to the nature and extent of petitioner's injury, the Arbitrator makes the following conclusions of law:

Petitioner sustained a torn complex tear of the anterior horn of the lateral meniscus with minimal degenerative changes for which she underwent arthroscopic surgery.

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:

With regard to subsection (i) of §8.1b (b) the Arbitrator notes that there was no permanent partial disability impairment rating provided. The Arbitrator, therefore, cannot give any weight to this factor.

With regard to (ii) of §8.1b (b) the occupation of the injured employee, the Arbitrator notes petitioner was employed in quality control and packing. The injury did not affect petitioner's ability to perform her job. Therefore, the Arbitrator gives no weight to this factor.

With regard to (iii) of §8.1b (b) the age of the employee at the time of the injury was 52 years of age. The Arbitrator gives some weight to this factor.

With regard to (iv) of §8.1b (b) the employee's future earning capacity, the Arbitrator notes petitioner was capable of returning to her usual employment with respondent without a loss of earning capacity. The Arbitrator, therefore, gives no weight to this factor.

With regard to (v) of §8.1b (b) evidence of disability corroborated by the treating medical records, the Arbitrator notes that as of November 3, 2015, Dr. Walsh reported petitioner had good motion and strength, with no effusion or instability of the right knee. The Arbitrator gives little weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds Petitioner sustained permanent partial disability to the extent of 15% loss of use of the right leg pursuant to §8(e)12 and awards 32.25 weeks of permanent partial disability at the rate of $362.05 per week.

M. With respect to the issue of whether penalties or attorneys' fees should be imposed upon respondent, the Arbitrator makes the following conclusions of law:

Although the evidence was sufficient to support petitioner's overall claim, the fact that there were questions: as to whether petitioner was entering respondent's premises at the proper location; whether petitioner suffered another injury when she reportedly bumped her right knee at home after the work accident; and the lack of clear cut medical opinions as to the causal connection of petitioner's right knee condition and the work accident, the Arbitrator finds respondent's actions were not unreasonable or vexatious and denies the claim for penalties and attorneys' fees.

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

Pedro San Miguel,
Petitioner,

vs.

Ford Motor Company,
Respondent.

20IWCC0341

NO: 15 WC 3193

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, bills, temporary disability and permanent disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 4, 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.

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: JUN 19 2020
o5/21/20
DLS/rm
046

Deborah L. Simpson

Deborah L. Simpson

Barbara N. Flores

Marc Parker

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

20IWCC0341

SAN MIGUEL, PEDRO
Employee/Petitioner

Case# **15WC003193**

FORD MOTOR COMPANY
Employer/Respondent

On 3/4/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

1067 ANKIN LAW OFFICE LLC
SCOTT G GOLDSTEIN
10 N DEARBORN ST SUITE 500
CHICAGO, IL 60602

0560 WIEDNER & McAULIFFE LTD
DANIEL A BRIANARD
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

20 IWCC0341

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

Pedro San Miguel,
Employee/Petitioner

v.

Ford Motor Company,
Employer/Respondent

Case #: **15 WC 03193**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Robert M. Harris**, Arbitrator of the Commission, in the city of ***Chicago***, on ***January 3, 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 *12/22/14*, 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*** given to Respondent.

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

In the year preceding the injury, Petitioner earned ***$44,496.40***; the average weekly wage was ***$855.70***.

On the date of accident, Petitioner was *37* years of age, ***married*** with *2* dependent children.

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

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

Respondent shall be given a credit of ***$1,611.12*** for TTD, ***$0.00*** for TPD, ***$0.00*** for maintenance, and ***$0.00*** for other benefits, for a total credit of ***$1,611.12***.

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

ORDER

Petitioner failed to prove he sustained an accident that arose out of and in the course of his employment. The Arbitrator further finds Petitioner failed to prove his current condition of ill-being is causally connected to his employment duties. Accordingly, all claims for compensation are therefore denied.

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

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

Robert M. Harris

Signature of Arbitrator Robert M. Harris

March 4, 2019
Date

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

As of December 22, 2014, Petitioner was a 37-year-old married male with two dependents under 18. AX2. By that time, Petitioner had worked as an Assembler at Ford's Chicago Assembly Plant since 2010. T13-14. Petitioner testified that in December of 2014, he was performing a "build up" job. T15. This required him to lift two parts from one rack and place into a wielding machine which would weld the parts together into an "L" shape. T15-18. Petitioner estimated the final piece weighed about five pounds. T16. He would then take the finished parts and load them onto a rack. T17. Petitioner estimated that he performed this duty about 600 times each shift. T16.

Petitioner testified that in December of 2014, he began to feel dull to sharp pain in his low back when performing this duty. T23. He testified that he initially worked through the pain but ultimately sought treatment at PRO Clinics on December 22, 2014. T24.

Dr. Abdellatif of PRO Clinics evaluated Petitioner on December 22, 2014. PX 2, PX3 and PX4, some in PX 6. At that time, Petitioner complained of constant lumbar pain and reported performing various jobs and incidents at work with increasing pain over the past year. The doctor noted Petitioner had no history of low back pain prior to the date of injury; however, no date of injury was listed on the report. Dr. Abdellatif assessed Petitioner with lumbar facet syndrome, lumbar radiculopathy, and myofascial pain. Physical therapy, medications, an MRI, and an EMG were recommended. The doctor recommended light duty work but did not delineate any particular work restrictions. PX2. No accident opinion or causation opinion is mentioned.

On January 22, 2015, a lumbar MRI was performed and read by the radiologist to show: (1) mild abnormal anterolisthesis at L5-S1 with likely spondylosis and spondylolisthesis; (2) a disc herniation at L5-S1; and (3) a disc protrusion at L4-5 with mild bilateral foraminal narrowing. PX1. An EMG was performed on January 26, 2015 and was opined to show evidence of radiculitis affecting L4-S1 bilaterally. PX2.

After reviewing the studies with Petitioner on January 17, 2015, Dr. Abdellatif recommended a lumbar epidural injection, lumbar facet injections, physical therapy, medications, and potential trigger point injections. Petitioner could continue working light duty. PX2

On January 22, 2015, Dr. Abdellatif again examined Petitioner. Continued physical theory was recommended. PX 2. No accident opinion or causation opinion is mentioned.

On January 26, 2015 chiropractor Carlos Halwaji performed an EMG/NCV of the lumbar spine and wrote a report. PX2. The electrodiagnostic findings reveled a radiculitis affecting the L4-S1 bilaterally. There is noted a history of Petitioner's complaints while he is working but no history regarding any accident or injury. No accident opinion or causation opinion is mentioned.

On February 18, 2015, Dr. Abdellatif performed trigger point injections and lumbar medial branch blocks at L3-S1 bilaterally. An epidural injection was also performed at L4-5. PX2. No accident opinion or causation opinion is mentioned in any of the four separate records regarding multiple procedures performed on that date.

Petitioner reported a 40% improvement in his pain to Dr. Abdellatif on February 26, 2015. A second serious of lumbar injections along with physical therapy and medications were recommended. In the meantime, Petitioner could work light duty with no standing or sitting for more than two hours continuously. PX2 No accident opinion or causation opinion is mentioned.

On March 6, 2015, Dr. Abdellatif performed a radiofrequency ablation procedure bilaterally at L4-S1. An epidural injection was also performed at L4-5 on this date. PX2. The post-operative diagnosis was "degenerative disc disease, lumbar facet syndrome, herniation disc, lumbar (*sic*). No accident opinion or causation opinion is mentioned in any of the four separate records regarding multiple procedures performed on that date.

On March 16, 2015, Petitioner returned to Dr. Abdellatif and reported 60% improvement in his pain from the treatment. Petitioner continued to complain of increased pain at the end of his work shift. The doctor recommended physical therapy and additional injections. In the meantime, Petitioner could work light duty with no standing for over two hours continuously. PX2. No accident opinion or causation opinion is mentioned.

Dr. Abdellatif evaluated Petitioner again on April 9, 2015. Under the section of "Chief Complaint" Petitioner reported pain more so at towards the end of work due to continuous movement throughout the day. A third epidural injection was recommended along with work conditioning followed by an FCE. In the meantime, the doctor ordered Petitioner off work. PX2. No accident opinion or causation opinion is mentioned.

On April 16, 2015, Dr. Abdellatif performed epidural injections bilaterally at L4-S1. PX2. No accident opinion or causation opinion is mentioned in any of the four separate records regarding multiple procedures performed on that date.

An FCE was performed on April 20, 2015 at AMCI. PX 5. The FCE stated that Petitioner's job was classified in the medium physical demand level. The FCE found Petitioner able to work in the medium physical demand level but recommended limiting constant repetitive lifting to no more than eight pounds. PX5. **The FCE indicates an "Injury History" of a "work related accident onset 08/13/2013."** The FCE was performed by "Dr. Dale Hooton, D.C.", apparently a chiropractor.

Petitioner was reevaluated by Dr. Abdellatif on April 28, 2015 after his third injection. The doctor noted that Petitioner's pain and range of motion had improved by about 80% following treatment to include physical therapy, medications, and the injections. The doctor recommended a surgical consultation, consideration for trigger point injections, further therapy, and for Petitioner to take pain medications. Dr. Abdellatif released Petitioner to work according to the FCE. PX2. Petitioner testified that he did not engage in physical therapy. T35. No causation opinion is mentioned.

Respondent arranged a Section 12 examination with Dr. Kevin Walsh of DuPage Medical Group Bone, Joint & Spine Center. Petitioner was examined on May 7, 2015 and a report was issued dated May 9, 2015. Dr. Walsh recorded Petitioner's history of a specific, acute work-related event occurring on August 13, 2013 when he struck his lumbar spine on a rack. Petitioner told Dr. Walsh he never got better and he denied any other injury. Petitioner finally sought treatment form Dr. Abdellatif in December 2014. When asked to explain how his problem began, Petitioner "now reports his problem is due to repetitive motion over time." Dr. Walsh reviewed medical records which are summarized in his report. Dr. Walsh noted that one report dated April 25, 2014 regarding a visit to Respondent's medical clinic indicates Petitioner "reported lifting stick from a bin to a table, and when doing that he got sharp pain in his lower back." Dr. Walsh also noted Petitioner was seen again on December 10, 2014 requesting heat for a stiff back. Dr. Walsh opined that Petitioner's physical examination "has a paucity of objective abnormalities." Dr. Walsh opined that Petitioner sustained a contusion type injury in two separate work incidents on August 17, 2013 and April 25, 2014 (neither of which an Application for Adjustment of claim was filed). Dr. Walsh opined Petitioner had degenerative disc disease throughout his lumbar spine, specifically at L5-

S1. Dr. Walsh opined Petitioner has degenerative disease in his lumbar spine and neither of the injuries at work (8/17/2013 and 4/25/2014) caused the degenerative disease nor is it likely that the patient's report of repetitive motion over time caused the degenerative disease in his lower back; more likely than not, this is simply a degenerative process, probably not caused by "repetitive motion over time." Dr. Walsh also opined that the care provided by Dr. Abdellatif "was due to degenerative change, not caused, aggravated, or accelerated by the patient' work-related events." Dr. Walsh further opined that such was more likely than not simply a degenerative process not caused or related to any work incidents or repetitive motions over time. Dr. Walsh opined that all of the treatment engaged in was not causally related to Petitioner's employment. Dr. Walsh opined Petitioner was able to work full duty. RX1. Petitioner offered no expert medical opinion to challenge Dr. Walsh's opinions.

On June 8, 2015, Dr. Abdellatif again examined Petitioner and noted he made the same complaints about his back pain. The report noted Petitioner "continues to work despite initial improvement with procedures." The doctor recommended Petitioner consider a surgical consultation, trigger point injections, a CT scan, a discogram, undergo therapy, and take medications. Petitioner was able to work within the restrictions set forth by the FCE. PX2. No causation opinion is mentioned.

On July 13, 2015, Dr. Abdellatif again examined Petitioner. The notes indicated were nearly identical form those of June 8, 2015 aside from physical therapy and medications to be considered as needed. PX2. No causation opinion is mentioned.

Dr. Abdellatif re-evaluated Petitioner again on August 17, 2015. Petitioner complained of continued pain with numbness and occasional weakness into his legs. Dr. Abdellatif recommended that Petitioner continue physical therapy, be evaluated by a spinal surgeon, and return to work according to the FCE. PX1. No causation opinion is mentioned.

Petitioner testified he returned to work out of financial necessity after August 17, 2015. T28. However, there was also testimony from Petitioner wherein he could not recall when he returned to work or did not work. T40-41. Petitioner testified that he continues to work in the same capacity at Ford. T30-31. Petitioner testified that he continues to have low back pain while working but works through the pain. He testified that he undergoes injections to his back every 45 days and takes daily pain medications to include Norco. T30.

CONCLUSIONS OF LAW

As to issue C, whether Petitioner sustained an accident that arose of and in the course of his employment with Respondent on December 22, 2014, and issue F, whether Petitioner's current condition of ill-being is causally connected to the claimed injury, the Arbitrator finds and concludes as follows:

The Arbitrator incorporates the findings of facts indicated above into this Section.

The Arbitrator finds and concludes Petitioner failed to meet his burden of proof that he sustained accidental injuries arising out of and in the course of his employment with Respondent on December 22, 2014 and further finds and concludes Petitioner failed to meet his burden of proving his current condition of ill-being is causally-related to his employment and the claimed accident of December 22, 2014.

The Arbitrator notes this claim was specifically presented and tried under a theory of repetitive trauma - even though the evidence suggests Petitioner likely sustained two minor accidents while working for Respondent on dates different than, and prior to, the claimed December 22, 2014 accident date, namely, 8/17/2013 and 4/25/2014. However, Petitioner did not claim 8/17/2013 or 4/25/2014 as the accident dates, or pursue benefits connected with either date, but rather asserted that December 22, 2014 is the accident date, or, more accurately, the "manifestation date." That would be the date on which the connection between Petitioner's physical condition and his employment became apparent to Petitioner (a "reasonable person").

However, the records in evidence are absent any evidence that either Petitioner or his treating physician Dr. Abdellatif made this connection on December 22, 2014, when Petitioner first visited him for treatment. **Dr. Abdellatif's notes for that date are completely silent on this issue,** thereby leading to the conclusion that neither party made that necessary connection in order for December 22, 2014 to be deemed a proper "manifestation date." **In fact, Dr. Abdellatif never offered any opinion, at any time, that any date was the "manifestation date", nor did he offer any opinion, at any time, that causation exists between Petitioner's condition and his employment.**

The law regarding establishing causation in repetitive trauma claims is clear: Petitioner must prove by a preponderance of the credible evidence that he sustained an injury that arose out

of and in the course of his employment. *Hannibal, Inc. v. Ind. Comm'n.*, 38Ill. 2d 473 (1967). Petitioner also carries the burden of proving by a preponderance of the evidence that his current condition of ill-being is causally related to his employment. *Baldwin Assoc v. Industrial Comm'n.*, 232 Ill. App. 3d 928 (4th Dist. 1992).

However, and very significant, the Arbitrator emphasizes that **when a Petitioner alleges a *repetitive trauma* theory of injury, the Commission *requires* that medical evidence of causation be proffered.** *Russell v. Ruth Staffing*, 03 IIC 0034 (2003); *Gora v. Dept. of Transporation*, 05 IWCC 091 (2005); *Tokar v. All Town*, 07 IWCC 0621 (2007); *Selburg v. Peoria Ear, Nose & Throat*, 09 IWCC 0507 (2009). If no causation opinion is proffered, then Petitioner fails to meet his burden of proof as **the Commission has consistently held that causation between repetitive work duties and injuries requires sufficient expert testimony**. *Nunn v. Industrial Comm'n.*, 157 Ill.App.3d 470, 478 (4th Dist. 1987). The Appellate Court in *Nunn* held:

> **Although medical testimony as to causation is not necessarily required, where the question is one within the knowledge of experts only and not within the common knowledge of lay persons, expert testimony is necessary to show that claimant's work activities caused the condition complained of ... This is especially true in repetitive trauma cases. In a repetitive trauma case, there must be a showing that the injury is work related and not the result of a normal degenerative aging process.**

Nunn, at 470.

Here, the Arbitrator also emphasizes that this claim is a repetitive trauma claim, and therefore the question of causation is one within the knowledge of experts only and not within the common knowledge of lay persons. Therefore, expert testimony is necessary to establish causation. **The Arbitrator emphasizes that Petitioner offered no necessary expert testimony or opinion here** (while Respondent, on the other hand, did, offering persuasive rebuttal evidence). Petitioner's failure to offer any necessary expert testimony is a fatal deficiency.

Petitioner testified that his pain developed gradually from working at Ford and asserted a manifestation of December 22, 2014, which is when he first sought outside medical treatment. Petitioner's testimony and the histories contained in the medical records only provide a history that Petitioner experienced pain while working – and on dates not offered as the date of accident – and not any necessary expert opinion that such pain had a causal nexus to his employment. As

noted above, Petitioner has the burden of proof to show that his work activities caused or aggravated his medically diagnosed conditions of lumbar degenerative disc disease, facet/SI syndrome, lumbar radiculopathy, and myofascial pain, all of which he claimed were due to "repetitive trauma." Petitioner must present expert testimony in the form of a causation opinion from a physician in order to meet his burden of proof. **Petitioner's testimony, standing alone, no matter how detailed or otherwise credible, is legally insufficient to prove causation in a repetitive trauma claim.**

There is no medical evidence in the record drawing such a connection between Petitioner's condition and his employment with Respondent. Rather, the only expert medical evidence opinions in the record regarding causation are those found in Dr. Walsh's Section 12 report which disputes causation between Petitioner's lumbar condition and his work duties. **The Arbitrator notes Dr. Walsh's Section 12 report was admitted into evidence without objection; therefore, Dr. Walsh's opinions remain both unchallenged and unrebutted.** Conditions as complex such as those Petitioner alleges require more than Petitioner merely testifying that he noticed symptoms after performing certain job duties in order to meet his burden of proof.

Accordingly, as Petitioner failed to proffer any causation opinion (or any other expert medical opinion on his behalf) he therefore failed to meet his burden of proof as to accident and causal connection. Accordingly, all compensation must be denied.

As to issue J, whether the medical services that were provided to Petitioner reasonable and necessary, the Arbitrator finds as follows:

As accident and causation are denied, this issue is moot.

As to issue K, whether Petitioner is owed any TTD benefits, the Arbitrator finds as follows:

As accident and causation are denied, the TTD issue is moot.

As to issue L, the nature and extent of Petitioner's injuries, the Arbitrator finds as follows:

As accident and causation are denied, all other issues are moot.

Robert M. Harris

Arbitrator Robert M. Harris

Dated: March 4, 2019

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

Timothy Ligon,

Petitioner,

20IWCC0340

vs.

NO: 18 WC 8414
18 WC 8401

Eurest,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §8(a) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses and permanent disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. 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 16, 2019, is hereby affirmed and adopted.

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

20IWCC0340

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $50,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUN 19 2020
o6/4/20
DLS/rm
046

Deborah L. Simpson

Deborah L. Simpson

Barbara N. Flores

Marc Parker

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

8 (A)

20 IWCC0340

LIGON, TIMOTHY
Employee/Petitioner

Case# **18WC008414**

18WC008401

EUREST
Employer/Respondent

On 8/16/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.89% 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:

1824 STRONG LAW OFFICES
SEAN D OSWALD
3100 N KNOXVILLE AVE
PEORIA, IL 61603

2593 GANAN & SHAPIRO PC
DRU A DENNIS
411 HAMILTON BLVD SUITE 1006
PEORIA, IL 61602

20IWCC0340

20 IWCC0340

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
8(A)

Timothy Ligon
Employee/Petitioner

v.

Eurest
Employer/Respondent

Case # **18** WC **008414**

Consolidated cases: **18 WC 008401**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Seal**, Arbitrator of the Commission, in the city of **Bloomington**, on **March 29, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

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

20IWCC0340

FINDINGS

On **12/10/17 and 12/15/17**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**23,137.92**; the average weekly wage was $**444.96**.

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 $**0.00** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**0.00**.

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

ORDER

Respondent shall pay reasonable and necessary medical services of **$25,401.67**, as provided in Section 8(a) of the Act and pursuant to fee schedule.

Respondent shall authorize prospective medical treatment as recommended and prescribed by Dr. Li, along with any necessary resulting temporary disability benefits.

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

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

Signature of Arbitrator

August 12, 2019
Date

AUG 16 2019

Statement of Facts

Petitioner filed two Applications for Adjustment of Claim alleging two different accidents while employed by the Respondent. Petitioner's first Application for Adjustment of Claim, 18 WC 8414, alleges on December 10, 2017, Petitioner injured his right shoulder and man as a whole due to repetitive trauma. (PX 2) Petitioner's second Application for Adjustment of Claim, 18 WC 8401, alleges on December 15, 2017, Petitioner injured his right shoulder and man as a whole after carrying an ice bin. (PX 4)

At the time of hearing, Petitioner worked for Respondent for five years. He worked as a cook for Respondent and he testified as to his job duties. Petitioner testified regarding how he had to get orders off of a screen and that, when the screen was moved, he repeatedly had to look up and to his right above head level to read orders off the screen. Petitioner testified that, after a new system with an elevated screen was put in place, he began to notice problems where he couldn't turn his neck.

Petitioner's testified credibly, and no evidence rebutted his testimony. Dr. Mash's report (Rx 3) indicates that, although Petitioner had an underlying condition of cervical spinal stenosis, his symptoms were an aggravation of his underlying but previously asymptomatic condition.

The Employer's First Report of Injury or Illness was completed by Bill McGee on December 18, 2017. The first Report of Injury notes Petitioner was looking at a monitor at the grill when he strained his neck. The date of accident is noted as December 15, 2017, and the body parts affected are the neck. A First Report of Injury or Illness was not completed for Petitioner's alleged accident involving carrying an ice bin. (RX 8)

Medical records were entered into evidence for treatment prior to Petitioner's alleged December 10, 2017, and December 15, 2017, accidents. Specifically, Petitioner's medical records from Community Health Clinic ranging from November 2012, through December 2014 were entered into evidence. On November 28, 2012, Petitioner complained of right thumb burning pain radiating to the elbow and shoulder from the C6 dermatomal pattern. Petitioner's examination revealed tenderness and tightness of the right trapezius. Petitioner was diagnosed with right upper extremity radiculopathy. On January 9, 2013, Petitioner complained of right hand/arm pain from the thumb to the shoulder. On October 8, 2013, Petitioner had right thumb pain that radiated to the arm and shoulder. On February 27, 2014, Petitioner complained of tenderness to the anterior cervical region. On December 1, 2014, Petitioner complained to persistent right neck, shoulder, and arm pain after sleeping on the right side of his body with his arm above his head. On June 1, 2015, Petitioner complained of right arm/shoulder pain. The record notes Petitioner slept on his stomach with his head turned to the left side. Petitioner was diagnosed with a neck strain and advised to change sleep positions from his stomach to his back or side. (RX 6)

Following Petitioner's alleged December 10, 2017 and December 15, 2017 work accidents, Petitioner was first seen at Advocate Bromenn Medical Center on December 17, 2017. The history notes Petitioner was being evaluated for right shoulder and neck

pain for over one week. Petitioner reported significant pain with movement of the right shoulder, as well as moving his neck to the right. Petitioner reported he worked as a grill man and constantly raised his right arm for food orders. On examination, all extremities were noted as non-tender with no swelling and full range of motion. Petitioner was diagnosed with cervical radiculopathy and shoulder pain. Petitioner was discharged, with a recommendation for a potential future MRI study. (PX 7, RX 5)

Petitioner was next evaluated on December 19, 2017. The history notes Petitioner was unable to work due to worsening neck pain. Petitioner advised his pain radiated down his right arm, down the thoracic musculature, and up to the neck. Furthermore, the history notes Petitioner spoke with management and work about moving the location of an order screen, as his onset of symptoms began after the order screen was placed to his right. Petitioner noted he was unable to find comfort in a sleeping position and "can't take it", referring to his pain. On examination, Petitioner had tenderness along the right trapezius superior border, especially medially, with pain radiating to the deltoid and inferior trapezius. Petitioner was also tender along the right sided musculature, with limited range of motion of the neck. Petitioner was able to lift his arms over head without pain. Petitioner was diagnosed with a trapezius spasm and prescribed Tramadol. The record indicates that if Petitioner had no improvement in 4 to 6 weeks, physical therapy would be considered. (RX 5)

Petitioner was seen at OSF St. Joseph Medical Center on December 24, 2017. At that time, Petitioner's chief complaint was neck pain. The history notes Petitioner complained of muscle spasms to the right trapezius area. Petitioner stated his job had a monitor which required him to turn his head frequently throughout the day. Petitioner advised this activity made his muscle spasms worse. On examination, Petitioner exhibited tenderness to the right trapezius with palpable spasms, but he had normal range of motion and no edema. Petitioner was diagnosed with musculoskeletal pain and given medications. The emergency room record notes Petitioner's pain started weeks ago while at work after looking at a monitor which was elevated for an extended period of time. (PX 6, RX 4)

Petitioner returned to OSF St. Joseph Medical Center on December 30, 2017. The chief complaint indicates shoulder pain. The history notes Petitioner had right shoulder symptoms and pain for approximate two weeks. Petitioner stated he works on the grill and recently got a monitor switched while at work, causing him to turn his neck frequently during the day. Petitioner indicated he developed right sided neck pain and was diagnosed with a trapezius strain. Petitioner advised those symptoms recently resolved. However, Petitioner stated two weeks prior, he was carrying a large ice bin with another worker when the other worker dropped her end of the bin. Petitioner indicated he had a sudden increase of weight that he was carrying and tried to keep the bin from dropping to the floor, causing right shoulder pain. Petitioner denied any numbness or tingling, but he complained of increased pain when he raised his arms above his head. On examination, Petitioner's right shoulder exhibited decreased range of motion, tenderness, pain, and decreased strength. However, Petitioner had no swelling, no effusion, no

crepitus, and no deformity of the right shoulder. Petitioner's cervical spine exhibited normal range of motion with no tenderness. X-rays of the right shoulder were taken, which revealed no acute displaced fracture or dislocation, but osteoarthrosis of the AC joint. The acromioclavicular joint was aligned. Petitioner was diagnosed with a right shoulder injury and acromioclavicular joint arthritis. Petitioner is recommended to follow up with orthopedics and avoid heavy lifting or strenuous activity. Petitioner was given prescriptions for muscle relaxers and Norco for severe pain as needed. The emergency room triage records note Petitioner's right shoulder injury began when he was carrying a large ice bin with another worker, when the other worker "dropped her end, her end slipped". Petitioner advised he had a sudden increase of weight he was carrying when trying to keep the bin from dropping to the floor. (PX 6)

Petitioner followed up with Dr. David Braun at Advocate Health Care Clinic and Occupational Medicine on January 4, 2018. Petitioner's chief complaint was neck, right shoulder, and back pain. The description of accident notes Petitioner complained of severe pain in the right shoulder and back of his neck due to turning his head to the right to look at a screen at work. The history indicates on December 10, 2017, while working for a vendor on a site at State Farm in Bloomington, Petitioner was working as a cook. On or about December 10, 2017, Petitioner was lifting a tub of ice and food products he estimated to weigh 50 pounds with a coworker to move to a different counter to get ready for the lunch line. The coworker suddenly dropped her side of the ice bin and Petitioner took a sudden jolt to the right shoulder that caused a sudden, sharp pain. Petitioner advised he felt that something "popped" in his shoulder. Since that time Petitioner was unable to lift his right shoulder to the side. Petitioner noted his neck pain subsided and his pain was isolated to the right shoulder with continued limitations of motion and function. On examination, Petitioner's cervical spine did not have any pain on motion or to palpation. Petitioner's range of motion was normal with a negative Spurling's test bilaterally on the neck. With regard to the right shoulder, Petitioner had a positive drop arm test on the right with AC joint tenderness to touch. There was mild diffuse right trapezius tenderness with some weakness of the right forearm compared to the left side, as well as the right elbow flexion with mild weakness. Petitioner was diagnosed with a sprain of the cervical spine ligaments and right rotator cuff capsule. Dr. Braun suspected Petitioner had a chronic neck strain which worsened recently, but that was not Petitioner's main issue. Dr. Braun opined Petitioner's main issue from the recent injury was a rotator cuff injury with suspicion for a complete tear of the supraspinatus tendon. Due to Petitioner not using his right arm with much improvement, Dr. Braun indicated Petitioner developed some adhesive capsulitis. Dr. Braun recommended a right shoulder MRI to confirm any injuries to the supraspinatus tendon, as well as physical therapy. Dr. Braun noted Petitioner had good strength overall in the different muscle groups of the right upper extremity with no reports of paresthesias. Petitioner was recommended for restricted work duties. (PX 8, RX 5)

An x-ray of Petitioner's cervical spine was taken on January 4, 2018. The indication for the study was pain after a work injury. The impression revealed no acute fractures or dislocations, but degenerative changes at the C3-4 and C4-5 levels, as well as moderate changes at C5-6 with loss of disc height. (RX 5)

Petitioner returned to Dr. Braun on January 11, 2018. Petitioner stated his right shoulder was not any better and he was in terrible pain. Dr. Braun noted Petitioner's neck was feeling fine, but his shoulder was causing problems, including disrupting Petitioner's sleep due to pain. Petitioner was diagnosed with sprain of the cervical spine and sprain of the right rotator cuff capsule. Dr. Braun noted Petitioner's neck symptoms resolved, but his shoulder and lack of motion was his main issue creating problems. Dr. Braun opined Petitioner had internal derangement and would benefit from an orthopedic referral. However, Dr. Braun recommended a right shoulder MRI as Petitioner's exam was difficult and his history was "complicated." Petitioner was given restricted work duties and recommended to follow up following the MRI of the right shoulder. (PX 8)

Petitioner underwent an MRI of the right shoulder on January 24, 2018. The MRI notes it was an incomplete study due to limited motion. However, there was no evidence for a rotator cuff tendon tear, with mild tendinopathy of the supraspinatus tendon. There were moderate osteoarthritic changes with undersurface osteophytes at the right acromioclavicular articulation with a Type II acromion. The radiologist notes the findings should be correlated clinically to exclude shoulder outlet impingement syndrome. (PX 8, RX 5)

Petitioner returned to Dr. Braun on January 25, 2018. The history notes Petitioner's neck was feeling fine, but his right shoulder was causing problems. Petitioner advised his shoulder hurts every day, rating his pain on a 7/10 scale. Dr. Braun noted Petitioner's right shoulder MRI showed no internal derangement with degenerative changes of the AC joint and supraspinatus tendonitis. Given no internal derangement was found in the shoulder, Dr. Braun suspected Petitioner's inability to raise his arm and the deltoid weakness likely spawned from a C5 radiculopathy on the right. Dr. Braun recommended an MRI of the cervical spine. If the MRI did not reveal a C-5 herniation on the right and no impingement, Dr. Braun did not believe Petitioner's symptoms were due to a specific work event. Petitioner was given restricted work duties and advised to follow-up after the cervical spine MRI. (PX 8, RX 5)

Petitioner underwent a cervical spine MRI on January 31, 2018. The MRI revealed a mild central disc herniation at C3-4 with mild central and neuroforaminal stenosis. There is a mild central disc herniation at C4-5 with mild central bilateral neuroforaminal encroachment. A mild broad-based central disc herniation was seen at C5-6 with partial effacement of the thecal sac and mild to moderate central and neuroforaminal stenosis bilaterally. The radiologist noted developmental and acquired spinal stenosis at multiple levels, most pronounced at C3-4, C4-5, and C5-6. However, no central cord impingement or alteration of the cord signal was noted. (PX 8, RX 5)

Petitioner returned to Dr. Braun on February 22, 2018. Again, Dr. Braun noted Petitioner's neck was feeling fine, but his right shoulder was causing problems. Petitioner advised his pain was less than his previous evaluations. Dr. Braun noted the shoulder MRI revealed degenerative changes with inflammation the rotator cuff component. Dr. Braun further noted the cervical spine MRI revealed no impingement of a nerve root correlating with his right shoulder pain. Dr. Braun opined there was no evidence of the C-5 radiculopathy on the right, but Petitioner had subjective shoulder complaints with decreased range of motion. Dr. Braun opined Petitioner's symptoms would improve, and he would get back to baseline with therapy. Dr. Braun advised Petitioner to follow-up in one month and eased his restrictions. Petitioner was given a referral for physical therapy. (PX 7)

On February 13, 2018, a Section 12 exam was performed by Dr. Stephen Mash at Respondent's request. Dr. Mash noted Petitioner stated an injury occurred on December 15, 2017, while employed as a grill cook. Petitioner described the injury of constantly having to look to the right to see a screen for orders, as well as moving an ice bin weighing approximately 60 pounds. Petitioner noted the onset of discomfort in his right shoulder and pain at the root of the neck on the right. Petitioner's subjective complaints included pain at the base of the neck on the right which radiated to the right shoulder, as well as difficulty with overhead reaching on the right side. Dr. Mash diagnosed Petitioner with cervical spine stenosis. Dr. Mash noted the diagnosis was not related to the injury and was entirely pre-existing. However, Dr. Mash opined Petitioner's current complaints did relate to the December 15, 2017, accident. Dr. Mash opined Petitioner's pre-existing, underlying condition was aggravated as it was previously asymptomatic per Petitioner's history. Dr. Mash recommended treatment with a board-certified orthopedic physician consisting of oral anti-inflammatory medications and physical therapy. Dr. Mash further noted Petitioner may require epidural injections if his symptoms failed to improve. Dr. Mash recommended therapy for 4-6 weeks and was hopeful Petitioner would gain improvement toward maximum medical improvement. Dr. Mash opined Petitioner was able to return to work with restrictions, consisting of limited lifting to 10 pounds and no work with the right-hand or arm overhead. Dr. Mash did not testify prior to arbitration. (RX 3)

An initial physical therapy evaluation at ATI Physical Therapy was obtained on March 13, 2018. The assessment notes Petitioner was referred to therapy with signs and symptoms consistent with cervicalgia from possible disc injuries. Petitioner also had right shoulder pain from possible rotator cuff strain with impingement. The history notes Petitioner worked as a grill cook that required light – medium work duties. Petitioner was recommended for therapy three times a week for six weeks, for a total of 18 visits. (PX 8) A discharge summary from ATI Physical Therapy was given on March 21, 2018. The record notes Petitioner called the office stating that his lawyer told him to go see Dr. Li. Therefore, Petitioner was discharged from therapy. (RX 7)

Petitioner was first evaluated by Dr. Lawrence Li on March 21, 2018. The history notes Petitioner had right shoulder pain and neck pain. Petitioner advised he initially developed significant neck pain from turning his head and neck to look at an order screen. Dr. Li noted Petitioner has to do this all day long and the position of the TV screen was causing him to turn a lot, so Petitioner's boss actually moved the TV screen. Then, sometime during the next week, Petitioner and another worker were carrying 60 pounds of ice in a bin when the other worker's hand slipped. Petitioner advised he had to hold the ice bin by himself and injured his right shoulder. Petitioner complained of significant right shoulder and neck pain radiating down to his elbow. Petitioner's pain was made worse with reaching and lifting. Petitioner advised he felt weak and had lost range of motion. Dr. Li reviewed Petitioner's right shoulder x-rays, noting no displaced fractures or dislocations, but osteoarthritis of the AC joint. Dr. Li also reviewed Petitioner's cervical spine and right shoulder MRIs, indicating significant inflammation and fluid in the AC joint. Dr. Li further noted the right shoulder MRI study was incomplete, as not all sequences could be determined. Dr. Li did not see a full thickness rotator cuff tear. The cervical spine MRI revealed cervical spondylosis with spinal stenosis, worse at C4-5 and C5-6 with neuroforaminal stenosis bilaterally at both levels. On examination, Petitioner's cervical spine revealed a positive Spurling's test. Petitioner's shoulder exam revealed AC joint tenderness, with a positive Neer's and Hawkins impingement test. Dr. Li diagnosed Petitioner with cervical spondylosis and spinal stenosis with neuroforaminal stenosis aggravated by repetitive turning of the cervical spine at work. Dr. Li also diagnosed Petitioner right shoulder rotator cuff strain, impingement syndrome, and AC joint dysfunction secondary to a traction injury. Petitioner underwent a Lidocaine injection and was recommended for physical therapy for four weeks. (PX 5)

Petitioner began physical therapy on March 26, 2018. The initial evaluation notes Petitioner strained his neck at work due to repetitive head turns to the right over 8-9 months because he had to look to the right to see the order screen. Subsequently, Petitioner was moving an ice bin which slipped out of his hands and caused right shoulder pain. Petitioner noted the previous injection significantly helped his pain, but he still experienced tightness. The initial evaluation notes Petitioner was diagnosed with right shoulder pain and cervicalgia. The therapist indicated Petitioner demonstrated signs and symptoms consistent with his diagnoses, including deficits in the right shoulder and cervical spine range of motion, flexibility, strength, joint mobility, postural awareness, and pain. Petitioner is recommended for physical therapy 2-3 times per week for 8-12 weeks. (PX 5)

Petitioner underwent therapy on April 4, 2018, April 6, 2018, April 9, 2018, and April 16, 2018. The April 6, 2018, record notes Petitioner denied pain, but continued experiencing weakness in the right arm. The April 9, 2018, record indicates Petitioner's pain significantly improved following the injections, but his weakness in the right arm continued. The April 16, 2018, record notes Petitioner's injection wore off, but he was

getting better. Petitioner's neck was fine, but his pain continued in the anterolateral shoulder and upper arm. (PX 5)

Petitioner returned to Dr. Li on April 18, 2018. Petitioner reported that his neck was generally doing well, but his right shoulder was very bothersome. Petitioner noted that he was not making any improvements in right shoulder pain, but he did have improved range of motion. Petitioner advised the previous injection into the AC joint gave him relief for approximately 2 1/2 weeks until the pain came back. Petitioner's exam findings remained unchanged. Petitioner was given the same diagnosis of cervical spondylosis and spinal stenosis with neuroforaminal stenosis aggravated by repetitive turning of the cervical spine at work. The cervical spine symptoms were improved. Petitioner was also diagnosed with right shoulder rotator cuff strain, impingement syndrome, and AC joint dysfunction secondary to a traction injury, which his symptoms remain significant. Petitioner was given another Lidocaine injection into the AC joint and recommended for continued physical therapy. (PX5)

Petitioner continued to attend physical therapy from April 18, 2018, through May 16, 2018. The physical therapy records note Petitioner's right shoulder pain continued, but his neck pain improved. The April 25, 2018, record notes Petitioner's neck hurt occasionally on the right side only when his shoulder hurt. The May 15, 2018, therapy record notes Petitioner was working longer hours and required to perform additional work tasks, which significantly increased his right shoulder pain. The therapist noted Petitioner's shoulder regressed significantly and he was having pain on the right side of his neck. The assessment indicates Petitioner was no longer making significant progress with therapy and only receiving temporary relief. Petitioner was advised to follow-up with Dr. Li. (PX 5)

Petitioner returned to Dr. Li on May 16, 2018. Petitioner noted that his right shoulder pain was relieved for approximately 5 days after the previous injection until the pain returned. Petitioner's right shoulder bothered him with any over chest use and reaching. Petitioner was working with restrictions, but still had pain at work with certain movements. Petitioner's neck symptoms improved, but he continued to experience neck discomfort in the right paracervical region. However, Petitioner noted his neck symptoms were minimal compared to his shoulder pain. Petitioner's physical examination remain unchanged from the previous visit. Petitioner was diagnosed with right shoulder impingement syndrome, rotator cuff strain, AC joint dysfunction secondary to a traction injury. Dr. Li have recommended Petitioner undergo a right shoulder arthroscopy with arthroscopic sub acromial decompression and distal clavicle excision due to Petitioner's failure of non-operative treatment. Petitioner was advised to continue a home exercise program pending the recommended surgery. (PX 5)

Petitioner was reevaluated by Dr. Li on June 20, 2018. Petitioner continued to complain of right shoulder pain with any type of reaching or over chest movements. Petitioner advised he was tolerating work, but he continued to have pain on a daily basis. Petitioner occasionally had neck pain, but it was much less than his right shoulder. The

pain in Petitioner's neck was in the right paracervical region, but Petitioner experienced increased pain in the right shoulder going down the right arm. Petitioner's exam remained unchanged and he was diagnosed by right shoulder impingement syndrome, rotator cuff strain, and AC joint dysfunction. Dr. Li noted Petitioner's previous injections and therapy provided no relief. Petitioner's cervical strain still existed, but it was minor compared to his shoulder condition. Dr. Li noted Petitioner's motion was decreasing, causing concerns for a potential frozen shoulder. Dr. Li recommend continued physical therapy pending the surgical recommendation. (PX 5)

Petitioner returned to Dr. Li on July 20, 2018. Petitioner advised that he was having significant discomfort with therapy exercises with over chest work. Petitioner was concerned his right shoulder was getting worse. Dr. Li's exam findings and diagnosis remained unchanged. Dr. Li recommended Petitioner avoid doing any exercise which required reaching or over chest work due to increased pain. (PX 5)

On August 14, 2018, a Section 12 exam was performed by Dr. David Anderson at Respondent's request. Petitioner advised that one year prior, while working as a cook, his employer moved the order monitor to a point where it was set up about 90° from his workstation. Petitioner indicated this caused him to repetitively turn his head to the right side to review the orders. Petitioner stated the first week of December, 2017, he noted pain in the neck and right trapezius. Petitioner felt this was from repetitive work over the previous many months. Furthermore, Petitioner stated that the second week in December he was helping move a rectangular ice bin that was filled with objects weighing approximately 50-60 pounds. Petitioner stated his coworker was on the opposite side of the rectangular shaped bin when they both have their hands underneath the bottom portion while carrying it. Petitioner stated the coworker lost grip and was ready to drop the other end, but Petitioner was able to move his hands from the bottom side of the bin to the top side and hold the edge of the bin. Petitioner advised he held the bin by himself up against his body at chest level or just below. Petitioner stated he already experienced severe pain from the prior week and did not have increased pain in the shoulder or neck of the time of the incident with the ice bin. Petitioner's complaints were pain over the top of the shoulder in the area of the AC joint with radiation to the lateral aspect of the deltoid. Petitioner also complained of numbness in the same distribution. While most of Petitioner's pain was over the top and lateral aspect of the shoulder, Petitioner also had mild discomfort over the base of his neck. Petitioner stated his neck pain resolved, but it increased as his shoulder pain continued. Petitioner's stated his right shoulder pain increased with all movements. Petitioner noted stiffness in the right shoulder in the morning, which improved during the day as he used his right arm. Petitioner's pain was worse with overhead use, but also aggravated with activities below shoulder level. Petitioner denied experiencing numbness on the top of the shoulder radiating to lateral shoulder until June, 2018. There was no specific injury or incident that caused this difference in symptoms. Dr. Anderson noted Petitioner reported two separate accidents, one on December 10, 2017, and a second on December 15, 2017. (RX 2)

Dr. Anderson's physical examination noted that Petitioner would use his arms without displaying any limitations or guarding or evidence of pain. During the examination, Petitioner used his arms consistently during his conversations at his waist and mainly below shoulder level, but at times above shoulder level without any hesitations during normal conversation or distraction. Petitioner was able to put on and take off his shirt without any apparent difficulties or facial grimacing. Examination of the cervical spine revealed normal alignment with mild tenderness of the right trapezius. Petitioner had full range of motion with flexion, extension, right and lateral rotation, as well as right and left lateral bending. Petitioner had soreness with rotation to the right, but full motor strength with intact sensation throughout the upper extremities. Petitioner had a negative Hoffman test, Spurling's test to the right and left. Examination of the right shoulder revealed mild scapular disc kinesis bilaterally with tenderness to palpation over the AC joint, scapular spine, lateral acromion. There was mild swelling over the area of the AC joint, but no palpable crepitus with active or passive range of motion. Dr. Anderson noted when he performed a specific examine the right shoulder, Petitioner displayed guarding behavior with active forward reflection over 90°, but Petitioner put on and took off his shirt without difficulty. Dr. Anderson noted Petitioner was able to easily elevate his shoulder well above shoulder level without any distress or difficulties. Petitioner had full and symmetric internal and external rotation with the shoulders. Petitioner had full rotator cuff strength with pain referred over the AC joint with both supraspinatus testing and external rotation at the side. Petitioner had a positive AC provocative test, positive Neer's and Hawkins tests, but negative Speed's test, Jurgensen's test, Lift off test and belly press test. (RX 2)

Dr. Anderson reviewed Petitioner's medical records and radiographic studies, including the right shoulder MRI and cervical spine MRI. Regarding the right shoulder, Dr. Anderson did not find evidence of an injury as a result of December 10, 2017, reported work injury. Dr. Anderson noted Petitioner's medical records and accident history indicated an initial reported injury due to having repetitively turned his head to review an order screen. Furthermore, Dr. Anderson noted a second injury occurred on or about December 15, 2017. Petitioner stated at that time, he had severe limitations in the right shoulder range of motion. However, in reviewing the medical records, Dr. Anderson noted that the Advocate Bromenn Medical Center emergency room record from December 17, 2017, did not mention injury involving carrying an ice bucket. Furthermore, the examination from that date revealed no tenderness and swelling in all extremities and full range of motion with normal strength/sensation in all extremities. Dr. Anderson further noted Petitioner was evaluated on December 19, 2017, at which time Petitioner did not mention the alleged ice bin incident. The physical exam revealed that Petitioner was able to lift his arms over head without pain. The medical record from December 24, 2017, did not mention an injury involving carrying an ice bin and Petitioner's exam again revealed normal range of motion. Dr. Anderson noted the first indication of the ice bin incident was the emergency room record at St. Joseph Medical

Center on December 30, 2017. At that time, Petitioner's physical exam of the right shoulder first noted decreased range of motion, tenderness, and decreased strength area (RX 2)

Dr. Anderson opined that after reviewing the records and taking a history from Petitioner, he found significant discrepancies regarding the alleged right shoulder injury. Although the date of reported injury was not consistent, based on the records and Petitioner's given history, the right shoulder injury involving the ice bin occurred in the first two weeks (before December 17, 2017) of December 2017. Dr. Anderson noted Petitioner was evaluated on December 17, 2017, December 19, 2017, and December 24, 2017, during which time there was no mention of an injury involving an ice bin. The first documentation involving the ice bin was on December 30, 2017. In addition, Petitioner stated that following the ice bin accident and alleged injuries, he had severe limitations in the right shoulder range of motion. However, Dr. Anderson noted the medical records did not document any abnormal right shoulder range of motion until December 30, 2017. Regarding the described mechanism of injury to the right shoulder, Dr. Anderson found it unlikely that Petitioner sustained a significant right shoulder injury due to carrying an ice bin, based on the inconsistent accident histories and exam findings notes in the initial medical records. In reviewing the medical records and performing his physical examination, Dr. Anderson did not find any definitive evidence that Petitioner injured his right shoulder during the two alleged work injury on December 10, 2017, and December 15, 2017. (RX 2)

Dr. Anderson noted significant inconsistencies during the observed physical examination. Specifically, Dr. Anderson indicated that with normal conversation, Petitioner used his arms normally both below and above shoulder level and did not claim limitations or evidence of pain. In addition, on two separate occasions, Petitioner was able to put on and take off his shirt without any difficulties and did not display any pain behaviors. However, on examination, Petitioner displayed guarding behavior with active forward elevation. Therefore, Dr. Anderson opined that Petitioner exhibited evidence of non-anatomic findings and symptom magnification on exam. (RX 2)

Concerning causation, Dr. Anderson opined there was no evidence to relate Petitioner's ongoing symptoms to either the December 10, 2017, or December 15, 2017, accidents. Dr. Anderson again noted discrepancies between the histories in the medical records as well as symptomatic magnification on physical examination that did not support an injury to the right shoulder as a result of either of the alleged incidents. Based on Dr. Anderson's causation opinions, Dr. Anderson did not believe Petitioner required any off work or light duty restrictions. Dr. Anderson opined that Petitioner did not require any further, medically necessary treatment, diagnostic testing, or surgery in relation to the alleged injuries sustained on December 10, 2017, or December 15, 2017. Based on the many inconsistencies, Dr. Anderson opined Petitioner's ongoing right shoulder complaints were not related to an alleged work injury and, therefore, Petitioner was at maximum medical improvement. (RX 2)

Petitioner returned to Dr. Li on August 29, 2018, for a right shoulder evaluation. Petitioner noted he was able to get through work day using Mobic and Tramadol. Dr. Li's exam findings and diagnoses remained unchanged. Dr. Li recommend Petitioner maintained his prescribed medications for Mobic and Tramadol. (PX 5)

Petitioner was reevaluated on September 26, 2018, by Dr. Li. Petitioner advised that his pain was causing him to lose sleep. Petitioner was able to get through his work day with Tramadol and Mobic. Petitioner's exam and right shoulder diagnosis remained unchanged. Dr. Li recommended Petitioner continue his medications and follow-up pending future surgery. (PX 5)

Petitioner returned to Dr. Li October 24, 2018. Petitioner continued to have difficulty with right shoulder pain and trouble sleeping. Petitioner advised any type of reaching or raising his arm was difficult. Dr. Li recommended that Petitioner continue conservative treatment until the surgery was approved. (PX 5)

Petitioner was reevaluated on November 28, 2018. Petitioner advised that he was following his restrictions at work, but his pain continued to wake him up. Petitioner was taking Tramadol each day before work to make it through the day. Petitioner had pain with any lifting his arm or reaching over chest level. Dr. Li's exam findings revealed a negative Neer's and Hawkins impingement test. Petitioner was given the same diagnosis. Dr. Li noted that Petitioner failed non-operative treatment, but his claim was awaiting resolution through litigation. (PX 5)

Petitioner last saw Dr. Li on February 6, 2019. Petitioner reported that his pain was getting worse with cold weather, but he was able to work within his restrictions. Petitioner further noted as long as he was restricted from over chest use in reaching, he could tolerate his symptoms. Petitioner's exam findings revealed a positive Neer's and Hawkins test. Dr. Li's right shoulder diagnosis remained unchanged. Petitioner was given medications and prescriptions and advised to follow-up once his workers' compensation claim was adjudicated. (PX 5)

Dr. Lawrence Li Evidence Testimony:

Dr. Li testified by way of evidence deposition on November 5, 2018. Dr. Li testified he is an orthopedic surgeon, focusing his practice on treatment for the shoulders, hands, and knees. Dr. Li noted he treats all general orthopedic problems, but he treats extremities both non-operatively and operatively. For the spine, Dr. Li only provides non-operative treatment. (PX 9, pp. 4-5)

Dr. Li testified he first evaluated Petitioner on March 21, 2018. At that time, Petitioner advised in early December he developed significant neck pain from having to turn his neck to look at an order screen. Petitioner took orders and had a look at the order screen apparently all day long, causing him problems. Dr. Li further testified that sometime after that, Petitioner and a co-worker were carrying about 60 pounds of ice in

a bin when the other worker's hand slipped, and Petitioner had to hold it by himself, injuring his right shoulder. Petitioner's pain radiated into his elbow and was worse with any type of reaching or lifting. Petitioner advised he felt weak and had decreased range of motion. (PX 10, pp. 6-7)

Dr. Li testified he reviewed Petitioner's January 24, 2019, right shoulder MRI. Per Dr. Li's testimony, the MRI revealed osteoarthritic changes in the AC joint consistent with impingement syndrome. There was no clear-cut rotator cuff tear. Dr. Li also reviewed Petitioner's cervical spine MRI from January 31, 2018, which showed mainly degenerative changes. (PX 10, p. 7) Dr. Li testified the right shoulder MRI revealed a motion artifact, so it was not the best study. However, Dr. Li further testified the motion artifact did not invalidate the right shoulder MRI findings. (PX 10, p. 9)

Dr. Li testified his initial examination of the cervical spine revealed slight loss of range of motion, but Petitioner was neurovascularly intact. Petitioner did have pain with the cervical paraspinal muscles. On right shoulder examination, Petitioner had normal passive range of motion, but active range of motion was limited due to discomfort. Petitioner had weakness with testing of the rotator cuff muscles. Petitioner a positive Neer's and Hawkins impingement tests, consistent with impingement syndrome. Petitioner also had a positive cross arm abduction test, consistent with AC joint dysfunction and tenderness over the AC joint. (PX 10, pp. 9-10) Dr. Li testified his physical exam findings were consistent with the MRI findings. (PX 10, p. 10) Dr. Li testified his initial diagnosis was cervical spondylosis and spinal stenosis with neuroforaminal stenosis aggravated by repetitive turning of the cervical spine at work. Furthermore, Dr. Li testified the right shoulder diagnosis was a rotator cuff strain, impingement syndrome, and AC joint dysfunction secondary to a traction injury. (PX 10, p. 10) Dr. Li recommend Petitioner proceed with oral medications consisting of anti-inflammatories and muscle relaxants, along with a corticosteroid injection and physical therapy. (PX 10, p. 11)

In regard to the cervical spine, Dr. Li testified Petitioner's cervical spine strain improved with treatment. However, Dr. Li testified Petitioner had two problems, one with the cervical spine and another with the shoulder, with the more serious problem being the right shoulder. Dr. Li testified he agreed with Dr. Nash's Section 12 opinions, in that Petitioner had a pre-existing degenerative condition that was aggravated by repetitive motion. (PX 10, pp. 11-12) Dr. Li further agreed that the degenerative changes in the cervical spine were long standing. (PX 10, p. 12)

Dr. Li testified he re-evaluated Petitioner on April 18, 2018. At that time, Dr. Li indicated Petitioner advised his range of motion improved and the previous injection provided relief for approximately 2 1/2 weeks before the pain returned. Dr. Li indicated this helped with his diagnosis since the injection did relieve his pain, since injecting the area made Petitioner's symptoms feel better, and confirm the source of pathology was in the AC joint. Dr. Li testified he recommended Petitioner proceed with additional therapy medications, as well as a second injection. (PX 10, pp. 12-14)

Dr. Li testified that he reevaluated Petitioner on May 16, 2018, following the second injection. At that time, Petitioner advised the injection lasted five days, but his symptoms significantly worsened with any type of over chest or reaching work. Dr. Li testified Petitioner's neck pain continued to be better and better with minimal complaints. Dr. Li further testified it was very common for the second injection to provide more temporary relief that goes away quicker. Dr. Li further testified that it is common for a patient to have painful shoulder and neck complaints, since patients generally tense their paracervical muscles more, causing their neck pain. Dr. Li further testified that Petitioner's examination on May 16, 2018, revealed his active range of motion was not improving. Therefore, Dr. Li testified Petitioner was approximately five months from his alleged accidents, so surgery was indicated since Petitioner's improvement with conservative treatment plateaued. (PX 10, pp. 14-17)

Dr. Li testified Petitioner returned for reevaluation on June 20, 2018. At that time, Dr. Li testified Petitioner had no significant change in his complaints and his range of motion was actually worse. Based on Petitioner's regression, Dr. Li recommended a right arthroscopic shoulder surgery with sub acromial decompression and distal clavicle excision. (PX 10, p. 17).

Dr. Li testified he reevaluated Petitioner on August 29, 2018, September 26, 2018, and October 24, 2018. Petitioner's physical examination remained the same, with positive Neer's and Hawkins tests as well as cross armed abduction tests. Dr. Li testified there was no significant change in Petitioner's right shoulder condition. (PX 10, pp. 18-25) Dr. Li testified he reviewed the Section 12 report from Dr. Anderson, noting Dr. Anderson's objective findings were very similar to his exam findings from his previous evaluations for Petitioner's right shoulder complaints. (PX 10, p. 26)

Regarding causation, Dr. Li testified that the alleged work accident described by Petitioner as carrying a bin of ice with a coworker and the coworker dropping his part, causing Petitioner to bear all the weight, was consistent with his right shoulder diagnosis. Dr. Li testified that Petitioner suffered a traction injury when the coworker stopped carrying the bin, causing Petitioner's arm to be jerked. Dr. Li testified this was consistent with a rotator cuff strain causing impingement syndrome while also aggravating the pre-existing arthritic AC joint causing AC joint dysfunction. (PX 10, pp. 26-27) Dr. Li testified he would consider this to be a common mechanism of injury for shoulder pathology. (PX 10, p. 27)

Dr. Li testified all treatment rendered from Petitioner's right shoulder condition was reasonable and necessary in relation to the alleged work accident. (PX 10, p. 28). Furthermore, Dr. Li testified his recommendation for right shoulder surgery was necessary, as Petitioner failed conservative treatment. Dr. Li testified the surgery would be related to the work injury. (PX 10, p. 28)

On cross-examination, Dr. Li testified he reviewed the actual MRI images and reports for Petitioner's right shoulder and cervical spine MRIs, but he did not review the previous records until the month prior to his deposition. Specifically, Dr. Li testified he did not review any additional records outside of the MRI images and reports prior to his initial March 21, 2018, evaluation of Petitioner. Dr. Li further testified that at the time he recommended surgery, the accident history provided to him was Petitioner experienced pain in the cervical spine that radiated into his shoulder from turning his neck to look at a TV screen. Then, a week or two later, Petitioner is carrying an ice bin with his coworker when the coworker dropped it. Petitioner had to support the entire weight of the ice bin with his right arm which further aggravated his shoulder. Dr. Li testified the ice bin did not drop a long distance since Petitioner never let go of the bin. Dr. Li testified he was unaware of any additional accident histories provided to Petitioner's other treating physicians prior to his review of the medical records one month in advance of this evidence deposition. (PX 10, pp. 28-31)

Dr. Li testified Petitioner's shoulder injury was in relation to a traction injury. Dr. Li further testified to the example that a traction injury is one where the arm is pulled. To clarify, Dr. Li testified that when someone is falling down, they reach and grab onto a railing, which pulls the arm. This is equal to a traction injury. Dr. Li testified that the traction injury and ice bin carrying incident made Petitioner's shoulder worse, as Petitioner had shoulder pain following the alleged repetitive looking at the monitor incident. However, Dr. Li admitted that turning to look at a monitor would cause a cervical strain and did not cause AC joint impingement. (PX 10, pp. 31-32)

Dr. Li testified Petitioner did not give him a history of repetitively raising his arms as the cause of Petitioner's right shoulder pain. Rather, Dr. Li testified Petitioner's right shoulder complaints were due to a traction accident. Dr. Li testified that neck and shoulder complaints can be co-existent and synergistic. However, Petitioner's traction accident certainly made Petitioner shoulder symptoms worse. (PX 10, pp. 33-34)

Dr. Li testified that he did not review any medical records that occurred prior to December 2017. Per Dr. Li's testimony, Petitioner did not give a history of prior neck or shoulder issues. Dr. Li testified it was his understanding that Petitioner was not necessarily symptom-free, but he did not have any significant treatment for his neck or right shoulder prior to December 2017. Dr. Li testified that he could not testify whether Petitioner had symptoms, as he believed most people do. However, Dr. Li testified that any pre-accident medical records or treatment evidencing Petitioner's symptoms would be relevant to his opinions. (PX 10, pp. 34-36)

Dr. Li testified he reviewed the emergency room records for Advocate Bromenn Medical Center and OSF, as well as Dr. Anderson's formal Section 12 report. Dr. Li testified the additional records were provided to his office by Petitioner's attorney within one month prior to his deposition. Prior to his review of those records, Dr. Li had no knowledge of Petitioner's symptoms or complaints to any other doctor, as well as no knowledge of the described accident prior to March 2018. (PX 10, pp. 36-37)

Dr. Li testified that Petitioner did not give him a specific accident date of the alleged ice bin incident. Dr. Li admitted the ice bin incident was a specific, acute accident that happened on a specific date at a specific time. Dr. Li further admitted that when he normally treats patients and they suffer an acute accident that caused symptoms, the patient normally advises of the accident and give specifics of how the accident occurred. Dr. Li further admitted it is relevant to record the accident history a patient gives, as he did in his records. Dr. Li testified Petitioner advised his co-employee dropped the ice bin and he had to bear weight causing his shoulder symptoms. Dr. Li opined this acute accident caused a rotator cuff strain which involved AC impingement dysfunction. Dr. Li further testified that a patient's general history of the accident is more accurate closer in time to the acute accident than later in time. (PX 10, pp. 37-43)

Dr. Li testified that he was unaware how Petitioner was referred to his office for treatment, but he had no reason to disagree with the medical records indicating Petitioner was referred by his attorney to begin care with Dr. Li. Dr. Li testified that he is unaware of how patients are referred for his care, as he normally receives requests from the patient themselves. (PX 10, pp. 43-46)

Dr. Li admitted that he does not do operations or treat the spine. In Petitioner's case, Dr. Li opined Petitioner's cervical spine was improving with treatment and he did not recommend any additional cervical spine care. Dr. Li further admitted that Petitioner's cervical spine was doing well, and his right shoulder was the current issue. (PX 10, pp. 46-47)

Dr. Li testified that his review of the MRI studies revealed no tears in the right rotator cuff and that Petitioner's AC joint definitely was degenerative. Dr. Li did not believe the impingement was degenerative, but rather caused by a rotator cuff strain. The actual pathology of the AC joint was degenerative. Dr. Li further testified that the conditions found on the MRIs can be asymptomatic and become symptomatic without acute trauma. Dr. Li also admitted that a patient's symptoms can vary and take any form. Furthermore, Dr. Li testified Petitioner's symptoms could be caused by numerous things. However, Dr. Li testified he did not believe Petitioner's impingement would become symptomatic without an inciting event, as the rotator cuff strain and impingement go hand in hand. Dr. Li testified that a neck strain itself would not cause impingement syndrome, but that twisting and turning to look at the monitor could amplify the impingement syndrome complaints. (PX 10, pp. 48-50)

On redirect examination, Dr. Li testified the histories he reviewed in the emergency records from Advocate Bromenn Medical Hospital and OSF did not change his causation opinions. Additionally, Dr. Li testified he did not consider his treatment of Petitioner to be a referral from a law office, as there are only a few orthopedist groups in town and Petitioner decided to choose him. (PX 10, pp. 54-56)

On re-cross examination, Dr. Li admitted that unless a patient explicitly advises him, he is unaware of how a patient is referred to his office. Therefore, Dr. Li was unaware of whether Petitioner was referred by his attorney or some other source. (PX 10, pp. 56-57)

Dr. David Anderson Evidence Testimony:

Dr. David Anderson testified by way of evidence deposition on January 28, 2019. Dr. Anderson testified he is a board-certified orthopedic surgeon with emphasis in sports medicine, including shoulders and knees. Dr. Anderson further testified he became involved with this case at the request of Respondent to perform a Section 12 independent medical evaluation. (RX 1, pp. 5-7)

Dr. Anderson testified Petitioner stated one year prior, his employer moved a monitor to a point where it was set about 90° from his work station, causing him to repetitively turn his head to the right side to review orders. Petitioner stated in the first week of December 2017, he noted pain in his neck and right trapezius. Petitioner felt his pain was from repetitive work over the previous months. Furthermore, Petitioner advised in the second week of December 2017, Petitioner was helping move a rectangular ice bin that was filled with objects weighing approximately 50 to 60 pounds. Petitioner stated his co-worker on the opposite side of the rectangle shape been had her hands under the bottom portion of the bin while they were carrying it. Petitioner stated the co-worker lost grip and was ready to drop the other end, when Petitioner was able to move his hands from the bottom side of the bin to the top side of the bin and hold on the edge of the bin against his body at chest level or just below. However, Dr. Anderson testified there were multiple discrepancies in reviewing the records regarding Petitioner's reported accident dates and histories. Specifically, Dr. Anderson testified Petitioner's initial injury regarding the monitor was reported on December 10, 2017, with the subsequent ice bin accident occurring on December 15, 2017. (RX 1, pp. 11-13)

Dr. Anderson testified Petitioner's complaints at the time of the Section 12 exam were pain over the top of the shoulder area of AC joint with radiation to the lateral aspect of the deltoid. Petitioner advised his pain would worsen and he experienced numbness in the same distribution. Most of Petitioner's pain was over the top and lateral aspect of the shoulder, but Petitioner had some mild discomfort over the base of his neck. Petitioner complained of right shoulder pain with all movements involving the right shoulder, as well as a bout of stiffness in the morning which would improve throughout the day as he would use his arm. Petitioner stated his pain was worse with overhead use, but also aggravated with activities below shoulder level. (RX 1, p. 14) Dr. Anderson noted Petitioner was working within restrictions since February 2018, mainly working at the cash register. Dr. Anderson noted Petitioner's work duties as a cook typically involved shoulder use at counter level and not really any significant overhead activities. (RX 1, p. 15)

Dr. Anderson testified he reviewed Petitioner's voluminous medical records as part of this Section 12 exam. Specifically, Dr. Anderson testified he reviewed the records from OSF St. Joseph Medical Center, Doctor David Braun, Occupational Medicine Clinic, ATI Physical Therapy, and Dr. Lawrence Li. Dr. Anderson noted those records range from December 17, 2017 through at least May 16, 2018. (RX 1, p. 16) Dr. Anderson noted Petitioner's accident histories in the initial emergency records, as well as the injections performed by Dr. Li. Furthermore, Dr. Anderson noted that Dr. Li was recommending right shoulder surgery. (RX 1, p. 17)

Dr. Anderson testified he performed an examination of Petitioner's part of his Section 12 exam. As part of his examination, Dr. Anderson observed Petitioner using his arms normally with conversation. Petitioner did not display any limitations or evidence of pain, and constantly used arms at waist level and mainly below shoulder level, but at other times, above shoulder level. Petitioner did not appear to have any hesitations or restrictions or difficulties using his arm. Petitioner was able to take his shirt on and off without any observed difficulties, guarding, or facial grimacing. Dr. Anderson noted this included Petitioner using his right arm above shoulder level. (RX 1, pp. 17-18) When performing a more focused exam on the shoulder, Dr. Anderson testified Petitioner had tenderness to palpation of the AC joint, scapular spine, and lateral acromion. Petitioner had a small area of swelling over the AC joint. Petitioner did display some guarding behavior with active floor elevation over 90°, which was different than when Petitioner was using his arm through normal conversation and other portions of the examination. Petitioner had full asymmetric internal and external rotation with full rotator cuff strength and pain referred to the AC joint. Petitioner had positive AC provocative test and positive Neer's and Hawkins tests. Petitioner's Speeds, Jurgensen's, Liftoff, and belly press tests were negative. Dr. Anderson testified Petitioner's passive forward elevation was slightly decreased. However, when Petitioner displayed guarding the behaviors with forward elevation over 90°, Dr. Anderson testified it revealed Petitioner was very hesitant to raise his arm or shoulder above shoulder level. (RX 1, pp. 18-20)

Dr. Anderson testified he reviewed Petitioner's shoulder MRI images from January 24, 2018. Dr. Anderson indicated Petitioner's MRI revealed no evidence of a full thickness rotator cuff tear, but degenerative changes in the acromioclavicular joint. (RX 1, pp. 20-21) Dr. Anderson also review Petitioner cervical spine MRI of January 31, 2018. Dr. Anderson opined the MRI revealed some disc bulging at multiple levels, as well as cervical stenosis that was probably congenital in nature due to short pedicles. Dr. Anderson for further testified Petitioner's cervical spine exam revealed mild tenderness over the right trapezius, but full range of motion. Petitioner's neurological exam was normal in terms of strength, sensation, and reflexes. Dr. Anderson testified Petitioner cervical spine exam was normal. (RX 1, pp. 21-22)

At the time of his August 14, 2018 Section 12 examination, Dr. Anderson testified he diagnosed Petitioner with subjective right shoulder complaints, pain, and stiffness. Dr. Anderson testified he did not find definitive evidence Petitioner injured his right shoulder

during the two alleged work injuries on December 10, 2017, and December 15, 2017. Specifically, Dr. Anderson testified there was a fair amount of inconsistencies in the exact dates of Petitioner's alleged accidents, both in the medical records, as well as Petitioner's stated history. Dr. Anderson testified that regardless of the described injury, Petitioner advised he was unable to raise his arm above shoulder level and other limitations, which was not supported by the initial emergency room records. Dr. Anderson testified the initial emergency room record from December 17, 2017, which was after the alleged December 15, 2017, ice bin injury, noted Petitioner had no complaints or objective abnormalities regarding the right shoulder or elevating it. Dr. Anderson testified he reviewed the emergency room record from December 17, 2017, at Advocate Bromenn Medical Center, the medical evaluation on December 19, 2017, and the emergency record from OSF St. Joseph Medical Center in December 24, 2017. All of these visits were after Petitioner's alleged December 15, 2017, ice bin incident and did not mention an injury involving an ice bin incident. (RX 1, pp. 23-24) Dr. Anderson noted it was not until December 30, 2017, when there was a first documented evidence of some limitations in the right shoulder motion and function. Therefore, before that date, Petitioner was seen on at least three visits where his exam findings document full range of motion in the shoulder. (RX 1, pp. 22-23) Dr. Anderson testified as a treating physician, if a patient advises they were injured in a specific accident, they normally advised the facts of the accident. Dr. Anderson further testified it is a standard of practice as a physician that if a patient advises of an accident causing injuries, it is recorded in the medical records. Therefore, since Petitioner's accident histories were not contained in the initial treatment records, they are highly relevant in regard to the history inconsistencies. Dr. Anderson testified he would expect at least one of the records to contain the accident history, but it was suspicious all the initial treatment records did not contain a history of the alleged ice bin incident. (RX 1, pp. 24-25)

Dr. Anderson noted Dr. Li testified Petitioner suffered a traction injury after dropping the ice bin and catching it. Dr. Anderson testified he would expect abnormal exam findings following a traction accident, but Petitioner's exam findings were not abnormal until December 30, 2017. (RX 1, p. 25)

Dr. Anderson testified that the December 10, 2017 accident involving looking at the monitor repetitively would not cause an AC impingement syndrome or rotator cuff strain. Dr. Anderson testified that looking at the monitor had nothing to do with Petitioner's alleged shoulder injuries and complaints. Dr. Anderson further testified that Petitioner's right shoulder complaints at the time of his Section 12 examination were not the same subjective complaints contained in the initial emergency room records. Specifically, Dr. Anderson testified the initial emergency room record indicated Petitioner reported significant pain with movement of the right shoulder, as well as moving his neck towards the right, which were different than the complaints expressed during the August 14, 2018 Section 12 exam. (RX 1, pp. 25-26) Dr. Anderson testified his examination revealed Petitioner had a lot of guarding, supporting inconsistencies in that Petitioner

was able to use his right arm normally with conversation versus showing guarding and Limitations on more specific exam testing. (RX 1, p. 27)

Dr. Anderson opined that Petitioner's shoulder injuries were not caused or aggravated by his alleged work actions. Dr. Anderson noted numerous inconsistencies on physical examination, as well as inconsistencies in medical records. Dr. Anderson testified Petitioner did have pre-existing conditions that attributed to his shoulder complaints, including arthritis in the AC joint which predated any complaints. (RX 1, pp. 27-28)

Dr. Anderson testified he did not believe Petitioner required any work restrictions and was able to return to work in relation to his alleged work accidents and subsequent injuries. Dr. Anderson further testified Petitioner did reach maximum medical improvement in relation to his alleged work accidents, as he did not find evidence that Petitioner injured his right shoulder as a result of the alleged December 10, 2017 or December 15, 2017 work accidents. (RX 1, pp. 28-29)

On cross-examination, Dr. Anderson admitted cervical spine and shoulder injuries can mask one another. Dr. Anderson also admitted Petitioner was initially given a prescription at the emergency room evaluation for Hydrocodone, which is a narcotic pain medication. Dr. Anderson testified he would not prescribe Hydrocodone for a patient he did not believe had a medical condition. Dr. Anderson further testified Petitioner was given a morphine injection on December 19, 2017, which was a narcotic pain medication. Dr. Anderson assumed the morphine injection was given for pain complaints. Dr. Anderson testified he could not assume there was an injury at the time of the pain medication prescription, but he assumed Petitioner was having subjective pain complaints. Dr. Anderson further testified that it was not within the standard of care to give a patient morphine injections for simple pain complaints in the absence of any finding to indicate an injury. (RX 1, pp. 30-32)

Dr. Anderson testified that muscles spasms are identifiable by palpation rather than visual examination. However, if a patient truly has a muscle spasm, it is a subjective term, but can be an objective finding. Dr. Anderson testified an assessment of spasms in the trapezius muscles is not specific to the neck or the shoulder. Dr. Anderson admitted Petitioner was described anti-inflammatories and pain medications at his initial emergency room evaluations. Petitioner was also prescribed muscle relaxants. (RX 1, pp. 34-35)

Dr. Anderson testified regarding his exam findings. Dr. Anderson noted Petitioner had guarding with passive range of motion. Dr. Anderson further testified Petitioner had a positive Neer's and Hawkins test, which typically address rotator cuff irritation. Petitioner also had a positive AC provocative test. Dr. Anderson noted Petitioner had mild swelling of the AC joint of no real significance. Dr. Anderson admitted that swelling would be an objective and not a subjective finding. (RX 1, pp. 36-37)

Dr. Anderson noted Petitioner underwent two cortisone injections with Dr. Li, which reported 30%-40% relief for a period of approximately four weeks. Dr. Anderson testified there was no real significance regarding Petitioner's relief from the injections, but if Petitioner's symptoms improved with the injections, that's where you assume at least that percent of pain was coming from. (RX 1, p. 37)

Dr. Anderson testified his diagnosis Petitioner's right shoulder would be mild stiffness and likely symptoms from the AC joint with possible tendonitis. Without regard to causation, Dr. Anderson believed Petitioner's treatment represented in the medical records was reasonable for his shoulder complaints. Dr. Anderson also agreed performing an arthroscopic surgery would provide a superior view of what exists in terms of the shoulder pathology over the MRI findings. (RX 1, p. 38)

In relation to the alleged ice bin incident, Dr. Anderson testified he would not consider the described mechanism of injury as a traction injury. Dr. Anderson testified a traction injury is something that is pulling the extremity. Dr. Anderson testified assuming Petitioner's description of the accident was accurate, Petitioner was losing control of the ice bin. Dr. Anderson found it very hard, and potentially impossible, for Petitioner to move his hands from the top of the ice bin and hold onto it that quickly if the co-worker was dropping the bin. Dr. Anderson testified the Petitioner's accident history would not support a traction injury, as moving the hands from the bottom to the top with the forearms pronated, if anything, would cause an elbow or forearm strain and not a shoulder injury. (RX1, pp. 41-42) Dr. Anderson testified that for a motion or accident to occur to the shoulder, he did not believe that the accident requires the arm to be above shoulder level. (RX 1, pp. 42-43)

On redirect examination, Dr. Anderson testified Petitioner did not advise of any accident where his pain was caused by above shoulder level activities. Dr. Anderson admitted the medical records from December 17, 2017, December 19, 2017, and December 24, 2017, indicated prescriptions for certain narcotics and pain medications including morphine, anti-inflammatories, and muscle relaxers. Dr. Anderson testified Petitioner did express subjective complaints in those records and is normal for a patient to be prescribed pain medications due to subjective complaints. However, Dr. Anderson again testified the records did not note an alleged accident regarding an ice bin incident. (RX 1, pp. 43-45)

Arbitration Hearing:

Petitioner testified that he was employed by Respondent for five years as a grill cook. Petitioner testified that prior to the installation of the monitor, Petitioner would directly take orders from a person. However, a new system was put in where a monitor screen was installed, requiring Petitioner to take orders off of a screen. Petitioner testified his job required him to stand in a stationary position and look at the screen to his right. The screen is approximately 2 feet above head level and required Petitioner to look up to the right at greater than a 45° angle.

Petitioner testified that in the beginning of December 2017, he started feeling neck pain, where he could not turn his neck on his own. Petitioner testified he would have to turn his whole body. Petitioner advised he dealt with the neck pain for the first week, but at the end of the week he notified his boss that the monitor was causing problems with his neck. Petitioner indicated he advised he kept turning his neck, which caused a lot of pain. Petitioner testified he requested the screen be lowered so he did not have to look up and turn his head. However, the screen was not lowered.

Petitioner further testified that, a few days after he advised his boss of the monitor causing neck pain, he was involved in an incident with an ice bin. Petitioner testified the ice bin sits on a table right beside the grill. In the afternoon, the ice bin is moved over to the back table because the lunch cook uses the back table as a dressing table. The ice bin sits right by the cook because it has eggs and everything that is kept cold. Petitioner further testified he asked a co-worker to assist in moving the ice bin to the other table. Petitioner testified the ice bin was 3' x 2' and gradually gets narrower towards one end. Petitioner further testified that moving the ice bin is a task he had to perform every day, but he would ask for help because the employees were not supposed to perform activities like that on their own. Petitioner estimated the ice bin weighed approximately 50 pounds. Petitioner testified on the alleged accident date, a co-worker, Beth Smith, helped him move the bin. Petitioner indicated his grip was really well, but his co-worker was losing her grip. Therefore, Petitioner gripped the ice bin and used his body weight to hold it up so his co-worker could get her grip back. Petitioner testified the co-worker got her grip back and they were able to get the ice bin to the table. Petitioner testified he was holding the ice bin right under his chest, but when the weight of the ice bin shifted, he leaned back with the ice bin against his chest, so his co-worker could re-grip the bin. Petitioner indicated when he leaned back, he pulled the ice bin into his chest and used his upper strength to hold it.

Petitioner testified that, at the time of the ice bin incident, he was already experiencing pain in his neck, so he did not initially feel anything since he was hurting for over a week. Petitioner testified he did not think anything of it, until he got home, at which time his pain became worse. Petitioner testified his pain was different than before, as it started going towards the back of his neck and down his shoulder and back. Petitioner indicated he dealt with the symptoms for the next two days, until he was seen in the emergency room.

Petitioner testified he sought treatment at OSF St. Joseph Hospital, Advocate Bromenn Hospital, Advocate Health Care with Dr. David Braun, and orthopedic evaluations with Dr. Lawrence Li. Petitioner testified Dr. Braun was the only doctor he saw before hiring an attorney and going to Dr. Li. Petitioner testified he underwent physical therapy for his shoulder, as his neck symptoms just cleared up. Petitioner testified the physical therapy for his shoulder helped resolve his neck symptoms. However, his shoulder symptoms remained. Petitioner further testified he received two cortisone injections into his

shoulder, but he did not receive any injections for his neck. Petitioner testified his neck gets stiff at times, but it is not a problem in relation to his shoulder pain.

Petitioner advised he continued to work for Respondent under light duty restrictions for the previous year. Petitioner testified the Respondent was accommodating those restrictions and Petitioner was working as a cashier. Petitioner indicated that his work duties as a cashier did not require him to lift anything, but just run the cash register.

Petitioner's further testified the physical therapy helped his neck, but the conservative treatment, including injections, did not alleviate his shoulder pain. Petitioner further testified that Dr. Li recommended shoulder surgery, which Petitioner wished to proceed. Petitioner testified he was taking medications in relation to his injuries, including pain pills, muscle relaxers, and stress pills. Petitioner testified he was not on any medications prior to the alleged accidents.

Petitioner testified that on or around December 10, 2017, he was experiencing pain in his neck from the monitor. Subsequently, on December 15, 2017, the ice bin incident occurred.

On cross-examination, Petitioner testified the accident involving the monitor screen was not a single incident, but rather a repetitive, continuous issue. Petitioner testified he is required to continuously look at the monitor to perform his job duties. Petitioner testified his neck pain increased over the course of a year after the monitor had been implemented. Petitioner further testified the monitor incident caused neck pain, but Petitioner did not have any shoulder issues as a result of the monitor alleged matter accident.

Petitioner further testified on cross-examination that the alleged ice bin accident occurred on December 15, 2017. Petitioner testified following the December 15, 2017, accident, his shoulder pain began. Petitioner testified he was experiencing neck pain prior to that time, but subsequent to December 15, 2017, his shoulder pain increased, and he went to the hospital on December 17, 2017. Petitioner testified he did not have any shoulder problems prior to December 15, 2017.

Petitioner testified he advised his boss about the December 10, 2017, accident, but did not fill out an incident report. Petitioner indicated he reported the December 15, 2017, accident the following Monday, as there was no one around at the time of the accident to report it.

Regarding the December 15, 2017, ice bin accident, Petitioner testified the ice bin did not fall to the ground, as he was able to maintain it while his co-worker re-gripped the bin. Petitioner testified that his co-worker did not let go of the ice bin.

At the time of arbitration, Petitioner testified his neck was better and he was not actively receiving treatment for his neck. Petitioner testified his real issue was his right shoulder, which was causing him to lose sleep. Petitioner further testified he had unrelated sleep apnea, which required a CPAP machine.

Petitioner testified he reviewed his medical records with his attorney. Petitioner further testified he had no reason to question the medical records from Advocate Bromenn Medical Center or Dr. Lawrence Li. Petitioner further testified he didn't see Dr. Li until after he hired representation, at which time his attorney referred him to Dr. Lawrence Li.

On redirect examination, Petitioner testified the ice bin accident caused an increase in his pain. Petitioner testified that his pain became intensely worse after December 15, 2017, so he sought treatment.

On re-cross examination, Petitioner testified at the time of the ice bin accident, the ice bin never fell to the ground because he held the bin against his body weight. Petitioner again admitted that the co-worker's hands never came off the ice bin, but she was losing grip. Petitioner testified his arms were not pulled away from his body when the co-worker lost her grip. Petitioner confirmed he did not experience shoulder pain at the time of the alleged monitor incident, but his shoulder pain began after the alleged December 15, 2017, ice bin incident.

Conclusions of Law

In support of the Arbitrator's decision relating to:

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

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

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

(O) Prospective medical and choice of physicians.

With regard to the accident of December 15th, 2017, Petitioner's testimony was credible and unrebutted. While his histories vary slightly, when Petitioner initially sought treatment, it was primarily for his neck which was aggravated by the use of the elevated monitor. Petitioner first reported and complained about neck pain. The shoulder injury was discussed and reported in the occupational medicine visit of 1/4/18 (Rx 5)

Petitioner's description of the incident with the ice bin was credible. He described moving an ice bin that was a daily task and one which he was unable to perform by himself. He described a traction type injury where his co-worker stopped carrying part of the weight of the ice bin and Petitioner had to suddenly bear the full weight. Given the credibility of Petitioner's unrebutted testimony and his medical history

testified to by Dr. Li, the Arbitrator finds that Petitioner also sustained a second accident to his shoulder on December 15th, 2017.

Dr. Li, testified that he reviewed the prior medical records, performed extensive physical exams, and tried various conservative treatment modalities. Dr. Li's opinions are credible. The opinions of Dr. Li providing a causal connection to the shoulder are based on the medical records, history, and diagnostics along with the petitioner's description of how the injury occurred.

Based on the opinions of Dr. Li, the Arbitrator finds that Petitioner's current condition of ill-being in his right shoulder is causally related to the work accident of December 15th, 2017. Based on the findings regarding accident and causation, the Arbitrator finds Respondent to be responsible for medical bills as outlined in Px 12 subject to fee schedule and any appropriate 8(j) credits.

Regarding the issue of prospective medical, the medical records and opinions of Dr. Li, as well as the credible testimony of the Petitioner, show that Petitioner has failed conservative treatment and his only remaining course of treatment is surgery as recommended by Dr. Li. Therefore, the Arbitrator finds that Respondent should authorize the surgery and associated post-operative care for the petitioner as recommended by Dr. Li, as well as any necessary resulting temporary disability while undergoing Dr. Li's recommended course of treatment.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

BLAS AZCATL,

Petitioner,

vs. NO: 08 WC 51086

City Iron Works Corporation & IL State Treasurer as *ex officio* Custodian of the Injured Workers' Benefit Fund,

20IWCC0342

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent, Illinois Injured Workers' Benefit Fund, herein and notice given to all parties, the Commission, after considering the issues of benefit rate and permanent disability, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

Permanent Disability

The Commission agrees with the Arbitrator's award, however, notes a discrepancy regarding Petitioner's testimony in the Arbitrator's Decision. Therefore, the Commission strikes the third sentence in Section L, "What is the nature and extent of the injury," beginning with, "He testified that since this injury…"

The Commission notes that Petitioner testified that he still experienced pain at a level of five on a scale of one to ten as a result of the work-related accident of June 19, 2008. The last medical treatment he received on November 5, 2008 included x-rays of Petitioner's right middle finger and those were compared to x-rays from August 27, 2008. The Findings show that there is redemonstration of a tuft fracture involving the third digit. There does appear to have been interval

20IWCC0342

healing as evidenced by some bony bridging that is best seen on the lateral view. Bony deformity and soft tissue deformities remain. The Radiologist's Impression was, "Interval healing of a tuft fracture involving the third digit as described above. Interval development of finding suggestive of disuse osteoporosis. Silver nitrate was applied; triple antibiotics." (PX2)

Based on the foregoing factors, the Commission agrees with the Arbitrator and finds that Petitioner suffered 35% loss of use of the right middle finger.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's Decision filed on January 25, 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 $330.00 per week for a period of 13.3 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the 35% loss of use of the right middle finger.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Mt. Sinai Hospital $85.00 (after $996.00 write-off) and Dr. Kaymakcalan $1,180.00 for medical care provided for the work-related injury on June 19, 2008, for medical expenses under §8(a) of the Act adjusted in accord with the medical fee schedule provided by §8.2 of the Act

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

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

The Illinois State Treasurer, ex-officio custodian of the Injured Workers' Benefit Fund, was named as a co-respondent in this matter. The Treasurer was represented by the Illinois Attorney General. This award is hereby entered against the Fund to the extent permitted and allowed under Section 4(d) of this Act.

In the event the Respondent/Employer/Owner/Officer fails to pay the benefits, the Injured Workers' Benefit Fund has the right to recover the benefits paid due and owing the Petitioner pursuant to Section 5(b) and 4(d) of this Act. Respondent/Employer/Owner/Officer shall reimburse the Injured Workers' Benefit Fund for any compensation obligations of Respondent/Employer/Owner/Officer that are paid to the Petitioner from the Injured Workers' Benefit Fund.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $5,800.00.

20IWCC0342

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 22 2020
KAD/bsd
004/29/20
42

Kathryn A. Doerries

Thomas J. Tyrrell

Maria E. Portela

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

AZCATL, BLAS
Employee/Petitioner

Case# **08WC051086**

CITY IRON WORKS CORPORATION & ILLINOIS STATE TREASURER AS EX OFFICIO CUSTODIAN OF THE INJURED WORKERS' BENEFIT FUND
Employer/Respondent

20IWCC0342

On 1/25/2018, 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 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.

0243 JAMES ELLIS GUMBINER & ASSOC
CHRISTOPHER COOPER
180 N MICHIGAN AVE SUITE 2100
CHICAGO, IL 60601

0000 CITY IRON WORKS CORP
2310 S AVERS
CHICAGO, IL 60623

0639 ASSISTANT ATTORNEY GENERAL
CHARLENE C COPELAND
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Blas Azcatl
Employee/Petitioner

v.

Case # **08** WC **51086**

Consolidated cases: _____

City Iron Works Corporation &
Illinois State Treasurer as ex officio Custodian of the Injured Workers' Benefit Fund
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Steven Fruth**, Arbitrator of the Commission, in the city of **Chicago**, on **10/24/2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

20 I W C C 0 3 4 2

O. ☐ Other _____

FINDINGS

On **June 19, 2008**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**28,600.00**; the average weekly wage was $**550.00**.

On the date of accident, Petitioner was **30** years of age, ***married*** with **2** dependent children.

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

Respondent employer ***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 §8(j) of the Act.

ORDER

Respondent shall pay Mt. Sinai Hospital $85.00 (after $996.00 write-off) and Dr. Kaymakcalan $1180.00 for medical care provided for the work-related injury on June 19, 2008, adjusted in accord with the medical fee schedule provided by §8.2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $330/week for **13 & 2/7** weeks, because the injuries sustained caused a **35%** loss of the right middle finger.

Petitioner failed to prove that he is entitled to total temporary benefits.

The Illinois State Treasurer, ex-officio custodian of the Injured Workers' Benefit Fund, was named as a Co-Respondent in this matter. The Treasurer was represented by the Illinois Attorney General. This award is hereby entered against the Fund to the extent permitted and allowed under §4(d) of this Act. In the event the Respondent/Employer/Owner/Officer fails to pay the benefits, the Injured Workers' Benefit Fund has the right to recover the benefits paid due and owing Petitioner pursuant to §5(b) and §4(d) of this Act.
Respondent/Employer/Owner/Officer shall reimburse the Injured Workers' Benefit Fund for any compensation obligations of Respondent/Employer/Owner/Officer that are paid to Petitioner from the Injured Workers' Benefit Fund.

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

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

Signature of Arbitrator

January 24, 2018
Date

JAN 25 2018

Blas Azcatl v. City Irons Works Corp. and the State Treasurer, as *ex-officio* Custodian of the Injured Workers' Benefit Fund,
08 WC 51086

INTRODUCTION

This matter proceeded to hearing before Arbitrator Steven Fruth. The disputed issues were: ***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 accident?; ***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? TTD; ***L:*** What is the nature and extent of the injury?

FINDINGS OF FACT

At arbitration hearing on October 24, 2017, Petitioner Blas Azcatl introduced notice of the hearing to Respondent-Employer City Iron Works Corp. ("City Iron") by U.S. Certified mail and U.S. regular mail (PX #5). At the time of hearing Respondent City Iron did not appear nor did legal counsel for City Iron appear. Petitioner was present and represented by counsel. Attorney General's office appeared on behalf of the Illinois State Treasurer as ex-officio Custodian of the IWBF. Petitioner's Exhibit #4 verified that Respondent-Employer City Iron did not have workers' compensation insurance at the time of Petitioner's accident.

Petitioner testified that he was working for Respondent-Employer City Iron in June 2008. Petitioner testified that he was hired by Arturo Villanueva to work for as a welder. Arturo would tell the Petitioner where and when to work. Additionally, Arturo would tell him where to go and Petitioner was paid an average of $550.00 a week. Petitioner was paid in cash and checks.

Petitioner's work involved welding, working with metals, and performing any other duties Arturo assigned. Arturo would assign each week's schedule and work to Petitioner. Petitioner also testified that Arturo had exclusive control of his hours; specifically, Arturo controlled what time Petitioner could arrive on the job site and when he could leave.

Petitioner testified that he was working for Respondent-Employer Iron Works on June 19, 2008. At that time Petitioner was 30 years-old and married with two minor children. Petitioner was working when a piece of metal fell and sliced his right middle finger. Arturo took him to the emergency room at St. Mary St. Elizabeth Medical Center (PX #3). Petitioner was diagnosed with a finger-tip amputation of the right 3rd (middle) finger and received 8 sutures in his finger. He testified he was referred to Mount Sinai Hospital for follow up.

Petitioner followed up with care for his injured finger with Dr. Orhan Kaymakcalan on June 24, 2008 at Mt. Sinai Hospital (PX #2 & PX #6). Dr. Kaymakcalan diagnosed a comminuted fracture of the PIP (proximal interphalangeal) of the distal phalanx of the right long finger. Petitioner followed with Dr. Kaymakcalan sporadically, missing several scheduled appointments, through November 5, 2008 (PX #6).

Petitioner testified that he did not return to work for Iron Works. He is currently working as a welder.

Petitioner testified that he still suffers from pain in his middle finger that can intensify to an 8 or 9. He testified that part of his finger turned black and the skin around his fingernail died. Surgery was recommended, but Petitioner was not working and did not have insurance and could afford the surgery. He also testified that he has hand pain when he carries items.

CONCLUSIONS OF LAW

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

The Arbitrator finds that Petitioner and Respondent were operating under the Act on June 19, 2008. In so finding, the Arbitrator relies on Petitioner's credible and uncontested testimony that his duties required him to use company equipment, gloves, and other welding activities.

B: Was there an employee-employer relationship?

The Arbitrator finds that Petitioner proved that on June 19, 2008, an employee/employer relationship did exist between Petitioner and Respondent-Employer Iron Works. According to Petitioner his work day and work duties were directed and managed exclusively by Arturo Villanueva. The tools and materials used by

Petitioner were supplied by Respondent-Employer Iron Works. He further stated that Arturo obtained all projects and customers and provided any equipment required for the Petitioner to accomplish his work.

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

The Arbitrator finds that Petitioner proved that his accidental injury arose out of and in the course of his employment by Respondent-Employer Iron Works. In so finding the Arbitrator relies on Petitioner's testimony and the medical records, to find that Petitioner sustained a work-related accident resulting in injury to his middle finger, which arose out of and in the course of his employment.

Petitioner was performing a task he was instructed to perform by the Respondent-Employer. The task was an employment related risk as it involved in welding. Moreover, there is little doubt that Petitioner's accident occurred in the course of his employment with Respondent-Employer as he was assigned to work on the day of the accident. He was performing task assigned to him at the directions of the owner, Arturo Villanueva. Petitioner's medical records also support his testimony of having sustained injury to his back while under the scope of employment.

D: What was the date of the accident?

Petitioner proved that the accident occurred on June 19, 2008, by testifying to that date and entering into evidence several medical records that support a finding of June 19, 2008 as the date of injury.

E: Was timely notice of the accident given to Respondent?

The Arbitrator finds that timely notice was given to Respondent-Employer, based on Petitioner's testimony that Arturo Villanueva, Respondent-Employer, was at the worksite and took the Petitioner to the emergency room. Given the fact that Petitioner testimony was uncontested and credible the Arbitrator finds that notice was properly provided to the Respondent-Employer on June 19, 2008.

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

After a careful review of all the evidence, including Petitioner's testimony, the Arbitrator finds Petitioner's account of the mechanism of injury was proved by a preponderance of the evidence and given the medical treatment related to said accident,

Petitioner's current condition of ill-being in his right middle finger is causally related to his June 19, 2008 injury.

G: What were Petitioner's earnings?

Based on the evidence presented at trial and Petitioner's credible testimony, the Arbitrator finds that Petitioner average weekly wage was $550.00

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?

The Arbitrator finds that Petitioner presented sufficient evidence to establish his age and marital status at the time of the accident. At trial, Petitioner's unrebutted testimony was that on the date of accident, he was 30 years old and married with two children.

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 that Petitioner proved that the emergency medical care provided at St. Mary St. Elizabeth Medical Center, as well as the follow up care provided by Dr. Kaymakcalan at Mt. Sinai Hospital, were reasonable and necessary to cure or relieve the effects of Petitioner's work-related injury. Respondent-Employer is liable for the medical treatment rendered to Petitioner as a result of the work accident on June 19, 2008. Petitioner's medical records document timely medical care provided to treat Petitioner's right middle finger injury sustained as a result of his work accident.

Petitioner presented the following medical bills: Mt. Sinai Hospital (after $996.00 write-off), $85.00, Dr. Kaymakcalan, $1,180.00.

Respondent-Employer shall pay directly to Petitioner the reasonable and necessary medical services as provided in § 8(a) and adjusted in accord with the medical fee schedule provided in §8.2 of the Act.

K: What temporary benefits are in dispute? TTD

Petitioner offered no evidence that he was unable to return to work because of his injury. There was no evidence that any healthcare provider directed Petitioner to take off work because of his injury. The Arbitrator finds that Petitioner failed to prove that he is entitled to total temporary disability benefits.

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

Petitioner sustained an amputation of the tip of his right middle finger and a comminuted fracture of the distal phalanx of that finger. Petitioner testified that he continues to feel pain, discomfort, and suffers in his middle finger. He testified that since sustaining this injury he has had trouble with gripping and carrying. Based on the foregoing, The Arbitrator finds that Petitioner suffered a permanent partial disability of 35% loss of use of the right middle finger, 13.3 weeks, as provided in §8(e) of the Act.

Insurance coverage and liability of the Injured Workers' Benefit Fund

The Illinois State Treasurer as *ex-officio* custodian of the Injured Workers' Benefit Fund (the Fund) was named as a party respondent in this matter. Respondent-Employer Iron Works was properly served with notice of these proceedings. The Arbitrator finds that Respondent-Employer was not properly insured. In the event of the failure of Respondent-Employer to pay the benefits due and owing the Petitioner this award is hereby also entered against the Fund to the extent permitted and allowed under §4(d) of the Act. Respondent-Employer shall reimburse the Fund for any compensation obligations of Respondent-Employer that are paid to Petitioner from the Fund, including but not limited to the full award in this matter, the amounts of any medical bills paid, temporary total disability paid or permanent partial disability paid. Respondent-Employer's obligation to reimburse the Fund, as set forth above, in no way limits or modifies its independent and separate liability for fines and penalties set forth in the Act for its failure to be properly insured.

Steven J. Fruth, Arbitrator

January 24, 2018
Date

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jacqueline Robinson,
Petitioner,

vs.

NO: 16 WC 19976
20 IWCC 317

Walmart,
Respondent.

ORDER OF RECALL UNDER SECTION 19(f)

This matter comes before the Commission on Respondent's motion to correct a clerical error in the Decision and Opinion on Review of the Commission filed June 10, 2020. After reviewing the Decision on Review, the Commission recalls the Decision for the purposes of correcting the clerical error.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision dated June 10, 2020, is hereby vacated and recalled pursuant to Section 19(f) for a clerical error contained therein.

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

DATED: JUN 22 2020
DLS/rm

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 Choose reason	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify: Up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JACQUELINE ROBINSON,

Petitioner,

vs.

NO: 16 WC 19976
20 IWCC 317

WALMART,

Respondent.

CORRECTED DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of average weekly wage, benefit rate, temporary total disability ("TTD"), and 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.

Petitioner testified that while she was off work due to her work-related injury, she received income of $10.50 an hour for 15 hours a week from Help-at-Home working as a caregiver for her mother. Petitioner's testimony was not rebutted. The Arbitrator awarded Petitioner 25&6/7 weeks from September 7, 2016 through March 7, 2017, the date of Petitioner's termination. The Arbitrator found that normally Petitioner would be entitled to TTD from June 16, 2016 to March 7, 2017 for 39&5/7 weeks. "However, Petitioner testified that she received wages from Help-at-Home during this period." Therefore, she was not temporarily totally disabled for that period. He also noted that she did not claim temporary partial disability benefits. Therefore, the Arbitrator awarded TTD for only 25&6/7 weeks.

The Commission finds that the Arbitrator erred in denying all temporary disability benefits for the period of time Petitioner received some income from Help-at-Home. While she did receive some income for that work, that did not suggest that she was able to return to work at her prior job with Respondent. We conclude that Petitioner is entitled to temporary partial disability benefits for that period representing 2/3 of the difference in her average weekly wage and the income she received from her work for Help-at-Home. The Commission has the authority to award such benefits when the record indicates that they are warranted even though the Petitioner did not formally request temporary partial disability benefits. We do not believe it is appropriate to punish a claimant because of a failure to formally request a certain benefit when the record indicates that such benefit is due. Based on the evidence in the record, the Commission awards an additional award of $148.33 for a period of 13&6/7 weeks, representing 2/3 of the difference between her average weekly income of $380.00 and the actual income she received from Help-at-Home of $157.50 for that period.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $253.00 per week for a period of 25&6/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the additional sum of $143.33 for a period of 13&6/7 weeks, that being the period of temporary partial incapacity for work under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner permanent partial disability benefits of $253.00 per week for a period of 40 weeks, because the injuries sustained caused the loss of the use of 8% 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 $20,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUN 2 2 2020

Deborah L. Simpson

Barbara N. Flores

Marc Parker

DLS/dw
O-4/16/20
46

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ROBINSON, JACQUELINE
Employee/Petitioner

Case# **16WC019976**

15WC027066
16WC022314

WAL-MART STORE 3601
Employer/Respondent

20IWCC0317

On 10/22/2018, 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 2.41% 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:

0612 DWYER AND COOGAN
CAROLEANN GALLAGHER
140 S DEARBORN ST SUITE 1603
CHICAGO, IL 60603

5074 QUINTAIROS PRIETO WOOD & BOYER
MICHAEL J SCULLY
233 S WACKER DR 70TH FL
CHICAGO, IL 60606

20IWCC0317

20 IWCC0317

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

Jacqueline Robinson
Employee/Petitioner

v.

Wal-Mart Store 3601,
Employer/Respondent

Case # **16** WC **019976**

Consolidated cases: **15 WC 027066**
16 WC 022314

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jeffrey Huebsch**, Arbitrator of the Commission, in the city of **Chicago**, on **2/8/2018, 3/2/2018 and 4/6/2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

20IWCC0317

FINDINGS

On **May 30, 2016**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**19,760.00**; the average weekly wage was $**380.00**.

On the date of accident, Petitioner was **51** years of age, ***single*** with **1** dependent children.

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

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

Respondent shall be given a credit of $**10,868.00** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**10,868.00**.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $253.00 per week for 25-67 weeks, commencing 9/7/2016 through 3/7/2017, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $253.00 per week 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 the compensation benefits that have accrued from 5/30/2016 through 4/6/2018, 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

October 22, 2018
Date

OCT 22 2018

INTRODUCTION

This matter was tried with two companion cases, Case Nos. 15 WC 027066 and 16 WC 022314, which involved the claimed accident date of June 8, 2015 (after amendments of the Applications for Adjustment of Claim at the end of Petitioner's testimony).

FINDINGS OF FACT

Petitioner was employed by Respondent as a cashier. She began working for Respondent in May of 2014.

On May 30, 2016, Petitioner was working the self check registers. Petitioner was struck by a pole on the left side of her face as she tried to get supplies for the registers. Petitioner testified that she was struck on the left side of her head, left side of her face, her left eye, left ear, jaw and forehead. There wasn't any blood, but there was swelling. She was dazed and grabbed a cart to steady herself. A co-worker summoned help. Petitioner sat down and was attended to by the night manager. He brought a first aid kit and ice for her face. The night manager said he was getting paperwork for an incident report. He did not come back, apparently going home. Petitioner then found her supervisor, LaTasha Muse and told her that she was hit in the face. Petitioner said that she wanted to go home. Muse said that she would be assessed attendance points if she went home. Another supervisor, Clinique, had Petitioner fill out paperwork and had her sit in the self checkout area until her shift was over.

The next day, Petitioner contacted Muse and inquired about seeing a doctor, as she was dizzy, could not hear, had a black eye, her face was swollen and her head was pounding. Muse said that she would get back to Petitioner, but she did not. Petitioner called Muse the next day and was instructed to come into the store. Muse took Petitioner to Concentra on June 2, 2016. This is where Petitioner first received medical care for her injuries.

Petitioner had treatment at Concentra from June 2, 2016 to June 7, 2016. On June 2, 2016, She was seen with a history of being struck in the face with a shepherd's hook on May 30, 2016. Her complaints were of left ear pain and pressure, headache, nausea, blurred vision, swelling in the eye and neck pain. There was no loss of consciousness or fall. The physical exam showed very mild swelling of the left lower eyelid. The rest of the PE was benign. The diagnosis was: cervical strain; facial contusion and eye contusion. The recommendations were: Ibuprofen; CT of the head and orbital CT. She was taken off work for June 2 and could work modified duty thereafter. (PX 10)

Petitioner was seen for re-check on June 3, 2016. She had complaints of dizziness, blurred vision and headaches. The CT was negative for intracranial hemorrhage. She had been working her regular duties. An ophthalmology referral was made. Petitioner could return to work, sitting work only. Petitioner was seen on June 7, 2016 and was referred to a neurologist. It was recommended that she be seen that week. She was taken off work, effective June 7, 2016 and instructed to limit activities ("No activity, no work"). (PX 10, PX 11)

Petitioner was sent by Respondent to Dr. Andriani Siavelis, OD at Westchester Eye Surgeons. She was seen on June 7, 2016. The diagnosis was: 1. Cortical senile cataract; 2. Macular edema absent; 3. Type II DM; and 4. Moderate head injury (without injury to the eyeball). A neurologic exam was recommended and the patient was to be off work until the exam by a neurologist.

Apparently, there was a delay in setting up the neurologic consult. Petitioner's attorney and Respondent were able to agree that Petitioner be examined by Dr. Richard Lazar on February 21, 2017. Dr. Lazar's assessment was that Petitioner sustained a concussion at work, that she was experiencing headaches with some features due to post-concussion and some due to stress and emotional components, but that her headaches were getting better. Petitioner told Dr. Lazar that she wanted to return to work but that she also wanted some symptomatic headache treatment. Dr. Lazar recommended her primary care physician "administer something like Limbitrol or Fiorinal" on an as needed basis, that Petitioner have two more weeks off of work to get the medications and make any necessary adjustments, at which point she could return to work without restriction. (RX 9)

Petitioner's employment with respondent was terminated February 8, 2017. This was apparently due to alleged deficiencies in her FMLA paperwork. It appears that Petitioner could re-apply for a job at Respondent, but she has not done so. Petitioner has applied for perhaps 300 jobs since February of 2017, but has not been hired, apparently because of limitations regarding her shoulder.

Petitioner testified that she does not hear as well as she did before the accident. She cannot see as well as before the accident. She has headaches and ear pain. She complains of vertigo. She has problems sleeping. She copes with the headaches as best she can.

Petitioner testified that she received TTD benefits from Walmart from June 2, 2016 through March 14, 2017. Petitioner claims that she is owed TTD benefits from Respondent from March 8, 2017 through March 2, 2018.

Petitioner testified that she was employed by Help at Home, LLC as a home health care aid from September 11, 2014 through September 6, 2016 and earned $10.05 per hour. She agreed that she worked about 15 hours per week for Help at Home, LLC. Petitioner denied filing an unemployment claim against Help at Home, LLC but testified that she had filed a claim for unemployment against Respondent. No documentation of an unemployment claim against Respondent was offered at trial.

Evidence of Petitioner's unemployment claim against Help at Home, LLC was admitted. These records show that Petitioner filed a claim for unemployment benefits against Help at Home, LLC, as well as two appeals of administrative determinations regarding her claim. The claims adjudicator determined that Petitioner was not eligible for benefits. Following the claims adjudicator's determination, the claim was appealed to a Referee, then to the Board of Review, and finally to the Circuit Court of Cook County. (RX 15)

On April 23, 2017, Petitioner filed a claim for unemployment insurance against Help at Home, LLC. The employer protested Petitioner's right to benefits, and submitted allegations that Petitioner voluntarily quit and provided no reason or notice despite the availability of continuing work. On May 17, 2017, the claims adjudicator denied Petitioner benefits because the evidence showed that Petitioner was not available for work and that Petitioner conditionally narrowed her opportunities and had no reasonable prospects for securing work. Petitioner appealed the denial. (RX. 15)

A telephonic hearing was held regarding Petitioner's appeal of the claims adjudicator's determination that she was not eligible for benefits on June 8, 2017. During the telephonic hearing testimony was taken under oath by the Referee. Petitioner testified that she was released to return to work without restrictions sometime at the end of February of 2017. Petitioner also provided "pages 4 and 5 of a purported medical note releasing her to return to work" and a discharge summary from Petitioner's physical therapy provider. Petitioner further testified that she had made five job contacts each of the two weeks under review, or ten job contacts total. Petitioner also admitted that she had not contacted Help at Home, LLC following her release to return to work. The representative for Help at Home, LLC testified that Petitioner would be returned to work if she attended a three-day training session. (RX. 15)

On June 9, 2017, the Referee issued an Administrative Law Judge's Decision, which affirmed the determination of the claims adjudicator. The Referee found that "Her testimony and work search was not credible," and that Petitioner failed to meet her burden to establish her eligibility for benefits. (RX. 15)

Petitioner appealed the Administrative Law Judge's Decision to the Board of Review on July 7, 2017. The Board of Review issued a decision on August 30, 2017 finding that Petitioner did not did not meet her burden to show that she was entitled to receive unemployment benefits in light of testimony from Petitioner that was inconsistent with the medical records she provided as evidence. (RX. 15)

On October 2017, Petitioner filed a Pro Se Complaint for Administrative Review in the Circuit Court of Cook County, Law Division. On February 14, 2018, Judge Daniel Kubasiak entered an Opinion and Order in the case which includes a Procedural History, Facts, Discussion, and Order. Judge Kubasiak found that Petitioner told her employer that she was not coming back to work during a phone conversation on October 31, 2016 and that her testimony was inconsistent with the medical records she provided as evidence. The judge also found that "The manifest weight of the evidence supports the finding that Plaintiff merely made a perfunctory effort in her work search to qualify for unemployment benefits." Judge Kubasiak confirmed the decision of the Board of Review. (RX. 15)

Petitioner's testimony establishes that she worked for and collected wages from Help at Home LLC while she was collecting TTD from Respondent. She stopped working for Help at Home, LLC when she had the shoulder surgery by Dr. Sonnenberg.

Petitioner's claimed bills regarding this case were admitted as PX 19. Respondent's Medical Payment Ledger was admitted as RX 14. Respondent's TTD Ledger was admitted as RX 13.

CONCLUSIONS OF LAW

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

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

including that there is some causal relationship between her employment and his injury. Caterpillar Tractor Company v. Industrial Commission, 129 Ill.2d 52, 63 (1989) To be compensable under the Act, an injury need only be a cause of an employee's condition of ill-being, not the sole or primary causative factor. Sisbro, Inc. v. Industrial Comm'n, 207 Ill.2d 193, 205 (2003)

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

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

Petitioner sustained accidental injuries which arose out of and in the course of her employment by Respondent on May 30, 2016. This finding is based upon petitioner's testimony and the medical records.

WITH RESPECT TO ISSUE (E), WAS TIMELY NOTICE OF THE ACCIDENT GIVEN TO RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

Respondent disputed Notice, but the testimony establishes that Petitioner's supervisor took her to the company clinic for medical treatment on June 2, 2016, three days after the accident. Notice was proved.

WITH RESPECT TO ISSUE (F), IS PETITIONER'S PRESENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner's current condition of ill-being, as diagnosed by Dr. Lazar (status post concussion 5/30/2016 at work, with mixed headaches, post concussion and stress related) is causally related to the injury. This finding is based upon Petitioner's testimony, the medical records and Dr. Lazar's report.

WITH RESPECT TO ISSUE (G), WHAT WERE PETITIONER'S EARNINGS, THE ARBITRATOR FINDS AS FOLLOWS:

At the time of submission of exhibits on March 2, 2018, the Parties agreed that the TTD rate and the TTD rate would be $253.00. Therefore, the Arbitrator found Petitioner's claimed AWW of $380.00 to be correct, as is set forth above in this Decision.

WITH RESPECT TO ISSUE (I), DID PETITIONER HAVE A DEPEDENT CHILD AT THE TIME OF THE ACCIDENT, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner's unrebutted testimony establishes that she had a 16 year-old son at the time of the accident.

WITH RESPECT TO ISSUE (J), WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY AND HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner claimed medical expenses from Concentra, Skan-Bedford Park and Westchester Eye Surgeons, SC as a result of the injury. (PX 19). RX 14 and PX 19 show that the bills were paid by Respondent and there are no outstanding balances. Accordingly, no bills are awarded.

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

Given Petitioner's claimed TTD on ArbX 2, her testimony and the medical records, along with RX 13 (the TTD summary), Petitioner would be entitled to TTD from 6/2/2016 to 3/7/2017, a period of 39-5/7 weeks. However, Petitioner testified that she received wages from Help at Home during this time period, through September 6, 2016. Therefore, as she was not temporarily and totally disabled from June 2, 2016 through September 6, 2016, she is not entitled to TTD for that time period.

No wage or attendance records from Help at Home were submitted. There was no claim for TPD. Therefore, the wages from Help at Home do not impact the AWW and the Arbitrator relies on Petitioner's testimony in awarding TTD only from 9/7/2016 to 3/7/2017, a period of 25-67 weeks.

WITH RESPECT TO ISSUE (L), WHAT IS THE NATURE AND EXTENT OF THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

Pursuant to §8.1b of the Act, the following criteria and factors must be weighed in determining the level of permanent partial disability for accidental injuries occurring on or after September 1, 2011:

(a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall report the level of impairment in writing. The report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment. The most current edition of the American Medical Association's "Guides to the Evaluation of Permanent Impairment" shall be used by the physician in determining the level of impairment.

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

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

No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no permanent partial disability impairment report and/or opinion was submitted into evidence. Accordingly, this factor is given no weight in determining PPD.

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 cashier 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, per Dr. Lazar. This factor is given substantial weight in determining PPD.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 51 years old at the time of the accident. This factor is given some weight in determining PPD.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that Petitioner testified that her employment opportunities are limited due to her shoulder condition, which is not the subject of this case. This factor is given some weight in determining PPD.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that it took some time for an examination by a neurologist to be done, even though Respondent's clinic documented the urgency of an examination (as was documented by the eye doctor, Dr. Siavelis). The Arbitrator does give weight to Dr. Lazar's opinions that the post-concussion headaches are at least in part related to the injury. Thus, some of Petitioner's subjective complaints are corraberated by medical records and the opinion of a specialist. Moderate weight is given to this factor in determining PPD.

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 8% loss of use of the person as a whole, pursuant to §8(d)2 of the Act.

WITH RESPECT TO ISSUE (N), IS RESPONDENT DUE ANY CREDIT, THE ARBITRATOR FINDS AS FOLLOWS:

Respondent paid Petitioner $10,868.00 in TTD benefits. The TTD rate is $253.00 per week. Petitioner is awarded 25-6/7 weeks of TTD, or $6,541.82. There has been an overpayment of TTD benefits in the amount of $4,326.18, for which Respondent is entitled to a credit against the PPD award.

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

ANTHONY SANDERS,

Petitioner,

vs. NO: 11 WC 34754

CITY OF CHICAGO,
DEPARTMENT OF WATER MANAGEMENT,

Respondent.

20IWCC0343

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

The Petitioner sustained a work-related injury on July 19, 2011 resulting in injury to his right knee, right elbow, left finger and right foot. The Arbitrator awarded Petitioner a wage differential award pursuant to Section 8(d)1 of the Act due to his right knee injury and 5% loss of use of the right arm and 15% loss of use of the left little finger pursuant to Section 8(e) of the Act.

The issue of whether Petitioner can receive an award pursuant to Section 8(e) and Section 8(d)1 of the Act for multiple injuries resulting from the same accident was addressed in *General Electric Co. v. Industrial Com.*, 89 Ill. 2d 432, 433 N.E.2d 671, 1982 Ill. LEXIS 245, 60 Ill. Dec. 629. The court held that compensation is proper under either section 8(e) or 8(d)(1), but not both at once. In light of the holding in *General Electric*, Petitioner is precluded from obtaining both Section 8(e) and Section 8(d)1 awards. Therefore, the Commission vacates the Arbitrator's award of 5% loss of use of the right arm and 15% loss of use of the left little finger pursuant to Section 8(e) and affirms the wage differential award pursuant to Section 8(d)1 of the Act.

The Commission further vacates the award penalties pursuant to Section 19(l) in the amount of $4,080.00 and attorney fees of $816.00 pursuant to Section 16.

Section 19(*l*) of the Act provides:

> If the employee has made a 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*).

The record reveals that Petitioner's job search logs were incomplete and that he was not following up with potential employers. The Respondent sent Petitioner a letter stating that his benefits were being suspended as he was not diligent in his job searches. The Commission finds that Respondent's actions were not unreasonable. Accordingly, the Commission vacates the Arbitrator's award of 19(l) penalties.

As the Arbitrator declined to award penalties pursuant to Section 19(k), the award of attorney fees pursuant to Section 16 was improper. Therefore, the Commission vacates the award of attorney fees pursuant to Section 16 of the Act.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 10, 2019, is hereby modified as stated above, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $938.67 per week for a period of 277 weeks, July 20, 2011 through November 8, 2016, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner maintenance benefits of $938.67 per week for a period of 97-1/7 weeks, November 9, 2016 through September 19, 2018, as provided in Section 8(a) of the Act.

IT IS FURTHER ORDERD BY THE COMMISSION that Respondent shall be given a credit of $329,873.46 for temporary total disability and/or maintenance benefits that have been paid.

20IWCC0343

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner permanent partial disability benefits, commencing September 20, 2018, of $778.67 per week for the duration of the disability, because the injuries sustained caused the loss of earnings, as provided in Section 8(d)1 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay reasonable and necessary medical services contained in Petitioner's exhibits 1-20, 24 through 27 and 32 through 34, as provided in Section 8(a) and 8.2 of the Act which are related to the treatment of the right knee, right elbow, and left 5th finger. Respondent shall pay reasonable and necessary medical services contained in Petitioner's exhibits as provided in Sections 8(a) and 8.2 of the Act which are related to the treatment of the right foot/ankle in 2013, but Respondent is not liable for any subsequent treatment of the right foot/ankle.

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

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: JUN 22 2020

D. Douglas McCarthy

DDM/tdm
O: 5/6/20
052

Stephen Mathis

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

SANDERS, ANTHONY Case# **11WC034754**
Employee/Petitioner

CITY OF CHICAGO/DEPT OF WATER MGMT
Employer/Respondent

20IWCC0343

On 5/10/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.38% 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:

2988 CUDA LAW OFFICES LTD
ANTHONY CUDA
6525 W NORTH AVE SUITE 204
OAK PARK, IL 60302

0113 CITY OF CHICAGO CORP COUNSEL
STEPHANIE LIPMAN
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
CORRECTED ARBITRATION DECISION

ANTHONY SANDERS
Employee/Petitioner

v.

CITY OF CHICAGO / DEPARTMENT OF WATER MGMT.
Employer/Respondent

Case # **11** WC **34754**

Consolidated cases: _____

20IWCC0343

An *Application for Adjustment 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 **September 19, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **July 19, 2011**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**73,216.00**; the average weekly wage was $**1,408.00**.

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

To date, Respondent has paid $**329,875.46** in TTD and/or for maintenance benefits and is entitled to a credit for any and all amounts paid via either workers' compensation payments or group disability benefits under Section 8(j) of the Act.

Respondent is entitled to a credit for any awarded medical expenses that were paid by Respondent prior to hearing via either workers' compensation or group health pursuant to Sections 8(a) and/or 8(j) of the Act.

Respondent shall hold Petitioner harmless with regard to any noted weekly benefit and medical expense credits pursuant to Section 8(j) of the Act.

ORDER

The Arbitrator finds that the Petitioner's right knee, right elbow and left 5th finger injuries are causally related to the July 19, 2011 accident. The Arbitrator finds that the Petitioner's preexisting right foot/ankle condition was temporarily aggravated as a result of the July 19, 2011 accident and that the Petitioner's treatment in 2013 was causally related to the accident, but that any subsequent problems or treatment of the right foot/ankle are not causally related to the July 19, 2011 accident.

Respondent shall pay Petitioner temporary total disability benefits of **$938.67 per week** for **277 weeks**, commencing **July 20, 2011 through November 8, 2016**, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner maintenance benefits of **$938.67 per week** for **97-1/7 weeks**, commencing **November 9, 2016 through September 19, 2018**, as provided in Section 8(a) of the Act.

Respondent shall be given a credit of **$329,875.46** for temporary total disability and/or maintenance benefits that have been paid.

Respondent shall pay reasonable and necessary medical services contained in Petitioner's Exhibits 1 through 20, 24 through 27 and 32 through 34, as provided in Sections 8(a) and 8.2 of the Act which are related to the treatment of the right knee, right elbow and left 5th finger. Respondent shall pay reasonable and necessary medical services contained in Petitioner's Exhibits as provided in Sections 8(a) and 8.2 of the Act which are

related to the treatment of the right foot/ankle in 2013, but Respondent is not liable for any subsequent treatment of the right/foot ankle.

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

Respondent shall pay Petitioner permanent partial disability benefits of **$695.78 per week**, the maximum allowable statutory rate, for **12.65 weeks**, because the injuries sustained caused the loss of use of **5% of the right arm**, as provided in Section 8(e) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of **$695.78 per week**, the maximum allowable statutory rate, for **3.3 weeks**, because the injuries sustained caused the loss of use of **15% of the left little finger**, as provided in Section 8(e) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits, **commencing September 20, 2018**, of **$778.67 per week** for the duration of the disability, because the injuries sustained caused a loss of earnings, as provided in Section 8(d)1 of the Act.

Respondent shall pay to Petitioner penalties of **$816.00**, as provided in Section 16 of the Act; **$0**, as provided in Section 19(k) of the Act; and **$4,080.00**, as provided in Section 19(l) of the Act.

Respondent shall pay Petitioner compensation that has accrued from **July 19, 2011** through **September 19, 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

May 8, 2019
Date

MAY 10 2019

STATEMENT OF FACTS

The Petitioner worked for the Respondent as a construction laborer since August 1999 in the Department of Water Management and testified he had not been terminated by Respondent as of the hearing date. His job

involved repairing water and sewer mains, catch basins and fire hydrants, among other things, at various Chicago locations. This can require working on his knees or lying on his stomach or back to make such repairs. The Arbitrator notes that a job description for "Construction Laborer" was part of the record of evidence (see Px29) and was consistent with the Petitioner's testimony. It specifically noted the requirements of heavy lifting (up to 100 pounds), extensive standing and walking, the need to quickly bend/stretch/twist/reach with the arms and legs, use of hand and power tools and equipment and the ability to access difficult to enter spaces.

On 7/19/11, Petitioner testified he was working at a location near 102nd and Longwood Avenue. He took his break between 11:00 a.m. and 11:15 a.m. Because they had no bathroom facility set up at the site, Petitioner went to a nearby Wendy's to use the bathroom at his foreman's direction. He was riding his motorcycle to the location when he hit an object in the street, the bike veered, and he went down. This was about a half block from the job site. He had immediate right leg pain and couldn't get up, so he was taken by ambulance to the Christ Hospital ER. The parties have stipulated that the Petitioner sustained accidental injuries arising out of and in the course of his employment on 7/19/11.

A 7/19/11 right knee CT scan reflected a markedly comminuted displaced tibial fracture and a fibular (neck) fracture with some significantly displaced tibial fragments, as well as a punctate lateral femoral cortical avulsion fracture. Significant calf edema was also observed. X-rays noted an old healed fracture of the distal right fibula with implanted plate and screws with apparently maintained ankle joint mortise. (Px9). After examination, Mr. Sanders was diagnosed with a slightly displaced and angulated 5th metacarpal fracture to his left hand, a bicondylar severely comminuted proximal tibia fracture involving the joint on both the medial and lateral sides of his right knee, along with a grade 3b open right olecranon fracture with 4cm skin loss. (Px1).

On 7/20/11, Dr. Durudogan performed multiple surgeries. As to the right leg, this involved a four-compartment fasciotomy, irrigation and debridement of multiple blisters, and closed reduction of right tibial plateau fracture with an external fixator. He also underwent irrigation and debridement of skin to bone at the right elbow with removal of a right olecranon fracture fragment. Dr. Durudogan also performed a closed reduction and percutaneous pinning on the left 5th metacarpal. Post-operative diagnoses were: 1) right tibial plateau fracture, 2) right grade 3B open olecranon fracture with skin loss, 3) left 5th metacarpal fracture and right leg compartment syndrome. (Px1). The Arbitrator notes that Dr. Chandler, Dr. Chaudri and Dr. Durudogan all practice out of Southwest Center for Healthy Joints.

Mr. Sanders remained in the hospital through 7/28/11, and this included inpatient physical therapy and wound care through Evergreen Health. (Px1; Px3). Petitioner then underwent a second surgery with Dr. Chandler on 8/2/11. Noting the tibial plateau fracture was bicondylar and severely comminuted, Dr. Chandler performed open reduction with internal fixation using a tibial plate and bone grafting, with removal of the external fixation. On 8/6/11, due to both ongoing compartment syndrome and an infected medial incision, Dr. Chaudry performed another right leg fasciotomy with irrigation and debridement and application of a wound vacuum-assisted closure. On 8/8/11, Dr. Habeeb diagnosed deep vein thrombosis (DVT) with a subsequent massive pulmonary embolism, despite the use of anti-coagulants. He performed surgical placement of an inferior vena cava (IVC) filter/rod in the right leg to assist with blood flow. Dr. Chandler performed a repeat irrigation and debridement surgery to the right leg on 8/9/11 with IVC placement. No necrotic tissue was found but there did appear to be ongoing infection. On 8/12/11, Dr. Chaudri repeated this procedure, and also removed the pins from the prior left-hand surgery. The 5th metacarpal fracture was noted to be stable via fluoroscopy. On 8/17/11, Petitioner saw Dr. Kalimuthu at Christ Hospital for additional wound care, and he performed debridement of the right knee with vacuum placement, as well as primary closure of the right medial leg. He performed further debridement on 8/20/11, and this was followed by a muscle flap and skin graft to cover the right knee wound because the plate hardware was exposed. (Px1).

Petitioner was discharged on 8/31/11. He testified he was in pain during this time and had again undergone physical therapy at the hospital with Evergreen Health. He was transferred to RIC for inpatient rehabilitation from 8/31/11 through 9/11/11. (Px9a).

Petitioner was transferred back to Christ Hospital on 9/12/11 due to ongoing infection and failure of the skin graft, and on 9/16/11 again underwent irrigation and debridement of the right tibia to the bone with placement of a wound VAC. Petitioner remained admitted to the hospital until his 9/20/11 discharge. (Px1). He then returned to RIC on 9/20/11 for additional therapy through 9/29/11. (Px9b).

On 9/30/11, Petitioner followed up with Dr. Chandler, x-rays were obtained, and Petitioner was advised he would need to have the implanted plate removed at some point and then have a plastic surgery consult regarding wound closure. (Px9). He testified he was still in pain at that point and was using a walker/crutches.

On 10/18/11, Petitioner underwent yet another surgery with Dr. Chandler, this time to remove the implanted hardware due to infection. This again involved irrigation and debridement and vacuum-assisted wound closure. An infectious disease consult was obtained with Dr. Andreoni on 10/19/11. He diagnosed osteomyelitis at the right knee fracture site and recommended continued IV antibiotics. At the time of discharge on 10/22/11, Dr. Chandler noted that there was still non-union of the tibial plateau fracture per a 10/19/11 CT scan, and Petitioner was advised to remain non-weightbearing. Petitioner was also fitted with an AFO brace after it was noted he had some level of foot drop. (Px1). The Arbitrator notes that the radiologist indicated the CT scan also showed possible abscess formation in the calf area and that the fibular fracture was partially healed with a mildly angulated fracture deformity. On 10/31/11, Dr. Chandler noted Petitioner's fracture was not healed, though he was using a bone stimulator, and he should remain non-weight-bearing. (Px9).

On 11/25/11, Dr. Kalimuthu performed an additional debridement of the right knee wound and repeat skin grafting at the site with skin harvested from the right thigh. It was noted that the wound was foul-smelling and that some infection remained. On 11/27/11, Dr. Chaudri noted that updated films indicated the tibial fracture showed slight angulation and that there was minimal callus formation. At discharge on 11/29/11, Dr. Beck noted Petitioner continued to have an IVC filter and was to restart Coumadin, and he recommended that Petitioner begin weightbearing on the right leg. (Px1). Petitioner testified he continued to use an assistive device while seeing Dr. Chandler between 11/25/11 and 12/28/11, and that he remained off work during this period. (see Px9).

Petitioner testified that his wound remained open and he continued to follow up with Dr. Chandler. On 1/18/12, Petitioner was initially evaluated at Accelerated Rehabilitation Centers. On 2/6/12, Dr. Chandler issued a work note indicating no work at all with the right leg. Dr. Plummer was consulted on 3/6/12 for infectious disease, and she suspected possible ongoing bony structure infection and/or necrosis and recommended a CT scan and lab testing for further evaluation. On 3/20/12, Dr. Plummer indicated the CT scan showed severe deformity of the proximal tibia, but that there was some mild healing taking place with some coalescence of the comminuted fracture fragments. Due to worsening of soft tissue inflammation, joint effusion and an eroded tibial cavity with free-floating cement present, she recommended another irrigation and debridement procedure. She noted that "until there is a communication between the skin and bone, the healing will less likely happen." (Px1; Px9).

Petitioner testified that home health care nurses were sent to is home around this time to help with wound care.

The impression in a 4/23/12 right knee MRI was of an acute/subacute bicondylar comminuted intraarticular fracture involving the right proximal tibia with a fracture gap noted that represented air versus a foreign body. A CT scan was recommended for further evaluation. (Px8; Px9).

On 5/4/12, Petitioner saw Dr. Chandler and presented a jar of bone fragments he indicated "fell out of his right knee." He was noted to have a draining pinhole sized opening in the knee. Infection was suspected, and on 5/8/12, Dr. Psaradellis performed irrigation and debridement of right tibial osteomyelitis. Petitioner underwent surgery again with Dr. Durudogan on 5/9/12 involving irrigation and debridement and a change of antibiotic beads. There was no sign of acute infection. On 5/11/12, Dr. Chaudri performed yet another irrigation and debridement procedure to the right knee with removal of antibiotic beads and wound closure. (Px9).

On 5/25/12, Dr. Chandler indicated Petitioner was showing signs of a right meniscal tear, including symptoms of give-way, and he stated this was common with Petitioner's type of injury. The doctor indicated that he would need to finish his course of antibiotics and to have an infectious disease consult before a meniscal surgery could be performed. (Px9).

X-rays obtained on 6/19/12 were read by Dr. Holland as indicating deformity consistent with old fracture and delayed healing with possible ongoing osteomyelitis. She noted a fracture line was still present but "somewhat healed" when compared to October 2011 films. (Px1).

On 7/6/12, Dr. Chandler prescribed physical therapy, which Petitioner started on 7/17 at Accelerated. (Px11).

A 7/12/12 right knee MRI showed continued displacement of the fracture fragments, bone marrow edema at the fracture sites, possible abscess and marked osteoarthritic changes in all three knee compartments with osteophyte formation. There was possible posterior horn medial and lateral meniscus tearing, a Grade III tear of the anterior horn of the lateral meniscus, a grade II MCL sprain and a "fanned out" ACL. (Px9). On 7/18/12, Dr. Chandler noted that updated x-rays indicated a healing tibial fracture with some collapse of the medial side resulting in a valgus positioning. (Px9).

On 7/31/12, Dr. Chandler performed right partial medial and lateral meniscectomies with extensive debridement and manipulation of the knee under anesthesia due to arthrofibrosis. Irrigation and debridement was also performed again, again with placement of antibiotic beads. (Px9).

Much of Petitioner's pathology testing from August 2011 through August 2012 was performed via Midwest Diagnostic Pathology. (Px5). Various pieces of reasonable and necessary home care equipment in 2011 and 2012 was billed via LCM Home Health Care Equipment. (Px6).

Petitioner continued to follow-up with Dr. Chandler between 8/29/12 and 1/9/13, during which he continued to be held off work. Slow healing of his right knee wound post-operatively was noted, however testing revealed no sign of recurrent infection. The fracture was continuing to heal and consolidate but with evidence of post-traumatic arthritic changes. Petitioner continued to attend formal physical therapy at Accelerated and continued to report improvement in his right knee symptoms. On 1/9/13, Dr. Chandler noted that Petitioner complained of right foot pain and swelling, and a right foot x-ray was obtained. This was noted to show a hallux valgus but no acute findings. The right foot was injected at the first MTP joint. He had no right knee complaints. (Px9; Px11).

On 2/6/13, Petitioner reported temporary improvement with the injection but that he was having difficulty walking, so Dr. Chandler referred him to podiatrist Dr. Linde for the right foot "toe/bunion issue." (Px9).

On 2/15/13, Dr. Linde diagnosed sinus tarsi syndrome, hammerdigit syndrome, hallux interphalageous (congenital anomaly) and generalized osteoarthritis at multiple sites. She noted deterioration to the level of bone on bone of the right foot/ankle and that this would continue to progress over time. Multiple forms of conservative treatment were recommended, including orthotics, with therapy prescribed on 2/22/13, and noting the last resort would be joint arthrodesis. On 2/22/13, Dr. Linde indicated Petitioner was following up for "traumatic DJD – right foot/ankle." (Px14).

On 2/27/13, Petitioner reported he was treating with Dr. Linde for his right foot, that he had no right knee complaints and that he was to restart therapy that day. Dr. Chandler noted Petitioner would resume therapy so long as the orthotics provided sufficient pain relief. He planned to obtain a functional capacity evaluation (FCE) at the next visit, indicating Petitioner remained restricted from any right leg use. (Px9).

Petitioner testified that at some point in April 2013 further therapy was not authorized by Respondent. However, the records indicate he remained in therapy with Accelerated into July 2018. The right foot was noted and appeared to have received some level of treatment, though exactly how much treatment was directed to the knee versus the ankle/foot was not clear. (Px11).

On 3/1/13, Petitioner reported to Dr. Linde that taping/strapping his foot provided 50% to 60% improvement, and that he was attending physical therapy. On 3/22/13, he received fitted orthotics. (Px11).

On 3/18/13, Petitioner reported some minor right knee pain and a feeling of give-way in the knee. He also reported some swelling at the knee incision site, so Dr. Chandler recommended an infectious disease consult. On 3/29/13, Petitioner reported his wound had opened again and that he had seen infectious disease specialist Dr. Kumar. A right knee CT scan was prescribed to evaluate if Petitioner had an ongoing abscess. On 4/5/13, Dr. Chandler noted Dr. Kumar found no sign of infection. He advised Petitioner to complete physical therapy, to be followed by the FCE. (Px9).

On 4/18/13, Petitioner reported to Dr. Linde that the orthotics helped him, as well as therapy, and that he had significantly reduced right foot/ankle pain. (Px11).

On 4/25/13, Petitioner underwent an FCE which indicated he provided excellent effort and was capable of work in the heavy category, but that he did not meet his job requirements as a construction laborer. (Px9; Px11).

On 4/26/13, Petitioner reported increased right knee pain following his FCE, and Dr. Chandler provided a Toradol injection (Px9), which Petitioner testified provided only temporary improvement. Petitioner returned to Dr. Chandler on 5/3/13 with a more pronounced limp, reporting no improvement with the injection, and that he was back at therapy with no relief. The FCE was reviewed and Petitioner's restrictions of no right leg use, along with other specific restrictions, were continued. (Px9).

Petitioner testified that a Respondent nurse case manager (NCM) was present at all of his medical visits, noting that he voluntarily agreed to allow this.

On 5/23/13, Dr. Linde, Petitioner reported increased pain after participating in a strenuous work conditioning program, i.e. the FCE. He had not been able to wear his orthotics due to swelling. She believed he likely had a flare-up of his degenerative joint disease due to overdoing it, and the right foot was injected. On 5/30/13, Petitioner indicated this and taping helped, and that his swelling had reduced. (Px11).

On 6/3/13, Petitioner reported he was to begin "extensive" therapy and continued to walk with a limp. Dr. Chandler advised that Petitioner wanted to try to return to work within his restrictions, noting that he believed he could perform the duties of a "sub-form" position, noting he had the seniority for this position. Dr. Chandler released Petitioner to return to work pursuant to the FCE restrictions, along with no squatting, running, climbing, kneeling or walk/standing over one hour at a time. (Px9).

Petitioner testified Respondent's NCM referred him for an evaluation with Dr. Cole. At their 6/24/13 visit, Petitioner's accident and treatment history was noted. Petitioner reported pain and reduced right knee flexion due to stiffness and joint deformity, which Dr. Cole noted was limited to 90 degrees. X-rays showed tricompartmental degeneration. Dr. Cole noted the FCE was valid and did not allow Petitioner to return to his regular job, and that it would be unreasonable for him to do so given his pain and swelling. He recommended that Petitioner consider a total knee replacement and recommended that he follow up with Dr. Sporer. Otherwise, he should consider returning to work per his treating physician. (Px12).

On 7/11/13, Petitioner indicated that his right foot/ankle was stable, though he had not been in therapy since his last visit with Dr. Linde, noting the injection helped and he was able to use his orthotics again. A 7/18/13 discharge note from Accelerated stated that Petitioner had not returned since 5/31/13, after 96 visits, because additional therapy had not been authorized by Respondent. (Px11).

On 7/15/13, Petitioner returned to Dr. Chandler. He reported feeling a pop in the right knee about five days prior with anterior and lateral pain since that time. Petitioner was not in formal therapy but was performing a home exercise program. Updated x-rays showed a healed tibial fracture with medial collapse, unchanged from prior films, and arthritic changes were again noted. The right knee was injected, a knee brace was prescribed, and Dr. Chandler indicated he was essentially in agreement with Dr. Cole that Petitioner's knee was as good as it was going to be at this point. He indicated that Petitioner would ultimately need a knee replacement when his pain became intolerable. Petitioner advised that his pain remained worse following the pop in his knee, and that if the replacement would allow him to be more functional, he wanted to go through with it. Dr. Chandler noted the pre-operative testing that would need to be performed due to his history of DVT and infections, as well as that Petitioner would likely need to have a revision replacement at some point given his age if he planned to try to return to a laboring position. (Px9). Petitioner testified that the knee brace helped somewhat. His right foot would still swell at times, and he testified that Dr. Linde indicated this this would continue for life.

On 8/12/13, Dr. Chandler ordered pre-operative right knee MRI and labs to make sure there was no residual infection. He also noted that Petitioner was at risk of amputation if infection set in post-operatively. (Px9). Biomet MRI of the right hip, knee and ankle was performed on 8/16/13, and indicated extensive irregular region of osteolysis/marrow replacement throughout the proximal tibia extending to the articular surface with areas of marked signal heterogeneity centrally, with a suspected medial fracture. It was noted the findings were of uncertain etiology and may be due to neoplasm, posttraumatic change or possibly erosive arthroplasty. (Px13).

Petitioner last treated with Dr. Linde on 8/22/13 per the records in evidence. At that time, Petitioner reported he was planning to undergo a total knee replacement. He reported 0/10 to 2/10 pain but complained of overall stiffness in the foot and ankle and stated that he had never really engaged in any significant foot/ankle therapy. Dr. Linde recommended six to eight weeks of directed foot/ankle therapy after his knee replacement surgery and prior to entering any work conditioning program. She further advised him on a home exercise program. (Px11).

On 8/30/13, Dr. Chandler indicated Petitioner's last lab testing showed no ongoing signs of infection, the right knee MRI was reviewed, and he advised Petitioner he believed he could safely move forward with knee replacement. Noting this would not be a standard knee replacement, he recommended that Petitioner consult

with a fellowship-trained joint specialist specializing in knees and complex primaries, as well as possibly with a plastic surgeon. (Px9).

Petitioner saw Dr. Bedikian on 9/19/13 on referral from Dr. Chandler. Petitioner reported pain and difficulty with right knee range of motion, prolonged standing or sitting, stairs and arising from a seated position. X-rays continued to show mal-union of the tibial plateau fracture. Given the history of infection and malunion, Dr. Bedikian recommended a possible two-stage surgery. This would involve an initial irrigation and debridement to determine if there was any sign of osteomyelitis, implantation of a cement spacer and 6 weeks of IV antibiotics, with possible plastic surgery if a skin flap were needed. The second stage would involve the total knee replacement. He opined that Petitioner likely had a chronic infection that was suppressed and doing this in two stages would give him the best chance given he was at high risk for DVT, recurrent infection, neurovascular injury and loss of limb. (Px9).

On 11/1/13, Petitioner advised Dr. Chandler that he was increasing his activities and that his right knee pain was increasing as a result. Petitioner was advised to adhere to his FCE restrictions and to avoid any squatting, running, climbing and prolonged standing or walking. On 12/4/13, Petitioner reported significant medial knee pain and he felt like he could hardly walk if he was not wearing his knee sleeve. Dr. Chandler noted Petitioner had concerns about knee replacement after seeing the specialist and planned to get a second opinion. (Px9).

Petitioner testified that Dr. Cole advised him to see Dr. Levine, and Petitioner initially did on 12/17/13, reporting worsening frontal and inner right knee pain. Dr. Levine recommended that Petitioner either live with his condition as is, undergo a two-stage primary total knee arthroplasty, or arthrodesis. He noted that knee replacement would be complex and that he would need to see a plastic surgeon preoperatively. (Px12). The recommendation was very similar if not identical to that of Dr. Bedikian.

On 1/13/14, Petitioner had an infectious disease consult with Dr. Kumar. He opined that Petitioner's chronic suppressive antibiotic treatment could be discontinued and that he could undergo an initial debridement procedure with antibiotic beads as planned by Dr. Levine, but that intraoperative cultures should be obtained. (Px9).

Petitioner last saw Dr. Chandler on 1/15/14. He was limping but not using any assistive devices, indicating he used a knee sleeve with any prolonged walking. He reported continued right knee pain, especially with prolonged walking or standing, running, kneeling, squatting and stair use. Weakness was noted due to pain and loss of motion. Dr. Chandler noted Petitioner had met with Dr. Levine and wanted to proceed with the recommended replacement procedure, so he released him to Levine's care. In the meantime, he advised Petitioner to bear weight as tolerated and to follow up if needed. As to work, he advised that Petitioner continue to adhere to restrictions indicated by the FCE. (Px9).

On 2/25/14, Dr. Levine noted Petitioner's main complaint was a loss of right knee motion and that he had discontinued antibiotic treatment in anticipation of total knee replacement. Dr. Levine was not certain that a two-stage knee replacement would improve his motion due to the likelihood of extended post-operative immobilization given presumed difficulty with wound closure. He referred him to plastic surgeon Dr. Derman to evaluate the likely length of such immobilization. Petitioner was continued off work. (Px12).

Petitioner saw Dr. Derman on 3/12/14. He noted Petitioner lacked full right knee flexion or extension, that some of the scarring/grafting at the knee was thin, and that he also had hammertoes with decreased range of motion of the ankle. He indicated to Petitioner that there were no guarantees that any surgery or reconstruction would be successful in improving his function, and that he could end up with further loss of function or even amputation,

as well as possible DVT or pulmonary embolus. He agreed with Levine that making sure there was no ongoing infection first had to be determined, and that they should proceed with revisions of his multiple scars so that he would have good tissue in anticipation of total knee surgery. (Px18).

On 4/8/14, Dr. Levine noted Dr. Derman's indication of an unknown amount of post-surgical immobilization until the knee was visualized in surgery. If Petitioner's main concern was motion, Dr. Levine again told him there was no guarantee he wouldn't need to have extended immobilization and that this could impact his ability to maximize his range of motion. He referred Petitioner to Dr. Bush-Joseph for consideration of arthroscopic lysis of adhesions as an alternative. If not feasible, he recommended an FCE to determine work restrictions pending any planned knee replacement procedure. (Px12).

Petitioner saw Dr. Bush-Joseph on 5/2/14, reporting his main problem was right knee stiffness versus pain. As to consideration of lysis of adhesions, the doctor advised that about 75% of patients would improve with such surgery, but also that Petitioner was at higher risk due to his history of infection and the less than ideal quality of the surrounding structures. Petitioner was going to think about it. (Px12).

On 12/5/14, Petitioner saw Dr. Bush-Joseph, reporting worsening medial right knee pain since his last visit. Significant limitation of range of motion was noted and that x-rays showed severe tricompartmental arthritis. At that point, Dr. Bush-Joseph recommended against the arthroscopic procedure and advised Petitioner not to exceed sedentary work duties and to avoid ladders, squatting or standing for more than an hour at a time. A brace was prescribed. (Px12).

On 2/6/15, Dr. Bush-Joseph noted Petitioner was improved with an unloader brace but was now complaining of mild left-sided symptoms. X-rays showed near bone-on-bone degeneration on the right with significant heterotopic change and residual osteomyelitis, while the left knee was normal. He recommended no further treatment and permanently limited Petitioner to sedentary work duties with no lifting, ground level work only and no standing more than an hour at a time. (Px12).

On 4/27/15, Petitioner saw infectious disease specialist Dr. Segreti on referral from Dr. Derman. He noted Petitioner had stopped taking antibiotics in 2013 and had no ongoing signs of infection. He opined that there was a low probability that Petitioner had infection with retaining hardware, per Dr. Kumar, and that additional antibiotic treatment was not needed at that time. He would need tissue testing prior to any total knee replacement surgery to ensure this and would then require treatment with IV antibiotic. (Px19; Px24).

On 12/10/15, Dr. Derman performed scar revision surgery in preparation for knee replacement surgery. This included scar excision with local tissue advancement, gastrocnemius flap advancement to close the area and application of a long leg splint. It was noted that the scarring was thin and adherent to bone and tendon. Excellent blood flow to the flaps was noted post-operatively. He was discharged the next day with a walker and crutches for stair use. (Px24; Px34).

Petitioner followed up with Dr. Segreti on 6/23/16. He noted no symptoms or exam abnormalities which suggested any ongoing infection and opined that there was no contraindication to surgery, but he recommended intraoperative cultures should be assessed for infection at the time of total knee replacement surgery. To be safe, he ordered labs to test for infection and released Petitioner to return to work from an infectious disease perspective. (Px24).

Petitioner returned to Dr. Levine on 7/12/16. Limited right knee flexion was again noted, and Petitioner was uncertain about proceeding with total knee replacement. Prior right knee x-rays showed degenerative joint

disease, some sequestrum and what appeared to be osteomyelitis in the proximal tibia. Dr. Levine indicated there was no need for Petitioner to rush into surgery until he was ready, noting the surgery would be complicated and could potentially lead to further problems. (Px12).

On 9/13/16, Petitioner again reported that he had concerns about the risks of undergoing a total knee replacement and was not currently interested in surgery. He requested an FCE so he could try to return to work, and Dr. Levine provided a prescription for this, advising him to return when he felt he was ready for knee replacement surgery. (Px12).

The 9/26/16 Athletico FCE results indicated Petitioner was functioning at the heavy physical demand level. While his job was categorized at this same heavy level, the job required lifting and carrying up to 100 pounds, but the Petitioner demonstrated the ability to occasionally lift up to only 70 pounds. As such, it was determined that he did not demonstrate the physical abilities to perform all of the essential functions of his job. Of the 30 or so different job demands listed by Athletico, the Petitioner met only approximately 12 of them. The evaluator indicated Petitioner provided consistent performance and acceptable effort. (Px11).

On 11/8/16, Dr. Levine noted that the FCE was reliable and opined that Petitioner was ready to return to a reasonable level of work, though not the type of job he had before: "His upper body functions very well and I think he is [sic] got to focus along those lines." He determined that Petitioner had reached maximum medical improvement (MMI) and advised him to return as needed. (Px12; Rx5). Petitioner testified that the Respondent did not authorize any further therapy following the FCE.

On 8/2/17, vocational rehabilitation company Vocamotive wrote to Petitioner's counsel indicating the Respondent had referred Petitioner's case to them for vocational services and requested permission to meet with Petitioner for an initial interview. (Rx6). On 9/8/17, a vocational rehabilitation plan was prepared by Certified Rehabilitation Counselor Lisa Helma of Vocamotive. She indicated that, based on the FCE, Petitioner was capable of only 41.38% of the physical requirements of his job. The plan was to complete vocational testing and to provide comprehensive job skills instruction and computer proficiency, to evaluate his potential for appropriate and cost-effective retraining, and to facilitate his return to work within 150 days after training, which she estimated would take about 8 to 10 weeks. Counselor Helma believed the vocational rehabilitation efforts would produce a return to work with earnings between $10 and $13 per hour. (Px21).

On 1/30/18, Petitioner saw Dr. Levine, who noted x-rays showed significant post-traumatic arthritis with bone-on-bone articulation. He also noted Petitioner had previously been encouraged to seek employment within his 2016 FCE findings. (Px12).

On 4/3/18, Petitioner returned to Dr. Levine. He reported minimal knee pain but suboptimal range of motion and that he felt ready to have knee replacement surgery. Dr. Levine recommended the same two-stage surgery, indicating this would be performed in conjunction with plastic surgeon Dr. Derman given Petitioner's past history of multiple surgeries and scarring. Risk of infection, clots and suboptimal range of motion were noted. (Px12; Px32).

The Petitioner saw Dr. Linde one additional time on 4/8/18. He reported right foot pain that had progressively worsened over the last 4 weeks, and that it was currently at a 9/10 level in the dorsal right midfoot. He also reported swelling that made it hard to wear shoes. He noted he carried a cane with him because he would never know when his pain would become so bad that he would need to use it. Right ankle x-rays indicated evidence of sclerosis and narrowing of the joint space at the right ankle, subtalar and midfoot joints that was more pronounced since 2013. Pre-accident internal fixation was noted, as were bilateral hammertoes. Dr. Linde

recommended 6 to 8 weeks of physical therapy and an AFO brace she described as necessary for long term management. Petitioner requested a disabled parking placard, which she agreed to authorize for 6 months. (Px23).

On 7/11/18, Dr. Levine indicated that the Petitioner would need to see his primary care physician for a pre-operative evaluation 30 days prior to the proposed date of surgery. (Px27). On 7/31/18, Dr. Tseng cleared Petitioner for surgery. On 8/8/18, Nurse Practitioner Emily Stouffer also cleared the Petitioner for surgery. (Px32). Petitioner testified that the surgery had been scheduled for 8/30/18 but was postponed. The Arbitrator does not recall any testimony which indicated the reason for the postponement.

The Petitioner testified he currently continues to have occasional leg pain with walking and difficulty with bending his knee, indicating he can get it just short of 90 degrees. He testified that he can walk about a block or two before he develops pain and cannot walk long distances. He has to wear a brace at times. He testified he has to lift his leg to go up stairs due to his inability to flex and has to kind of "hop" to go down stairs. At the FCE, he testified he had to "hop" up the ladder because he couldn't climb it normally.

Petitioner testified that the vocational counselor from Vocamotive indicated to him that there were certain jobs he could or couldn't do, but that he never heard back from them again following the interview. Instead, Petitioner testified he then was advised by Respondent to meet with Ashley Pak, another Water Department employee. He did not know her job title. As a result of that meeting, he was advised to do ten job searches a week and to bring logs of these searches to Ms. Pak every Monday. He testified he was not given any further instructions and was not advised about what types of jobs to look for. He was not asked to follow up with any vocational contacts. He testified he started making these contacts in January of 2017 and continued to make them through the present. He testified he was never advised on how to complete the job log forms he received from Ms. Pak. Every Monday he would bring in 10 or more job contacts to Ms. Pak. He would meet her at the DePaul Center at 333 S. State St. He could not say what Ms. Pak did with the logs after she took the forms from him. He testified she never indicated to him that there was anything wrong with the logs and didn't recommend or provide any other instruction to him. No one from the Respondent ever told him he was doing anything wrong in terms of his job searches. Petitioner testified he has continued to provide job logs through 9/17/18, the Monday prior to the hearing date. The Arbitrator notes that the Respondent did not produce Ms. Pak or any witnesses for testimony in rebuttal.

Petitioner testified that the first time he learned the Respondent was questioning his job search was when he received a letter from the Respondent's Department of Finance in approximately April 2018, indicating he was not doing it properly and terminated his benefits. He testified that at that time he called Ms. Pak with his attorney on the line and inquired if anything was wrong with his job searches, and that she indicated there was no problem. Thus, the letter was the only indication he had of any problem with his job search/logs.

Petitioner testified he also contacted his department to inquire about lighter duty work, noting he is aware there are such lighter jobs in the department, but was never offered a job. He did not testify to whom he spoke. Following an objection from Respondent, Petitioner testified he applied for jobs in his department that were within his restrictions but was not offered a job. He testified he didn't know why he would have to fill anything out for a job within the department he was already an employee. He testified that if he were offered a job within his restrictions he would take it. The Petitioner presented evidence from Laborers' International Union of North America which indicates that, pursuant to contract with the Construction and General Laborers' District Council of Chicago and Vicinity, effective 6/1/17 he would be earning $41.20 per hour. (Px28). The Respondent stipulated that this hourly rate is accurate in terms of what Petitioner would currently be making in his regular job. (Tr. 113)

Petitioner's subsequent job search logs indicated he had made over 900 contacts. These logs are from Indeed.com and appear to have been received by Petitioner's counsel from the IRS on 6/15/18. Why or how these were obtained via the IRS was not clear. The Arbitrator notes the cover sheet indicates that these logs covered 501 days of Petitioner's job applications. Unfortunately, the entries themselves are undated. The Petitioner testified that out of all these contacts, he received no job offers. The Arbitrator notes that while job titles are listed, there is no information regarding job duties. Some appear on their face to be jobs that would be within Petitioner's limitations, while many of them, such as laboring positions that would require him to be on his feet, do not. (Px22).

On cross examination, the Petitioner testified that he had no prior right leg injuries and had sustained no new injuries since the accident date. He agreed an NCM was not initially assigned to him and he did not know if authorization had been sought from Respondent for his initial surgeries or his treatment at RIC. When he had nurses coming to his home, they were drawing blood and changing his dressings because his right knee wound remained open. Petitioner agreed he worked 40 hours per week for Respondent until he was injured. Petitioner is right hand dominant.

After his FCE, Petitioner received restrictions, at which point he was most likely not going to be able to return to his regular job. Ms. Pak provided him with the job logs to help him find employment. As to the forms, Petitioner indicated Ms. Pak provided no explanation of how to complete them but agreed that the titles on each column of the job log forms were self-explanatory. they did have columns referencing the information that was to be included and he agreed he didn't need an explanation of how to complete the forms themselves. He was unable to answer questions regarding the content of the forms without having them to look at. Petitioner agreed the job logs he entered into evidence were not the forms themselves. Petitioner reiterated that he completed at least 10 job searches per week and that the time required for weekly searches varied, so he couldn't say how long the searches took week to week. He agreed he never followed up with any employers in person or by phone, he just completed applications. He testified that he could not recall how many he did in an average day. Petitioner did receive confirmations when he submitted applications online. If the entries in his job logs are not dated, Petitioner agreed he could not say when he submitted each application. He agreed the job logs submitted as Px22 do not indicate dates, business addresses, phone numbers or contact names applications, no dates, no phone numbers or contact people. The logs contained in Px22 were given to Ms. Pak along with the forms.

As to applying for jobs with Respondent, Petitioner testified he would look online to determine what jobs were available and he would apply for them. He could not recall when he first looked or last looked for jobs with the City but testified he has looked "quite often", and when pressed estimated he looked about 30 times since he began a job search. He testified he has applied to work within the Water Department as a sub foreman but could not recall any other specific jobs he applied for. As to Vocamotive, he agreed he never tried to contact them himself following his interview. In answers to questions about his understanding of the ADA, it was clear the Petitioner did not know what the Americans with Disabilities Act was.

On redirect, Petitioner testified he fully cooperated with Vocamotive, including providing his prior educational and vocational information at their meeting which was over several hours, and he answered them as best he could. Again, he testified he was advised they he would be contacted by Vocamotive but never was. He was never contacted by either Ms. Pak or the Committee on Finance about working with Vocamotive to find employment. He had not been directed by anyone from Respondent to do anything after the initial interview with Vocamotive other than complete the job logs. As to the jobs he applied for, including the online applications listed in Px22, Petitioner testified that the forms he turned in to Ms. Pak contained more information about many of those jobs. Again, his job search has continued from January 2017 to the present. On

further cross-examination, Respondent's counsel correctly indicated that the documents in Px22 were printed in June 2018 and therefore did not contain any applications between that time and the hearing date.

An assortment of correspondence was submitted into evidence as Px31. These letters indicate the Respondent terminated benefits as of 4/13/18 based on non-diligent job searches. Petitioner's counsel responded on 4/23/18 indicating Petitioner represented that he had provided 10 job searches per week for the prior year and provided them to Ashley Pak at the DePaul center, and that Ms. Pak had advised counsel that she had accepted his job search forms each time. He indicated Petitioner had not been given any job search guidance, and that if the Respondent wanted to start supervised job searches they would agree to use Vocamotive. He requested reinstatement of benefits and that the Respondent contact Ms. Pak to discuss further. The vocational report of Vocamotive was then emailed to Respondent's counsel that same day. Respondent's counsel emailed Petitioner's counsel on 5/23/18 indicating that benefits had been discontinued pursuant to the *Johnson* case. Petitioner's counsel responded the next day again indicating Petitioner had complied with the job search requirements he had been provided with ("He was only given blank forms and was told to complete them"), that he looked for jobs he felt he was physically capable of performing and that he had never previously been informed that there was any problems with his searches. He again demanded reinstatement of benefits and that he would agree to formal services with Vocamotive. On 6/15/18, he advised that the 9/8/17 vocational rehabilitation plan had been completed and demand was made for vocational rehabilitation services. An email that same day indicates the job searches were sent to Respondent's counsel. On 7/11/18, Petitioner's counsel contacted Respondent indicating he had scheduled knee replacement surgery with Dr. Levine on 8/30/18 and had scheduled pre-surgical testing with Dr. Tseng on 7/31/18, and again demanded the reinstatement of benefits. On 8/9/18, Petitioner's counsel contacted Respondent reiterating the previously noted indications that Petitioner was providing his job searches as instructed and that the Respondent had retained Vocamotive to prepare the vocational rehabilitation plan, but it was never implemented. (Px31; Rx4; Rx6).

Respondent submitted evidence of payments made towards the Petitioner's weekly benefits (Rx1) and medical expenses (Rx2 & 3). The Petitioner submitted evidence indicating that Petitioner's group carrier through Respondent, Blue Cross/Blue Shield, held a lien totaling $549,347.14.

CONCLUSIONS OF LAW

WITH RESPECT TO ISSUE (F), IS THE PETITIONER'S PRESENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

Based on a review of the Respondent's Statement of Exceptions, the basis of the dispute with regard to causation involves the Petitioner's right ankle/foot. The parties stipulated that the Petitioner was injured in an accident which arose out of and in the course of his employment with Respondent on 7/19/11. The evidence clearly supports a causal connection between the 7/19/11 accident and injuries to the Petitioner's right knee, right elbow and left small finger. The initial emergency room records reflect injuries to these body parts which were acute and consistent with the mechanism of injury, specifically a motorcycle accident where the Petitioner went down due to hitting something in the street. The Petitioner testified that he had no prior right knee problems, and no evidence was presented which rebutted or tended to show this was not true. These noted body parts do not require any expert opinions with regard to causation, as the preponderance of the evidence strongly supports causation by a chain of events analysis.

Based on the evidence in the record, the Arbitrator finds that the Petitioner had preexisting conditions with regard to the right foot and ankle, including hammertoes, bunions and a prior surgery that involved open

reduction and internal fixation of the tibia at or near the ankle joint. Given the degree to which the Petitioner's right knee was injured and the clear impact it had on his gait, the Arbitrator believes that the need for treatment of the foot/ankle in 2013 is causally related to the accident. It appears to the Arbitrator that the Petitioner had an increase in his symptoms as a result of the accident, and this symptomatic increase resulted in treatment with Dr. Linde and possibly some physical therapy in 2013. This being said, the Petitioner clearly had a significant prior injury and an ongoing level of degeneration with regard to the right ankle/foot, and there is no basis in the record to conclude that any permanent disability or worsening in this body part was the result of the accident or the right knee injury. The Arbitrator finds that the need for treatment from 7/19/11 through 8/22/13 was causally related to the accident. Any subsequent right foot/ankle treatment would not be related to the accident. It appears any such alleged treatment involved only a single 4/3/18 visit to Dr. Linde. This was approximately five years after his last visit to this physician. The Arbitrator finds that this visit was not causally related to the accident, and that the Petitioner's ongoing right foot/ankle condition is not related to the 7/19/11 accident.

WITH RESPECT TO ISSUE (J), WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY AND HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, THE ARBITRATOR FINDS AS FOLLOWS:

The Petitioner has submitted numerous medical bills into evidence, contained in multiple different exhibits. The Arbitrator has reviewed these bills and the related medical records. The Arbitrator finds that the Respondent is liable for all of the submitted medical expenses contained in Petitioner's Exhibits 1 through 20, 24 through 27 and 32 through 34, with the only exceptions noted below. These bills are awarded pursuant to Sections 8(a) and 8.2 of the Act.

At hearing, the Respondent argued that all of Petitioner's medical expenses had either been paid and are being asked to pay for balances in excess of what is allowed by the Act, or they are unpaid based on Respondent's argument as to liability for same. Respondent also indicated that some of the medical expenses paid by Blue Cross/Blue Shield were being disputed.

The Arbitrator also notes that the Respondent argues in its Statement of Exceptions that the Petitioner and/or the medical providers involved in this case are not liable for double payment of the same incurred expenses. The Arbitrator agrees. To the extent that the same medical expenses were submitted into evidence more than once, the Respondent is only liable for each charged service one time.

The Petitioner has submitted a Blue Cross/Blue Shield lien in an amount of $539,072.63. The Respondent, as well as the Petitioner, have submitted evidence purporting to support the Respondent's payment of the alleged medical expenses (see Px20, Px35, Rx2 and Rx3). The Respondent is entitled to credit for any awarded medical expenses that were paid by Respondent via either workers' compensation benefits or group health coverage. However, for any such credits, the Respondent shall hold the Petitioner safe and harmless from any claims for payment and/or reimbursement.

Finally, with regard to any expenses that were paid via the group health carrier, if any such payments were accepted as full payment for any such expenses, the Respondent is entitled to the benefit of that bargain and is only liable to reimbursement to the group carrier for the amounts it paid as full and final payment for any particular charge, unless such payments were in excess of what would Respondent would be liable for under the Fee Schedule contained in Section 8.2 of the Act. The Fee Schedule constitutes the maximum amount of liability to Respondent for any such charges. The hold harmless is imperative in this case in exchange for the

credit, as the Petitioner has indicated that Blue Cross/Blue Shield seeks reimbursement and that some of his allegedly unpaid expenses have been put into collection.

Ultimately, while the Respondent notes that some of the charged expenses were not specifically authorized by Respondent prior to services being rendered, the Arbitrator finds that the Petitioner was in an emergency situation, and essentially remained in an emergency situation, as to the right knee for several months after the work accident.

Regarding the right foot/ankle, the Arbitrator finds that the Petitioner is entitled to the medical expenses incurred with Dr. Linde and Accelerated Physical Therapy in 2013, but not to the charges from the 4/8/18 visit with Dr. Linde, which are denied.

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

The Arbitrator finds that the Petitioner is entitled to TTD from 7/20/11 through 11/8/16, the date that Dr. Levine determined that the Petitioner had reached MMI as to his right knee condition. A total knee replacement has been recommended to the Petitioner, however as of the date of hearing he had declined to undergo same. There was an indication that the surgery was scheduled just prior to the hearing date and then had been canceled, but there was no specific indication as to why it had been canceled.

The Arbitrator further finds that the Petitioner is entitled to maintenance from 4/13/18 through 9/19/18. The termination of benefits without the provision of any vocational assistance was not reasonable in the Arbitrator's view. The Petitioner sustained a severe right knee injury which resulted in significant loss of motion and ongoing pain. He may well undergo surgery for a right total knee replacement at some point in the future. Vocamotive, which had been retained by Respondent, recommended retraining in order to put the Petitioner in the best position to find a job. The evidence presented at hearing indicates the Respondent instead did not provide such vocational counseling or assistance, did not offer the Petitioner a job within his restrictions and instead simply asked him to provide ten job contacts per week, which the preponderance of the presented evidence indicates that he did. The unilateral termination of benefits in April 2018 was not reasonable in the Arbitrator's view given the Petitioner's request for vocational services and willingness to obtain same via the Respondent's chosen provider, Vocamotive. While, as noted below, the Arbitrator does believe that the Petitioner could have provided more effort in his essentially self-directed job search, he nevertheless was doing what he was asked to do by Respondent. The Arbitrator again notes with interest that the Petitioner's testimony regarding this process was unrebutted by any evidence presented by Respondent.

Respondent is entitled to credit of $329,875.46 (see Rx1) against this award, and shall hold Petitioner harmless regarding any payments via a group disability plan pursuant to Section 8(j) of the Act.

WITH RESPECT TO ISSUE (L), WHAT IS THE NATURE AND EXTENT OF THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that the Petitioner has failed to prove that he is permanently and totally disabled. While a job search was performed, the self-directed search was less than ideal. As noted in the penalty section below, this was not at all solely the fault of the Petitioner. However, based on the evidence presented from Vocamotive, the Petitioner is likely employable. While a failed job search can be significant evidence in support of a finding of an odd-lot permanent total disability under Section 8(f) of the Act, the Arbitrator finds that the evidence

presented is not sufficient to support this. The evidence submitted by Petitioner in support of his job search contains a paucity of information with regard to whether a particular job was within the Petitioner's restrictions nor whether he followed up with any of the noted prospective employers. In fact, the Petitioner testified to a lack of follow-up on his applications. Some of the jobs on their face do not appear to be jobs the Petitioner would be capable of doing given his restrictions. At the same time, the Petitioner testified that he had job logs which provided more specific information that were submitted to Respondent via Ms. Pak that are in the possession of the Respondent and were not produced by Respondent at hearing. The Petitioner also testified that he was provided with no instruction from Respondent other than to provide the job logs, and that he was never told that there was any problem with them for a significant period of time before the Respondent terminated his benefits. The Petitioner also could have sought vocational services via this hearing but chose instead to obtain a finding regarding the nature and extent of the injury, which is his right.

Overall, the Arbitrator finds that both parties share in some level of blame for a lack of proof of whether the Petitioner is permanently and totally disabled, but the burden of proving this is on the Petitioner. The Petitioner could well be permanently and totally disabled, but the Arbitrator believes that the greater weight of the presented evidence was not sufficient to support this.

The next inquiry under Illinois case law is whether the Petitioner is entitled to a Section 8(d)1 wage differential award. The Arbitrator finds that the Petitioner has shown entitlement to a wage differential award by the preponderance of the evidence. Under Section 8(d)1, this section is applicable where a claimant becomes partially incapacitated from pursuing his usual and customary line of employment as the result of a compensable accidental injury, in which case the claimant shall receive compensation for the duration of the disability compensation equal to 2/3 of the difference between the amount he would be able to earn in the full performance of his duties in the occupation in which he was engaged at the time of the accident and the average amount he is earning or able to earn currently in some suitable employment or business.

Petitioner testified he worked 40 hours per week for the Respondent. The parties have stipulated that the Petitioner would currently be able to earn $41.20 per hour as a construction laborer with the City per the union contract. For a 40-hour work week, this would translate to $1,648.00 per week.

As of July 1, 2018, the minimum wage in Chicago rose to $12.00 per hour, or $480.00 per week if working full time, 40 hours per week.

The vocational assessment prepared by Vocamotive indicated that through the vocational rehabilitation process, the Petitioner could be expected to earn between $10.00 and $13.00 per hour, or $400.00 to $520.00 per week. While this estimate presumed a level of retraining per counselor Helma, the Petitioner tried this matter on a permanency basis and did not seek this retraining at hearing.

As noted, there are two sides to this story. The Respondent retained Vocamotive for the analysis, and then instead of instituting the vocational rehabilitation process through Vocamotive, they asked Petitioner to produce evidence of 10 specific job searches per week and to turn them in to Ms. Pak. The Petitioner testified he had no assistance with this process whatsoever, and the Respondent did not produce any evidence to rebut this. At the same time, the evidence produced by the Petitioner at hearing regarding the job search, in the Arbitrator's view, was insufficient to show a failed job search. While the Petitioner made numerous contacts in the time he looked for work, it also appears that to some degree he was going through the motions of providing only what the Respondent requested, and the targeted jobs appear too often to have been in professions where the Petitioner would not be likely to obtain employment in a competitive environment or even solely based on his right knee restrictions. Again, it appears that Petitioner's chances would have been significantly improved had formal

vocational rehabilitation been instituted in this case. However, the Petitioner also has some responsibility for performing a more diligent or well-directed job search, in terms of both targeted jobs and application follow ups, which the Arbitrator believes that was lacking here to some degree, as well as providing sufficient supporting documentation.

Overall, given the Vocamotive analysis and the current minimum wage in Chicago, the Arbitrator believes the evidence supports that the Petitioner could currently earn $12.00 per hour, or $480.00 per week.

Taking the $1,648.00 he could be earning versus the $480.00 per week he is currently able to earn, this results in a wage differential award of $778.67 per week. His entitlement to this benefit should start as of 9/20/18 and will continue for the duration of his disability resulting from his right knee/leg injury, or age 67, whichever comes first, pursuant to Section 8(d)1.

The Arbitrator finds that the Petitioner's entitlement to Section 8(d)1 benefits is based on the injuries incurred to his right knee. The Petitioner sustained two other injuries in this accident involving the right elbow and the left small finger, both of which involved surgeries.

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 permanent partial impairment rating was submitted into evidence by either party with regard to the right elbow and left small finger injuries. With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes this factor is not really relevant in terms of the injuries to the right elbow or left small finger. There is no evidence which indicates that any inability of the Petitioner to return to his regular occupation has anything to do with these specific injuries. With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 46 years old at the time of the accident. Neither party has submitted evidence which would tend to show how the Petitioner's age may impact any permanent disability to the right elbow or left small finger as the result of the 7/19/11 accident. With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator again notes that while the Petitioner has suffered a diminution of earnings, as noted above, there is no evidence which supports that any

such diminution is related to the injuries to the right elbow or left small finger. With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that the Petitioner sustained a fractured right olecranon and underwent surgery to remove the fractured bone fragment, as well as closed reduction and percutaneous pinning of the left 5th metacarpal. The pins were removed on 8/12/11. The records in evidence do not really indicate much information regarding these body parts as everything was so heavily focused on the Petitioner's severe right knee injury, and Petitioner didn't provide any significant testimony as to the ongoing condition of the right elbow or left small finger, whether he has pain, loss of motion or functional loss. That said, the Petitioner clearly suffered injuries to these body parts which have resulted in a degree of loss based on prior Commission awards for similar conditions with favorable outcomes.

Based on the above factors, the record taken as a whole and a review of prior Commission awards with similar injuries similar outcomes, the Arbitrator finds that, in addition to the above noted Section 8(d)1 award, the Petitioner sustained permanent partial disability to the extent of the loss of use of 5% of the right arm and to the extent of the loss of use of 15% of the left small finger, both pursuant to §8(e) of the Act.

WITH RESPECT TO ISSUE (M), SHOULD PENALTIES BE IMPOSED UPON THE RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that the Petitioner has failed to prove entitlement to penalties and fees in this case pursuant to Section 19(k) of the Act. While the termination of weekly benefits arguably involved unreasonable and vexatious behavior on the part of the Respondent given the lack of instruction provided to Petitioner based on his unrebutted testimony, the Arbitrator notes, as indicated above, that there was evidence that the Petitioner could have performed a more diligent job search.

That being said, the standard for Section 19(l) penalties differs from that of Section 19(k) and is more in the way of a "late fee" per the Illinois case law. Under this Section, where an employee has made written demand for payment of medical or TTD benefits, the respondent has 14 days from the date of receipt to set forth in writing the reason for the delay. In this case, the Arbitrator finds that while the Respondent indicated the reason for the delay was non-diligent job searches and the *Johnson* case, the failure to provide further explanation of how that case applied or why vocational assistance was not provided in this case was unreasonable in the Arbitrator's view. Thus, the Arbitrator finds the Petitioner is entitled to Section 19(l) benefits totaling $4,080.00 based on the termination of Petitioner's weekly benefits. This is based on $30 dollars per day from 14 days after the date the Petitioner emailed the Respondent for an explanation of the Petitioner's lack of diligence beyond the single statement provided by Respondent, 4/23/18, and the hearing date, 9/19/18 (5/7/18 through 9/19/18 is 136 days). Additionally, the Petitioner is entitled to Section 16 attorney's fees of $816.00, which is 20% of the Section 19(l) award.

Again, while the Arbitrator notes that the Petitioner's job search could have been more diligent, the Respondent unilaterally terminated benefits and did not provide any detailed explanation for same in response to Petitioner's 4/23/18 request after the Petitioner had been providing the same information to Ms. Pak in the same fashion for well over a year with no evidence of complaint from Respondent. Simply stating this was done pursuant to the Johnson case is not enough in the Arbitrator's view, particularly where the Petitioner had been doing the same things he had in terms of his job search since January 2017 and was expressing a willingness to participate in vocational rehabilitation with Vocamotive. This is a situation where the claimant clearly could have used vocational assistance to assist in potentially obtaining a higher wage job.

WITH RESPECT TO ISSUE (N), IS THE RESPONDENT DUE ANY CREDIT, THE ARBITRATOR FINDS AS FOLLOWS:

The Respondent is entitled to credit for the payments it made prior to hearing towards TTD and/or maintenance which totaled $329,875.46, as well as any payments it made towards medical expenses via workers' compensation coverage or via group health coverage pursuant to Section 8(j) of the Act. Again, pursuant to Section 8(j), with regard to any such expenses for which this credit is provided, and to the extent of such credit, the Respondent shall keep the Petitioner safe and harmless from any and all claims or liabilities that may be made against him.

As noted above, the Respondent is also entitled to credit for the payments made by Respondent prior to hearing towards the expenses Petitioner is entitled to. The Respondent must hold the Petitioner harmless with regard to same, and this is very important in this case given the fact that the Petitioner is in collection for some of the allegedly unpaid expenses. It is important that this is addressed promptly by Respondent to make certain all bills are paid pursuant to Sections 8(a) and 8.2.

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JUDITH LONERGAN,

Petitioner,

vs. NO: 14 WC 2438

SANCTUARY HOSPICE,

20IWCC0344

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causation, medical, temporary disability, and permanent disability, and being advised of the facts and law, reverses the Decision of the Arbitrator.

Findings of Fact

The Commission adopts the Statement of Facts as set forth in the Decision of the Arbitrator and incorporates such facts herein.

Conclusions of Law

A "traveling employee" is one who is required to travel away from her employer's premises in order to perform her job duties. *Jensen v. Industrial Commission*, 305 Ill. App. 3d 274, 278, 711 N.E.2d 1129 (1999). The determination of whether an injury to a traveling employee arose out of and in the course of employment is governed by different rules than are applicable to other employees. *Hoffman v. Industrial Commission*, 109 Ill. 2d 194, 199, 486 N.E.2d 889 (1985). However, a finding that a claimant is a traveling employee does not relieve her from the burden of proving that her injury arose out of and in the course of employment. *Id.* The test for determining whether an injury to a traveling employee arose out of and in the course

of her employment is the reasonableness of the conduct in which she was engaged and whether the conduct might normally be anticipated or foreseen by the employer. *Howell Tractor & Equipment Co. v. Industrial Commission*, 78 Ill. 2d 567, 573, 403 N.E.2d 215 (1980). Under such an analysis, a traveling employee may be compensated for an injury as long as the injury was sustained while she was engaged in an activity which was both reasonable and foreseeable. *Wright v. Industrial Commission*, 62 Ill. 2d 65, 71, 338 N.E.2d 379 (1975).

Here, there is no question Petitioner was a traveling employee. Her job duties required her to cover her assigned territory making marketing calls at 40 to 45 facilities per week. Petitioner alleges she sustained a fall while making a cold call at Marley Oaks on January 17, 2014; Respondent disputes this, arguing the evidence indicates Petitioner did not visit Marley Oaks that day. The Commission observes Petitioner testified in great detail about spending approximately 60 minutes at Marley Oaks that Friday. Specifically, Petitioner described meeting with Senesac then touring one of the rental apartments on the lower level of the building, and when Petitioner was leaving, she walked out with Senesac and a gentleman named Bob whom Senesac was to drive home. The Commission finds Petitioner's testimony as to being at Marley Oaks on January 17, 2014 is credible. The Commission notes Senesac's email from March 3, 2014 corroborates Petitioner's testimony about touring the then-vacant rental apartment. PX11. We further note Senesac testified Bob is a former resident, and she "went out and got Bob every Friday to bring him to church and have lunch afterwards." T. 77. The Commission believes Bob's presence at the facility as well as his routine of eating lunch there every Friday are facts Petitioner would not have known had she not been present on the date in question. The Commission also observes Senesac's April 1, 2014 letter does not assert that Petitioner was not at the facility on January 17, 2014; rather it states Petitioner did not report falling on that date. The Commission believes this is a significant distinction. Like the Arbitrator, the Commission finds the credible evidence establishes Petitioner was at Marley Oaks on January 17, 2014. This, however, does not end our inquiry.

"Although the protection afforded a traveling employee by the [Act] (Ill. Rev. Stat. 1977, ch. 48, par. 138.1 et seq.) is considerably more extensive than that afforded other employees, the purposes of the Act do not require the employer to serve as an insurer for a traveling employee. (Citations omitted). The burden of establishing compensability rests upon the claimant, and proof that [she] would not have been at the place where the injury occurred but for [her] employment is not alone sufficient. (Citations omitted)." *Howell Tractor & Equipment Co. v. Industrial Commission*, 78 Ill. 2d 567, 574, 403 N.E.2d 215 (1980). To be clear, Petitioner's traveling employee status does not obviate the need to prove the cause of her fall. The Commission finds Petitioner failed to do so.

The Commission finds the evidence taken as a whole reflects Petitioner does not know what caused her knee injury. At trial, Petitioner described the incident as follows: "I got about halfway to my car down the walkway and slipped. I twisted my knee. I felt I believe I said I heard a pop and I fell." T. 16. Asked what caused her to fall, Petitioner stated, "I believe there was ice and I also believe there was uneven pavement." T. 39. In response to a similar question during her recorded statement, Petitioner stated:

At first I thought I just kind of slipped, slid…I initially thought that I slid on the,

> something in the pavement...I wasn't sure if it was ice. I wasn't, I really wasn't sure what it was. We went back, we went back there. I'm sorry. A couple weeks later maybe and we took photos. And there, where I was parked it looked like it was just maybe in the last few months, um, repaved. But where I had to walk was not and there was some uneven ground there. RX5.

The theory of uneven pavement, without any mention of ice, is echoed in Petitioner's Answers to Interrogatories for her civil claim. RX4. The Commission emphasizes, however, neither theory is supported by the initial treatment records.

The Little Company of Mary Emergency Room records from the date of the injury do not mention either ice or broken/uneven asphalt, and in fact do not state Petitioner fell. The triage history recorded by Kelly Hull, R.N., reflects Petitioner "SAYS SHE HURT HER KNEE A FEW WKS AGO AND WAS TOLD IT WAS A SPRAIN. PT SAYS SHE WAS WALKING AND HEARD A 'POP.'" PX1, RX1 (Emphasis in original). The emergency room physician, Dr. Salman Mamdani, memorialized the following history: "52-year-old female comes into the ED complaining of right knee pain ongoing for a few weeks ago, told her she had a knee sprain but states today she was walking and felt another pop in the back of her knee...symptoms ongoing for the last one week progressively worsened today when she heard a new pop earlier today..." PX1, RX1.

The Commission finds Petitioner does not know what caused her to fall on January 17, 2014. It appears from the initial medical records that Petitioner's knee simply gave out. While Petitioner thereafter theorized she could have slipped on ice, or tripped on uneven asphalt, or even slipped on icy uneven asphalt, the Commission finds this is mere speculation and insufficient to meet her burden of proof. See, *Baldwin v. Illinois Workers' Compensation Commission*, 409 Ill. App. 3d 472, 949 N.E.2d 1151 (2011).

Based on the above, the Commission finds Petitioner failed to prove by the preponderance of the credible evidence that she sustained an accidental injury arising out of and in the course of her employment on January 17, 2014.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 25, 2018 is hereby reversed, and the award of benefits therein is vacated.

The bond requirement in Section 19(f)(2) is applicable only when "the Commission shall have entered an award for the payment of money." *820 ILCS 305/19(f)(2)*. Based upon the denial of compensation herein, no bond is set by the Commission.

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

20IWCC0344

DATED: JUN 2 6 2020

L. Elizabeth Coppoletti

LEC/mck

D: 5/6/2020

Stephen Mathis

43

DISSENT

I respectfully dissent from the Majority's opinion. I find the Arbitrator's Decision to be thorough and well-reasoned. I would affirm and adopt the Arbitrator's Decision in its entirety.

D. Douglas McCarthy

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LONERGAN, JUDITH
Employee/Petitioner

Case# **14WC002438**

SANCTUARY HOSPICE
Employer/Respondent

20IWCC0344

On 6/25/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.07% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2221 VRDOLYAK LAW GROUP LLC
MIRKO AKRAP
741 N DEARBORN ST 3RD FL
CHICAGO, IL 60654

0532 HOLECEK & ASSOCIATES
KEN SMITH
161 N CLARK ST SUITE 800
CHICAGO, IL 60601

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Judith Lonergan
Employee/Petitioner

v.

Sanctuary Hospice
Employer/Respondent

Case # **14** WC **2438**

Consolidated cases: **N/A**

20IWCC0344

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gregory Dollison**, Arbitrator of the Commission, in the city of **New Lenox, Illinois**, on **May 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. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other

FINDINGS

On **January 17, 2014**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**60,000**; the average weekly wage was $**1,153.85**.

On the date of accident, Petitioner was **52** years of age, ***single*** with **1** dependent children.

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

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

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

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 $769.23/week for 15-4/7 weeks, commencing January 24, 2014 through May 12, 2014, as provided in Section 8(b) of the Act.

Respondent shall pay permanent partial disability benefits of $692.31 a week for 48.375 weeks, because the injury sustained caused 22-1/2% loss of use of the right leg, pursuant to Section 8(e) of the Act.

Respondent shall pay to Petitioner reasonable and necessary medical services of $28,506.79, as provided in Sections 8(a) and 8.2 of the Act.

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

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

Signature of Arbitrator

6/22/18
Date

JUN 25 2018

20IWCC0344

Statement of Facts:

Petitioner testified that prior to January 17, 2014, she had a minor issue with her right lower leg and knee. Petitioner indicated that approximately six weeks earlier she "had a misstep" and felt pain in right her leg and knee. Petitioner stated she went to the doctor where she underwent an x-ray, and received a medication prescription. Records submitted show Petitioner presented to Oak Forest Hospital on December 30, 2013 with a history of right knee pain of a two-week duration. Petitioner reported she was moving when she heard a pop in the right knee. Petitioner denied a fall or injury. An examination revealed effusion of the right knee with some tenderness in the popliteal area. Her range of motion was limited, extension and flexion, due to pain. X-rays taken showed right suprapatellar effusion with no fractures or arthritis. Petitioner was diagnosed with right knee pain. She was prescribed NSAIDS, given crutches and an ace wrap. She was also advised to limit her activities. (RX 2) Petitioner testified she had no other treatment and she was symptom-free prior to the claimed date of accident.

On January 17, 2014, Petitioner was an employee of Sanctuary Hospice. She began working for Sanctuary Hospice as a nurse liaison on November 11, 2013. She usually worked eight to 10 hours per day. Petitioner testified that as a nurse liaison, she would visit several different facilities, doctors' offices, hospitals in order to procure hospice referrals. She testified that about 90% of her job was outside of the office, visiting forty (40) to forty-five (45) facilities per week.

Petitioner testified that on January 17, 2014, she visited her first facility between 8:30am and 9:30am. She visited two facilities before heading to Sam's Club in Orland Park, IL to bring "goodies" for the facilities. After Sam's Club, she visited Marley Oaks Assisted Living in Mokena, IL. Petitioner testified that upon arrival at the Marley Oaks Assisted Living facility, she saw the administrator, Dawn Senesac. Petitioner stated they embraced and went into Dawn's office to chat about their personal life (i.e. both had sons who were not attending school but working instead). Petitioner stated they conversed for approximately one (1) hour. During that period, Dawn showed her two apartments that were used as supplemental income, not for assisted living purposes. At the end of their conversation, Petitioner and Dawn discussed Petitioner returning to the facility for an in-service visit on February 28, 2014. They both walked back upstairs as Dawn had to leave and take a gentleman, Bob, to lunch and then home. Petitioner stated there were two exits to the facility. Petitioner proceeded to leave out of the right door while Dawn and Bob left out of the left side door.

Petitioner testified that as she was walking outside towards her car, she slipped, twisted her knee, heard a pop and fell. Petitioner stated that she initially could not get up. However, she righted herself and drove home. When she arrived home, her son and daughter helped her out of the car and drove her to the emergency room at Little Company of Mary Hospital. The medical records of Little Company of Mary indicate that on January 17, 2014, Petitioner presented "...complaining of right knee pain ongoing for a few weeks ago, told her she had a knee sprain but states today was walking and felt another pop in the back of her knee... unable to bear weight secondary to pain, pain is 10 out of 10 right knee nonradiating worse with movement no other alleviating or aggravating symptoms ongoing for the last one week progressively worsening today when she heard a new pop earlier today...." X-rays taken revealed a small joint effusion. No fractures or dislocation was noted. Petitioner was diagnosed with acute right knee sprain. She was provided with a knee immobilizer, prescribed analgesics and advised to follow up with orthopedics. (PX 1, pp 5-7, 11)

Petitioner testified that due to the timing of the incident, emergency room visit, and the weekend, she reported the injury on Monday, January 20, 2014, to her manager, Lajewel Williams.

On January 24, 2014, Petitioner presented to Dr. Anas Alzoobi with a chief complaint of severe right knee pain. The doctor recorded a history that Petitioner sustained a fall while she was at work. The doctor noted she slipped over black ice and heard a pop. She could not stand up and she has been in severe pain ever since. Her pain was a 3/10 when sitting and 10/10 while standing and bearing weight on the knee. She was unable to bear any weight. Dr. Alzoobi assessed severe knee pain, possible ligament tear versus meniscus tear, or intraarticular derangement. Dr. Alzoobi recommended an MRI and ordered Petitioner off work. (PX 3, p 4) The MRI when performed on January 27, 2014 revealed focal subtle bone marrow edema, grade III tear in the posterior horn of medial meniscus, moderate Baker's cyst, moderate knee effusion, and mild suprapatellar bursitis. (PX 2, pp. 3-4)

Petitioner followed up on January 31, 2014 with Dr. Alzoobi. The doctor noted the MRI was positive for bone edema over the medial tibial head and a grade III tear of the posterior horn of the medial meniscus, partial tear of the lateral meniscus, knee effusion, and Baker cyst. Dr. Alzoobi diagnosed internal derangement, meniscus tear of the right [knee] with blunt trauma and referred Petitioner to Dr. Rubenstein, an orthopedic surgeon, for further evaluation. (PX 3, p 5)

Petitioner presented to Dr. Scott Rubenstein at the Illinois Bone and Joint Institute on February 7, 2014. Dr. Rubenstein recorded a history that Petitioner had problems with her knee since an injury sustained at work on January 17, 2014. The doctor noted Petitioner worked as marketer for a hospice company and was coming out of a building where she had made a sales call and slipped on the ice twisting her right knee. Dr. Rubenstein examined Petitioner and noted medial joint line tenderness and a positive McMurray's. The doctor recommended an arthroscopy and continued Petitioner's off work status. (PX 6, p 3)

On April 29, 2014, Dr. Rubenstein performed an arthroscopy of the right knee with resection of tear of the medial meniscus and medial femoral condyle chondroplasty. The postoperative diagnosis was complex tear of the medial meniscus of the right knee with minor articular surface damage of the right medial femoral condyle. (PX 9, p. 4-5)

Postoperatively, Petitioner presented to Dr. Rubenstein on May 7, 2014. Dr. Rubenstein noted Petitioner's preop symptoms were gone. An examination revealed minimal symptomology. The doctor provided that Petitioner could resume activity as tolerated and provisionally released her from care.(PX 6, p.5)

Petitioner testified that she returned to work on May12, 2014. She was terminated the following day, on May 13, 2014. Petitioner testified that she currently has right knee pain when going up and down stairs. Petitioner testified that her walking is limited indicating she "use to walk 3-1/2 miles." Petitioner also stated her attendance to the health club has decreased indicating she can only go twice a week as opposed to the three (3) days she attended prior to the injury.

Petitioner testified that in February 2014, she left a voicemail message on Marley Oaks phone system advising Dawn that she had to cancel the scheduled in-service meeting previously scheduled. Petitioner stated that Dawn returned her call on February 14, 2014. However, she missed the call. Petitioner provided a screen-shot depicting a missed call from "Marley Oaks Dawn Senesav" (815-485-5860) occurring on February 14th at 2:12 PM. (PX 12) On cross-examination, Petitioner testified that on February 28, 2014, she advised Dawn, via e-mail transmission, that she fell at the facility. The submitted e-mail states, "Again please accept my apologies for not being able to do your staff in-service due to my knee injury. I felt awful I didn't get back to you. Duh, I thought my cell was transferred to our main office…" (RX 6)

Respondent called its witness, Ms. Dawn Senesac, to testify. Ms. Senesac testified that she was employed at Marley Oaks Assisted Living Facility in January of 2014. She acknowledged knowing Petitioner prior to January 2014. She estimated Petitioner would stop by the facility "at least four times a year to five times

a year." Ms. Senesac testified that there are professional rules and regulations regarding people who visit the facility. She indicated that both OSHA and the Illinois Department of Public Health requires people sign in when visiting Assisted Living facilities.

Ms. Senesac testified that she does not recall Petitioner being present at the facility on January 17, 2014. She also provided that a review of the sign-in sheet for that day does not show Petitioner signed-in that day. (See RX 6) She didn't know Petitioner had a knee injury until she received an e-mail in February 2014. She further didn't know Petitioner was alleging the knee injury occurred in the facilities parking lot until she received an inquiry from Petitioner's attorney on April 1, 2014. (See RX 6)

Ms. Senesac acknowledged receiving an email from Petitioner on February 28, 2014, in which Petitioner stated she was not able to make the in-service due to "my knee injury." Ms. Senesac stated that she had no idea that Petitioner's reference to "my knee injury" emanated from a fall she suffered at Marley Oaks. Ms. Senesac also stated that the in-service meeting had been scheduled months prior to February 2014. She stated, "...It was like months ahead of time. Probably around – I don't know for sure, it's been too long. I'm not even going to speculate."

Ms. Senesac was questioned about an individual named Bob who was present at Marley Oaks every Friday. She testified that Bob would be there every Friday unless he was sick. When asked if Bob was there on Friday, January 17, 2014, Ms. Senesac could not recall. Lastly, Ms. Senesac testified that Petitioner "...could definitely come into the facility and go back to my office and talk to me without signing in, unless someone reminded her you need to sign in..."

Petitioner testified that she did not sign-in at the facility on January 17, 2014. She also provided that the facility was not a secure facility.

With respect to C.) Did Petitioner's accidental injuries arise out of and in the course of employment, the Arbitrator finds as follows:

A compensable injury occurs in the course of employment when it is sustained while a claimant is at work or while he performs reasonable activities in conjunction with his employment. Wise v. Industrial Commission, 54 Ill. 2d 138, 142, 295 N. E 2d 459, 461 (1973). An accident arises out of one's employment if its origin is in some risk connected with or incidental to the employment so as to create a causal connection between the employment and the accidental injury. Caterpillar Tractor Company v. Industrial Commission, 129 Ill. 2d 52, 58 (1989). The general rule is that an injury incurred by an employee in going to or returning from the place of employment does not arise out of or in the course of employment. Pryor v. Illinois Workers' Compensation Commission, 2015 IL App (2d) 130874WC . An exception applies when the employee is a traveling employee; a "traveling employee is one whose work duties require him to travel away from his employer's premises. *Id*; Kertis v. Illinois Workers' Compensation Comm'n, 2013 IL App 2d 120252WC, ¶ 13. A traveling employee is deemed in the course of employment from the time she leaves home until she returns home. Kertis, 2013 IL App 2d 120252, ¶16. An injury arises out of employment if she was injured while engaging in conduct that was reasonable and foreseeable. Id. Conduct is reasonable and foreseeable when the conduct might normally be anticipated or foreseen by the employer. Id at ¶16.

In this case, Petitioner was a traveling employee. Petitioner was injured in the course of employment as she was traveling from facility to facility as a marketing nurse liaison. Petitioner fell while she was exiting the facility and walking towards her car in the parking lot. Moreover, Petitioner was engaged in conduct that was reasonable and foreseeable by Respondent. Specifically, Petitioner testified that she traveled to Marley Oaks

Assisted Living Facility on January 17, 2014. Petitioner was walking from the facility to her car and slipped in the parking lot thereby injuring herself.

The main issue in this matter relates to whether Petitioner was at Marley Oaks at the time of the alleged accident. According to Petitioner's testimony, on January 17, 2014, she was working and traveling to multiple facilities, picked up goods at Sam's club, met with Ms. Dawn Senesac who gave her a tour of the new developments at Marley Oaks, met an individual named Bob who was there every Friday, and saw two new apartments that were independent of Marley Oaks. Respondent's dispute regarding accident centers around the testimony of Ms. Dawn Senesac. Ms. Senesac, testified that she does not recall Petitioner being present at the facility on January 17, 2014 largely based on the fact that Petitioner's name does not appear on the sign-in sheet for that day. However, Ms. Senesac also testified that Petitioner "...could definitely come into the facility and go back to my office and talk to me without signing in, unless someone reminded her you need to sign in..." It is undisputed that Petitioner did not sign-in at the facility that day.

The Arbitrator notes Respondent's Exhibit No. 6, that being Ms. Senesac's response to Petitioner's attorney inquiry regarding whether she had notice that Petitioner was claiming she fell at the facility. While Ms. Senesac denies receiving notification Petitioner injured herself at the facility, there is nothing in her response to indicate Petitioner was not there that day. Her response centers around not being notified of an injury sustained at the facility. Ms. Senesac wrote, "If Ms. Lonergam had indeed hurt herself here at Marley Oaks, then it would be protocol to at least inform the facility of this incident...On the date of the filed "accident" there were four employees on staff, including myself. Ms. Lonergan never came in and reported falling...As a matter of fact, Ms. Lonergan was due to give an in-service on February 28th, 2014, but never responded back to numerous phone calls..." Ms. Senesac's reference to Petitioner not coming in and report falling suggests Petitioner had to be there "on the date of the filed "accident" to "come in" and report falling. The Arbitrator also notes Petitioner's detailed testimony that Ms. Senesac gave her a tour of the new developments at Marley Oaks, met an individual named Bob who was there every Friday, and saw two new apartments that were independent of Marley Oaks. Ms. Senesac acknowledged that Bob came to Marley Oaks every Friday (unless he was sick) and that she and Bob would eat lunch and thereafter she would drive him home. When asked if Bob was there on Friday, January 17, 2014, Ms. Senesac could not recall. Lastly, Petitioner testified that at her visit on January 17th, Ms. Senesac showed her two apartments that were used as supplemental income. Petitioner's testimony regarding same seems to be substantiated by Ms. Senesac's e-mail to Petitioner dated March 5, 2014 and titled "Apartment." Ms. Senesac wrote, "Hi Judy! Sorry to hear about your knee. No, the apartment went in the first 2 days..."

Based on Petitioner's detailed and credible testimony, the Arbitrator finds that Petitioner was present at Marley Oaks Assisted Living on January 17, 2014. On said date, Petitioner was a traveling employee and sustained an accident that arose out of and in the course of her employment with Respondent.

With respect to F.) Is Petitioner's current condition of ill-being causally related to the work injury, the Arbitrator finds as follows:

It is undisputed that Petitioner hurt her right knee prior to the accident date, she hurt her knee. Petitioner testified that approximately five to six weeks prior she had a misstep and hurt her knee. Petitioner presented to Oak Forest Hospital on December 30, 2013 with a history of right knee pain of a two-week duration. Petitioner reported she was moving when she heard a pop in the right knee. Petitioner denied a fall or injury and her associated symptoms was noted as none. Petitioner was diagnosed with right knee pain. Petitioner testified she had no other treatment and she was symptom-free prior to the claimed date of accident.

Petitioner's testimony and the medical records indicate the work accident resulted in the immediate onset of pain to Petitioner's right knee. Petitioner initially presented to Little Company of Mary Hospital on the

date of accident. According to hospital records, Petitioner presented "...complaining of right knee pain ongoing for a few weeks ago, told her she had a knee sprain but states today was walking and felt another pop in the back of her knee... unable to bear weight secondary to pain, pain is 10 out of 10 right knee nonradiating worse with movement no other alleviating or aggravating symptoms ongoing for the last one week progressively worsening today when she heard a new pop earlier today...." Petitioner was diagnosed with acute right knee sprain. Although the hospital records fails to document that her acute right knee sprain was a work-related accident, Petitioner testified that she told the doctors that she slipped, fell, and heard a pop. This testimony was corroborated by the several subsequent visits to her treating physicians. In each visit the treating physicians describe the complaints and cause of the injury. Petitioner underwent conservative care with Dr. Alzoobi, initially on January 24, 2014. Those records indicate Petitioner sustained a fall while she was a work. Based on the physical examination and MRI films, Dr. Alzoobi referred Petitioner to Dr. Rubenstein at Illinois Bone and Joint. Dr. Rubenstein recorded a history that Petitioner had problems with her knee since an injury sustained at work on January 17, 2014. The doctor noted Petitioner worked as marketer for a hospice company and was coming out of a building where she had made a sales call and slipped on the ice twisting her right knee. Dr. Rubenstein examined Petitioner, reviewed the MRI, and recommended an arthroscopy of the right knee. Dr. Rubenstein performed the arthroscopy on April 29, 2014 rendering a postoperative diagnosis of complex tear of the medial meniscus of the right knee with minor articular surface damage of the right medial femoral condyle.

Based on the above, the Arbitrator finds that a causal relationship exists between Petitioner's right condition of ill-being and the work accident sustained on January 17, 2014.

With respect 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 as follows:

Petitioner submitted the following unpaid medical bills for services rendered. (PX 10)

NAME OF PROVIDER	TOTAL BILLS
Radiology Imaging Specialists	$110.00
Summit Pharmacy	$169.09
Dr. Anas Alzoobi	$461.28
IL Bone & Joint Institute	$4,989.00
Chicago Ridge Radiology	$3,105.00
Lincoln Park Anesthesia	$1,170.00
St. Joseph's Hospital	$16,815.42
Evergreen Emergency Services	$430.00
TOTAL:	$28,506.79

Having found the requisite causal relationship, the Arbitrator awards the bills indicated above. Respondent is ordered to pay the above -referenced amounts, as provided by Section 8(a) and 8.2 of the Act.

With respect to K.) What temporary benefits (TTD) are in dispute?

Respondent's dispute regarding temporary total disability is premised on its argument that Petitioner did not sustain a compensable accident. Having found in favor of Petitioner on the disputed issues of accident and causal relationship, the Arbitrator notes that the first documented off work authorization occurred on January 24, 2014, when Dr. Alzoobi assessed severe knee pain, possible ligament tear versus meniscus tear, or intraarticular derangement. Dr. Alzoobi recommended an MRI and ordered Petitioner off work. Dr. Alzoobi also referred to Dr. Rubenstein who also ordered Petitioner off work until May 7, 2014 when he provisionally

released her from his care. Petitioner testified that she returned to work for Respondent on Monday, May 12, 2014 and was subsequently terminated on May 13, 2014.

Based on the above, the Arbitrator find Petitioner was temporarily totally disabled from January 24, 2014 through May 12, 2014, a period of 15-4/7 weeks.

With Respect to L.) What is the Nature and Extent of the Injury, the Arbitrator finds as follows:

In determining the level of permanent partial disability for injuries incurred on or after September 1, 2011, the Commission shall base its determination on the following factors: (i) the reported level of impairment pursuant to the most current edition of the AMA's "Guides to the Evaluation of Permanent Impairment"; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; (v) evidence of disability corroborated by the treating medical records. (820 ILCS 305/8.1b)

No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order. (820 ILCS 305/8.1b)

Pursuant to Section 8.1b of the Act, the following criteria and factors must be weighed in determining the level of permanent partial disability, for accidental injuries occurring on or after September 1, 2011:

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

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

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

With regard to Section 8.1(b)(i) of the Act, the 8.1(a), the Arbitrator finds neither party presented an AMA Impairment Rating. Therefore, the Arbitrator gives no weight to this factor.

With regard to Section 8.1(b)(ii) of the Act, the occupation of the injured employee, the Arbitrator finds Petitioner was employed at the time of the accident as a nurse liaison with Sanctuary Hospice. On May 7, 2014, Petitioner's treating surgeon, Dr. Rubenstein released Petitioner to resume activity as tolerated and provisionally released her from care. Petitioner returned to regular work on May 12, 2014 before being terminated on May 13, 2014. Petitioner testified that her job required traveling upwards of 90% of the time. There is much walking and traveling in this type of employment. Therefore, the Arbitrator gives some weight to this factor.

With regard to Section 8.1(b)(iii) of the Act, the age of the injured employee at the time of the injury, the Arbitrator finds Petitioner was 52 years old at the time of the accident. As Petitioner is in the fifth decade of

life, she will live with disability for a shorter period than a younger individual, the Arbitrator gives less weight to this factor.

With regard to Section 8.1(b)(iv) of the Act, the employee's future earning capacity, the Arbitrator finds that no evidence was submitted regarding Petitioner's future earning capacity. As such, the Arbitrator gives no weight to this factor.

With regard to Section 8.1(b)(v) of the Act, evidence of disability corroborated by the treating medical records. The Arbitrator notes that on April 29, 2014, Petitioner underwent an arthroscopy of the right knee with resection of tear of the medial meniscus and medial femoral condyle chondroplasty. The postoperative diagnosis was complex tear of the medial meniscus of the right knee with minor articular surface damage of the right medial femoral condyle. Postoperatively, Petitioner was last seen by her treating surgeon on May 7, 2014. At that time Dr. Rubenstein noted Petitioner reported that her preop symptoms were gone. An examination revealed minimal symptomology. Petitioner was provisionally released her from care. Petitioner testified that she currently has right knee pain and discomfort when going up and down stairs. She also provided that her daily life activities have diminished. As a result, the Arbitrator gives greater weight to this factor.

Considering all the above factors, the Arbitrator finds that as a result of the of the accident sustained on January 17, 2014, Petitioner sustained 22-1/2% loss of use of the right leg pursuant to section 8(e) of the Act.

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

ERIN HOLLEY,
as representative of
THOMAS LEARNED, deceased,

Petitioner,

vs. NO: 15 WC 23353

THE AMERICAN COAL COMPANY,

Respondent.

20IWCC0345

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 occupational disease, causal connection, timely disablement, and permanent partial disability (PPD) and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

Subsequent to the Arbitration hearing, Petitioner's counsel filed a "Petition to Amend Application for Substitution of Party" before Commissioner Douglas McCarthy. Per the petition, Thomas Learned passed away April 28, 2016. An Amended Application was filed on February 5, 2018 and this matter proceeded to Arbitration on May 15, 2019 with the Estate of Thomas Learned as Petitioner. During the Arbitration hearing, Thomas Learned's daughter, Erin Holley, testified that her father was widowed and had three daughters including herself at the time of his death. She further testified that he died without a Will.

Petitioner's counsel, without objection from Respondent's counsel, requested that Commissioner McCarthy grant the petition and substitute Erin Holley as Petitioner as she is an eligible beneficiary under the Act. Commissioner McCarthy granted the petition on April 25, 2020 as Erin Holley is an eligible beneficiary under the Act.

20IWCC0345

Pursuant to Section *820 ILCS 305/8(e)19,*

> In a case of specific loss and the subsequent death of such injured employee from other causes than such injury leaving a widow, widower, or dependents surviving before payment or payment in full for such injury, then the amount due for such injury is payable to the widow or widower and, if there be no widow or widower, then to such dependents, in the proportion which such dependency bears to total dependency.

This issue was addressed recently in *Ill. State Treasurer v. Estate of Kormany*, 2019 IL App (1st) 180644WC, 140 N.E.3d 821, 2019 Ill. App. LEXIS 387, 435 Ill. Dec. 771. The Appellate Court held that it had no jurisdiction because the petitioner's attorney named the estate of the deceased injured claimant and there was no personal representative or administrator appointed. 2019 IL App (1st) 180644WC, ¶ 2.

The Majority finds *Kormany* distinguishable from the case at bar as there is no evidence that Kormany, the deceased claimant, died with a spouse or dependent as defined by the Act. In the case at bar, the evidence establishes that Erin Holley is an eligible dependent under the Act; therefore, her substitution is proper.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 16, 2019 is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $18,500.00. 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: JUN 26 2020

D. Douglas McCarthy

DDM/tdm
d: 5-19-20
052

Stephen Mathis

DISSENT

I respectfully dissent. Unlike the majority, I believe there exists case law directly on point (*Illinois State Treasurer, as ex-officio Custodian of the Injured Workers' Benefit Fund v. Estate of Gyula Kormany, A-Tech Stucco EIFS Company*, 2019 IL App (1st) 180644WC) which compels the Commission to vacate the decision of the arbitrator until such time as a representative of the Estate of Thomas Learned is properly appointed and substituted. The Majority, in arriving at its decision, attempts to distinguish the Court's holding in *Estate of Kormany* in order to find that the need to appoint a legal representative can be undertaken by the Commission. I believe the Court's holding is clear and should be applied, and the Commission possess no authority to appoint Erin Holley as representative of Thomas Learned, deceased.

In *Illinois State Treasurer, as ex-officio Custodian of the Injured Workers' Benefit Fund v. Estate of Gyula Kormany, A-Tech Stucco EIFS Company*, 2019 IL App (1st) 180644WC, claimant, Gyula Kormany, filed an Application for Adjustment of Claim alleging he sustained certain injuries while employed by A-Tech Stucco EIFS Company. Prior to the arbitration hearing, claimant died of causes unrelated to his claimed work injuries. The Application was amended to substitute the Estate of Kormany. A decision was issued by the arbitrator which was affirmed by the Commission awarding benefits to the Estate of Kormany.

The Appellate Court vacated the Commission's decision finding that until such time as a properly appointed representative of the Estate of Kormany could be substituted as the petitioner, the Commission's jurisdiction was suspended. *Estate of Kormany* at ¶ 2. The Court in rendering its decision relied upon *Washington v. Caseyville Health Care Association*, 284 Ill. App. 3d 97, 100, 672, N.E.2d 34 (1996), which holds "It is axiomatic that for every suit, there must always be a plaintiff, a defendant, and a court. *Mitchell v. King, 187 Ill. 452, 55 N.E. 637 (1899)*. An attorney's employment and his authority is revoked by the death of his client, so an attorney cannot proceed where he does not represent a plaintiff or a defendant. *Mitchell, 187 Ill. 452, 55 N.E. 637*." Once a claimant dies of unrelated causes, a legal representative must be appointed in order to continue the prosecution of the claim for the benefits to which the claimant was entitled prior to his death.

"The commission is an administrative body created by legislative enactment for the purpose of administering the Workmen's Compensation act. It is not a court and has no inherent powers of a court. It is a non-judicial body. It can only make such orders as are within the powers granted to it by the General Assembly, quoting *Trigg v. Industrial Commission*, 364 Ill. 581." *Michelson v. Industrial Commission*, 375 Ill. 462, 466-7, 31 N.E.2d 940 (1941). The Commission does not possess the authority to appoint a legal representative of a deceased claimant whose death is unrelated to his claim for compensation benefits. Certainly, once such representative is properly appointed and substituted, the estate may prosecute the claim and benefits may be awarded as delineated by Sections 8(e) and 19(h) of the Act. As noted in *Bell v. Illinois Workers' Compensation Commission*, 2015 IL App (4th) 140028WC, ¶ 19, "By their plain terms, these provisions merely establish *to whom benefits will be paid* if the employee dies with a spouse or dependents before he has been fully compensated for his work-related injury."

The Majority mistakenly frames the issue in terms of the appointment of an appropriate representative and, thereby, fails to appreciate that the Act creates two separate causes of action. As the Supreme Court of Illinois noted in *Board of Education v. Industrial Commission*, 57 Ill. 2d 307, 312, 312 N.E.2d 227 (1974), "Two causes of action are created by Section 8 of the Workmen's Compensation Act (Ill. Rev. Stat. 1969, ch. 48, par. 138.8) – one in favor of the employee for nonfatal injuries and another in favor of his dependents for fatal injuries. [citation omitted]." The Act specifically allows for a separate cause of action in favor of a deceased claimant's dependents to prosecute *their* claim for benefits where a claimant's work-related injury results in his death. As the Act creates a separate cause of action, the Commission merely recognizes the same, and no formal probate or circuit court proceedings are necessary. This is unlike a claimant's cause of action which abates upon his death, and until such time a representative is appointed and substituted for a claimant's estate, the Commission's jurisdiction is suspended. The Act contains no provision for the Commission to make such appointment/substitution.

As such, pursuant to the Court's holding in *Estate of Kormany*, I would vacate the decision of the arbitrator until such time as a representative of the Estate of Thomas Learned is properly appointed and substituted. Therefore, I respectfully dissent.

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ESTATE OF LEARNED, THOMAS
Employee/Petitioner

Case# **15WC023353**

THE AMERICAN COAL COMPANY
Employer/Respondent

20IWCC0345

On 7/16/2019, 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 2.01% 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:

5236 CULLEY FEIST KUPPART & TAYLOR
ROMAN P KUPPART
3 S MAIN ST SUITE #2
HARRISBURG, IL 62946

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

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

ESTATE OF THOMAS LEARNED
Employee/Petitioner

v.

THE AMERICAN COAL COMPANY
Employer/Respondent

Case # **15** WC **023353**

Consolidated cases: _____

20IWCC0345

An *Application for Adjustment 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. [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 **Disease, and Sections 1(d)-(f) of the Occupational Diseases Act**

FINDINGS

On **May 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 $**76,123.32**; the average weekly wage was $**1,463.91**.

On the date of accident, Petitioner was **64** 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 $**N/A** for TTD, $**N/A** for TPD, $**N/A** for maintenance, and $**N/A** for other benefits, for a total credit of $**N/A**.

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

ORDER

PETITIONER HAS PROVEN THAT HE HAS COAL WORKERS' PNEUMOCONIOSIS AND IS DISABLED BECAUSE OF HIS OCCUPATIONALLY INDUCED LUNG DISEASE, WHICH WAS CAUSED BY HIS OCCUPATIONAL EXPOSURE WITH RESPONDENT.

PETITIONER HAS PROVEN THAT HIS COAL WORKERS' PNEUMOCONIOSIS WAS PRESENT AND HE WAS DISABLED BY THE DISEASE WITHIN TWO YEARS OF HIS LAST EXPOSURE AS REQUIRED BY SECTION 1(F).

RESPONDENT SHALL PAY THE PETITIONER THE SUM OF $ 735.37/WEEK FOR A PERIOD OF 25 WEEKS, AS PROVIDED IN SECTION 8(D)(2) OF THE ACT, BECAUSE THE INJURIES SUSTAINED CAUSED A PERMANENT AND PARTIAL DISABLEMENT TO THE EXTENT OF 5% MAW.

RESPONDENT SHALL FURTHER PAY FOR NECESSARY FUTURE MEDICAL SERVICES, AS PROVIDED IN SECTION 8(A) OF THE ACT.

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

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

Edward Lee
Signature of Arbitrator

7/14/19
Date

JUL 16 2019

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FINDINGS OF FACT

On November 10, 2008, a chest film was taken at Harrisburg Medical Center as a part of a Pre-Employment physical for Petitioner. The lungs were clear of infiltrate. Heart size and pulmonary vessels were normal. No pleural fluid or pneumothorax. Degenerative spurring about the spine and shoulders with slight thorasic scoliosis convex to right. Dr. Youssef categorized the film as classification 0/0. Dr. Youssef's credentials are not in the record. (RX8, P. 2).

On November 17, 2009, Petitioner was seen by Dr. Resaba for cough and shortness of breath. Cough was for 3 days and productive of phlegm. Petitioner underwent a chest x-ray at Franklin Hospital. History indicated shortness of breath and cough. Impression was normal chest for age. (RX9, P. 43-46).

On February 22, 2010, Petitioner has a chest film taken at Franklin Hospital and read by Dr. Huan Nguyen. Impression was no active cardiopulmonary disease. (RX9, P. 35).

On March 10, 2010, Petitioner was seen by Dr. Shamsham for chest tightness and pain. Physical examination of the chest was clear to auscultation bilaterally. No rales or rhonchi found. (RX5, P. 12).

On December 12, 2011, Petitioner was seen by Dr. Harrison for congestion and bodyaches. Review of Systems was positive for cough, dyspnea on exertion and dyspnea. Physical examination of the chest was normal. URI was diagnosed. (RX7, P. 8-9).

On February 8, 2012, Petitioner was seen by Dr. Shamsham for a follow up visit. There were no complaints of shortness of breath and physical examination of the chest was normal. (RX5, P. 6).

On February 7, 2014, Petitioner was seen by Dr. Harrison for cough and congestion. Review of systems revealed cough. Physical examination of the chest was normal. (RX7, p 4).

On July 5, 2015, Dr. Henry K. Smith reviewed a chest x-ray taken on June 23, 2015. (PX2, Exhibit 2). Dr. Smith is board certified in radiology and is a NIOSH certified B-Reader. (PX2, Exhibit 1) Dr. Smith passed his initial B-Reader examination in 1987, and maintained his certification status continuously over 23 years. (PX2, Exhibit 1). Dr. Smith found that the chest film was a quality 1 film. Dr. Smith's impression was of simple coal workers' pneumoconiosis with small opacities, primary p, secondary p, all zones involved bilaterally, of a profusion 1/0.

Petitioner filed an Application for Adjustment of Claim with the Illinois Worker's Compensation Commission on July 31, 2015. Petitioner listed his date of accident as May 22, 2015, and listed that the accident occurred from inhalation of coal mine dust, including but not limited to, coal dust, rock dust, fumes and vapors for a period in excess of 38 years.

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On September 22, 2015, Dr. Suhail Istanbouly examined Petitioner and authored a report outlining the test results, diagnosis, and his opinions at the request of Petitioner's counsel. (PX1, Exhibit 2).

Dr. Istanbouly reported that Petitioner was a 64 years old male who has an occasional cough. The cough is triggered by brisk walking. The cough is mild in intensity with no significat sputum production. It was noted that Petitioner gets exertional dyspnea. Dr. Istanbouly noted that Petitioner gets short of breath walking two to three blocks and his physical capacity seems to have been slowly declining slowly. Petitioner has never smoked in the past. (PX1, Exhibit 2).

Dr. Istanbouly obtained Petitioner's occupational history. (PX1, Exhibit 2). He noted that Petitioner did work as a coal miner for a total of 38 ½ years, most of it underground. In the last year of employment he was a miner examiner, which required him to be up on his feet and walking frequently throughout the shift. Petitioner's last month of coal mining career was May, 2015.

Dr. Istanbouly reported that Petitioner's spirometry testing was within the normal range. Dr. Istanbouly personally reviewed the chest x-ray from Ferrell Hospital which was obtained on June 23, 2015, 2015, tiny bilateral round opacities consistent with simple coal workers pneumoconiosis. He also reviewed a B-reading of that same film. Dr. Istanbouly ultimately assessed Petitioner with coal workers' pneumoconiosis. He advised Petitioner to avoid further coal dust inhalation and to avoid going back into the mines to avoid any further lung damage. (PX1, Exhibit 2).

On June 21, 2016, Petitioner underwent a diffusing capacity test at the request of Respondent. Dr. Jeff Selby was the ordering physician. The interpretation was of normal diffusing capacity. A full spirometry test was not performed. (RX3).

On January 23, 2016, Dr. Cristopher A. Meyer, reviewed a chest x-ray of Petitioner dated June 23, 2015, at Respondent's request. (RX1, exhibit B). Dr. Meyer is a board certified radiologist and a NIOSH certified B-reader. (RX1, exhibit A). Dr. Meyer indicated the film was a quality 1. Dr. Meyer's impression was that there were no radiographic findings of coal workers' pneumoconiosis on the film.

On April 27, 2016, Petitioner was taken to the ER at Heartland Regional Medical Center by EMS. Petitioner has stomach cancer and refused treatment. Petitioner passed away at 4:18 am on 04/28/16. (RX10).

On April 28, 2016, Petitioner passed away. Causes of death as listed on the Death Certificate were: a) ANION GAP METABOLIC, B) ANURIC ACUTE RENAL FAILURE, and c) SEVERE DEHYDRATION. (PX3).

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On August 26, 2016, Dr. Christopher A. Meyer testified via evidence deposition at Respondent's request. (RX1, P. 4). Dr. Meyer testified that he is a board certified radiologist who has a B-Reading certificate. Dr. Meyer testified that he currently works as the Vice Chair of Finance and Business Development and professor of diagnostic radiology at the University of Wisconsin Hospital and Clinics in Madison, Wisconsin. (RX1, P. 15).

Dr. Meyer testified that he reviewed a PA and lateral chest x-ray of Petitioner dated June 23, 2015. (RX1). Dr. Meyer testified that the film was a quality 1. Dr. Meyer testified that it was his impression that there were no radiographic findings of coal workers' pneumoconiosis on that film. However, Dr. Meyer agreed that it was fair to say that experts with similar credentials may disagree on the reading of chest films, especially those in Category 1 of pneumoconiosis. (RX1, P.59).

On cross-examination, Dr. Meyer agreed that a negative chest x-ray for coal workers' pneumoconiosis does not necessarily rule out the disease. (RX1, P. 47). Dr. Meyer further agreed that many coal miners have had negative chest x-rays for coal workers' pneumoconiosis, but on biopsy or autopsy it is shown that they actually had the condition pathologically. (RX1, P. 48). Dr. Meyers agreed with the Laney and Petsonk study which stated, "[i]ndividual coal macules are generally too small to be appreciated on chest x-rays". Dr. Meyers explained that "[m]ost of the nodules that we see on chest x-rays are actually what are known as summation shadows, which means that multiple coal macules superimposed on one another form a shadow that's big enough for us to see." (RX1, P. 54-55).

On May 17, 2017, Dr. Istanbouly testified via evidence deposition at Petitioner's request. (PX1). Dr. Istanbouly testified that he is board certified in critical care medicine and pulmonary medicine. Dr. Istanbouly testified that he does black lung examinations for the U.S. Department of Labor. He has been the medical director of the pulmonary department at Herrin Hospital since 2005. He is also the director of the Intensive Care Unit at Carbondale Memorial Hospital and that he has been the director of the Intensive Care Unit at Herrin Hospital. (PX1, P. 4-6).

Dr. Istanbouly testified that he evaluated Petitioner on September 22, 2015. (PX1, P. 6). Dr. Istanbouly testified that he took a detailed history from Petitioner, performed a physical examination and reviewed the pulmonary function testing and the chest x-ray. (PX1, P. 7).

Dr. Istanbouly testified that the pertinent aspects of Petitioner's history were that Petitioner had worked as a coal miner for 38 ½ years. That Petitioner's last month of employment was May, 2015. That Petitioner never smoked. That Petitioner had multiple chronic respiratory symptoms, including cough and exertional dyspnea. (PX1, P. 7).

Dr. Istanbouly testified that it is not unusual for miners with simple coal worker's pneumoconiosis to be asymptomatic. He testified that if the miner was symptomatic they could have chronic cough, sputum production, shortness of breath on exertion, wheezing, and recurrent respiratory infections. Dr. Istanbouly testified that Petitioner's physical examination of his chest

was normal. (PX1, P. 8). Dr. Istanbouly testified that it is not unusual for someone with early stages of coal workers' pneumoconiosis to have a normal physical examination of the chest. (PX1, P. 8-9). Dr. Istanbouly testified the pulmonary function studies Petitioner performed were within normal limits.

Dr. Istanbouly testified that a person with coal workers' pneumoconiosis could have pulmonary function testing that is completely normal, which is not unusual in the early stages of the disease. (PX1, P. 9). Dr. Istanbouly testified that spirometry is a measure of the global impairment of both lungs rather than a focal impairment of a portion of the lungs. (PX1, P. 10). Dr. Istanbouly testified that a person could even have shortness of breath but have a normal pulmonary function test. (PX1, P. 10).

Dr. Istanbouly testified that he personally reviewed Petitioner's chest x-ray which was taken on June 23, 2015. (PX1, P. 10). Dr. Istanbouly testified that he personally reviewed and interpreted Petitioner's chest film, as he normally does in the care and treatment of his patients. Dr. Istanbouly testified that the chest x-ray was of diagnostic quality, and that it revealed tiny bilateral round opacities. Dr. Istanbouly testified that the B-reader read the film and found that the profusion was 1/0 primary p, secondary p, all zones involved bilaterally. (PX1, EX. 2).

Dr. Istanbouly testified that coal workers' pneumoconiosis is caused by the inhalation of coal dust that causes irritation and inflammation that will ultimately end up forming tiny scars. (PX1, P. 11-12). Dr. Istanbouly testified that the scarring is sometimes referred to as fibrosis, and that the scarring and fibrosis are permanent. (PX1, P. 12). Dr. Istanbouly further testified that the scarring and fibrosis cannot carry on the function of normal health lung tissue. (PX1, P. 12). Dr. Istanbouly testified that, by definition, if you have coal workers' pneumoconiosis that you have an impairment of the function of the lungs, at least at the site of the scar or fibrosis. (PX1, P. 12). Dr. Istanbouly testified that only exposure to coal dust can cause coal workers' pneumoconiosis. Dr. Istanbouly testified that there is no cure for coal workers' pneumoconiosis. (PX1, P.13).

Dr. Istanbouly testified that, based upon on a reasonable degree of medical certainty, Petitioner's coal workers' pneumoconiosis was caused by his long term coal dust inhalation. (PX1, P. 11). Dr. Istanbouly testified that abnormal pulmonary function test findings are not necessary to diagnose someone with coal workers' pneumoconiosis.

Dr. Istanbouly testified that based on Petitioner's x-ray and his chronic symptoms, it is not advisable for Petitioner to ever return to work in the coal mines. (PX1, P. 14-15). Dr. Istanbouly testified that any additional exposure to coal dust could cause the damage to his lungs to worsen. (PX1, P. 14-15).

On June 7, 2017, Dr. James R. Castle testified via evidence deposition on behalf of the Respondent. (RX2). Dr. Castle testified that he is a pulmonologist who is board certified in internal medicine with a subspecialty in pulmonology. Dr. Castle testified that he had a practice in Roanoke, VA for thirty years, beginning in 1977. (RX2, P. 7). Dr. Castle testified that in the

course of his practice he saw patients with all different types of chest disease. (RX2, P. 8). Dr. Castle testified that he semi-retired in 2007, (RX2, P. 12), and does not see patients any more, but he continues to do medicolegal types of exams and records reviews. (RX2, P. 16-17). Dr. Castle testified that he performs 5 – 6 reviews like this per month, and approximately 15 per year at the request of Respondent's counsel, Mr. Werts.

Dr. Castle testified that he was a B reader, but that his certification expired on June 30, 2017. (RX2, P. 20-21).

Dr. Castle testified that had reviewed medical records and films regarding Petitioner. (RX2, P.21). Dr. Castle testified that it was his opinion, within a reasonable degree of medical certainty, that Petitioner does not have any pulmonary disease or impairment as a result of his occupational exposure. (RX2, P.40-42).

On cross-examination Dr. Castle conceded that he had never met, spoken to, taken a history from, or physically examined the Petitioner. (RX2, P. 54-55). Dr. Castle also agreed that he did not have the charts or notes from any of the physicians that personally evaluated the Petitioner, so he does not know what questions were posed to Petitioner or what answers were obtained. (RX2, P. 56).

Dr. Castle testified that it would be fair to say that similarly qualified physicians can, and do, disagree as to the findings on chest x-rays. (RX2, P. 57). Dr. Castle testified that the only possible cause of pneumoconiosis is exposure to coal dust, and that there is no cure for that condition. (RX2, P. 46-47). Dr. Castle testified that he scarring and fibrosis that occurs in the lungs from pneumoconiosis is irreversible and permanent. (RX2, P. 47). Dr. Castle agreed that the scarring and fibrosis is an alteration of the lung tissue, and is also an alteration of the function of the involved lung tissue. (RX2, P. 47). Dr. Castle further agreed that the condition of pneumoconiosis can progress absent further coal dust exposure. (RX2, P. 47-48). Dr. Castle acknowledged that there are contradictory opinions as to whether or not there is a "safe" level of coal dust exposure, but even exposure to the alleged "safe" levels of coal dust are still causing some worker's to develop pneumoconiosis. (RX2, P. 49-50).

On cross-examination, Dr. Castle testified that an individual could have coal workers' pneumoconiosis and not know it because most people that have it are asymptomatic. (RX2, P. 51). On cross-examination, Dr. Castle agreed that a patient can still have shortness of breath despite having normal PFTs. (RX2, P.52). Dr. Castle further stated that having a normal PFT does not mean that the lungs are undamaged, it simply means that lung function is normal. (RX2, P. 52). Dr. Castle testified that it was even possible to have a normal PFT after a portion, or a lobe, of a patient's lung has been removed. (RX2, P. 53-54). Dr. Castle testified that spirometry is a measure of the function of the entire pulmonary system rather than a measure of focal areas or impairments of the lung. (RX2, P. 54).

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Dr. Castle also agreed that it was possible for a patient to have coal workers' pneumoconiosis without any abnormalities on physical examination of the chest. (RX2, P. 56)

On January 29, 2019, Dr. Henry K. Smith testified on behalf of the Petitioner. (PX2). Dr. Smith has been Board certified in Radiology since 1973 and has been a Certified NIOSH B-reader continuously since 1987. (PX2, P. 11). Dr. Smith holds medical licensure in 5 states. (PX2, P. 13). Dr. Smith is affiliated with or has privileges at numerous hospitals and clinics. PX2, Exhibit 1, P. 4-6). Dr. Smith discontinued seeing walk in patients in 2016, but continues to do consulting work to the present. (PX2, P. 15-16).

Dr. Smith reviewed a chest film of Petitioner dated June 23, 2015. (PX2, P. 35). He rated the film a quality 1 and noted the presence of small opacities, p primary, secondary p, upper, middle and lower zones bilaterally involved of a profusion of 1/0. (PX2, P. 36). Dr. Smith opined that Petitioner has coal worker's pneumoconiosis and has damage to his lungs as a result of his coal worker's pneumoconiosis. (PX2, P. 36-37).

TESTIMONY

Erin Holley

On May 15, 2019, Erin Holley Daughter of Petitioner testified at arbitration.

Mrs. Holley testified that she is 33 years old and lives at 1068 County Road 541, Valley Alabama. She is the daughter of Thomas Learned, who died on April 28, 2016. Decedent did not leave a Will and was widowed at the time of his death. Mrs. Holley testified that she has two other siblings. One is Kristen Tomshack of West Frankfort who is 24 years old and her other sister is Aleicia Morris who lives in Montgomery Alabama and is 35 years of age.

Mrs. Holley testified there was not an estate opened on her father's behalf but she did fill out a Small Estate Affidavit.

Mrs. Holley testified her father was a coal miner for approximately 38 years. Mrs. Holley testified he last worked at American Coal. Mrs. Holley testified that if there is an award issued in this case that she understands that it would have to be split between her and her two siblings.

Brandon Barker

Brandon Barker also testified at arbitration. Mr. Barker lives at 13381 Prosperity Road, Marion, Illinois. Mr. Barker's date of birth is October 25, 1980, and that he is currently thirty-eight years old.

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Mr. Barker testified he previously worked at American Coal for 11 years. Mr. Barker testified that he worked at American Coal with Mr. Thomas Learned for about five to seven years. Mr. Barker testified he worked with the Petitioner for the last five to seven years of his career. Both he and Mr. Learned examined the mine together. Mr. Barker testified that he and Mr. Learned started the shift together and ended the shift together. He testified that he was with Mr. Learned at least eight hours a day, if not twelve.

Mr. Barker testified that towards the end, Mr. Learned would become winded more easily and had to take more five or ten minute breaks in between doing their examinations. If he and Mr. Learned had side jobs to do, Mr. Learned would have to take a break more than what he normally would. Mr. Barker testified the side jobs would include building a stopping for ventilation or shoveling the belts or something to keep them busy. Mr. Barker testified while doing the side jobs he would notice that Mr. Learned would have to take more breaks than when they were just walking. Mr. Barker testified Mr. Learned did not try to hide taking his breaks from him and that Mr. Learned would tell him he needed to take a break. Mr. Barker could tell Mr. Learned did not want Mr. Barker him to notice that Mr. Learned needed to take a break, it but he could tell when Mr. Learned needed a break.

Mr. Barker worked with Mr. Learned until the mine shut down. He and Mr. Learned were both laid off on the same day.

On Cross Examination, Mr. Barker testified he was an examiner and as a mine examiner he makes sure the mine is safe for fellow miners and make sure the mine was safe for oncoming miners to go underground and work. Mr. Barker testified he and Mr. Learned would check for gas build up, make sure there was no damage roof bolts, and make sure there was no ribs that are blown out that could cause crushing. He and Mr. Learned would walk the belt lines, make sure that no rollers were running in the gob, that no rollers were froze up, which could be a potential fire hazard. They would check ventilation to make sure that there was enough air going to the right spot and not going someplace where it didn't need to be.

Mr. Barker testified that he and Mr. Learned would have to sign the books at the start of the shift and at the end of the shift they would both come out and sign the federal and state documents again. Mr. Barker testified the books are what MSHA and the State of Illinois requires. Mr. Barker testified he and Mr. Learned carried around a gas meter that measures the O2 and methane and things of that nature. Mr. Barker testified the he and Mr. Learned would walk anywhere from a five to nine mile route. The total would be at least 20 miles total between all three examiners on the belt lines and returns. Mr. Barker testified after lunch he and Mr. Learned would break off and do their own sections. Mr. Barker testified on the sections you might have to do a half mile total of walking between all the entries and faces and checking stuff. Mr. Barker testified that he and Mr. Learned could have three, two, or eight sections, it would just depend. Mr. Barker testified that building stoppings requires shoveling out and cleaning a clear spot to put up a cement block stopping and plastering it. Mr. Barker testified it could be 20 foot wide, 8 foot high or it could be 16 foot high and 10 foot wide. Mr. Barker testified that it

was physically demanding. Mr. Barker testified that he and Mr. Learned would shovel on the belt. They would shovel piles of coal or gob underneath the belt so it didn't catch fire and create a hazard. Mr. Barker testified that it was physically demanding job.

Mr. Barker testified he was laid off at the same time as Mr. Learned on May 22, 2015 and this was on a Friday on second shift.

CONCLUSIONS OF LAW

WITH RESPECT TO ISSUE (C), DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF THE PETITIONER'S EMPLOYMENT BY THE RESPONDENT, and WITH RESPECT TO ISSUE (F), IS THE PETITIONER'S PRESENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner has sustained an injury that arose out of an in the course of his employment. Section 1(d) of the Illinois Workers' Compensation Diseases Act states, in pertinent part:

> A disease shall be deemed to arise out of the employment if there is apparent to the rational mind, upon consideration of all the circumstances, a causal connection between the conditions under which the work is performed and the occupational disease. The disease needs not to have been foreseen or expected but after its contraction it must appear to have had its origin or aggravation in a risk connected with the employment and to have flowed from that source as a rational consequence. An employee shall be conclusively deemed to have been exposed to the hazards of an occupational disease when, for any length of time however short, he or she is employed in an occupation or process in which the hazard of the disease exists...If a miner who is suffering or suffered from pneumoconiosis was employed for 10 years or more in one or more coal mines there shall, effective July 1, 1973 be a rebuttable presumption that his or her pneumoconiosis arose out of such employment. 820 ILCS 310/1(d)

On June 23, 2015, Petitioner underwent an x-ray with PA & Lateral views of the chest for pneumoconiosis at Ferrell Hospital. On July 5, 2015, Dr. Henry Smith, a board certified B-Reader for over 23 years, performed a chest film interpretation and B-Reading. Dr. Smith's impression was of simple coal workers' pneumoconiosis with small opacities, primary p, secondary p, all zones involved bilaterally, of a profusion 1/0. Dr. Istanbouly testified that he physically examined Petitioner, and took a detailed medical and occupational history. Dr. Istanbouly also testified that he read Petitioner's chest x-ray film dated June 23, 2015, and that it was his opinion within a reasonable degree of medical certainty that Petitioner had coal workers' pneumoconiosis. Dr. Istanbouly testified that the cause of Petitioner's diagnosis was exposure to coal mine dust.

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Dr. Istanbouly's testimony reveals his significant experience and credentials in the field of pulmonary studies. Dr. Istanbouly testified that he is board certified in critical care medicine and pulmonary medicine. Dr. Istanbouly testified that he does black lung examinations for the U.S. Department of Labor. He has been the medical director of the pulmonary department at Herrin Hospital since 2005. He is also the director of the Intensive Care Unit at Carbondale Memorial Hospital and that he has been the director of the Intensive Care Unit at Herrin Hospital. Drs. Istanbouly and Smith's extensive experience, leads the Arbitrator to find that Petitioner has met his burden of proof in establishing that he has simple coal workers' pneumoconiosis.

Although Respondent's experts, Dr. Meyer and Dr. Castle, disagree with the findings and diagnosis of Drs. Smith and Istanbouly, their opinions are found to be less credible by way of their own testimony. On cross-examination, Dr. Meyer agreed that a negative chest x-ray for coal workers' pneumoconiosis does not necessarily rule out the disease. Dr. Meyer further agreed that many coal miners have had negative chest x-rays for coal workers' pneumoconiosis, but on biopsy or autopsy it is shown that they actually had the condition pathologically. Dr. Meyers agreed with the Laney and Petsonk study which stated, "[i]ndividual coal macules are generally too small to be appreciated on chest x-rays".

Dr. Castle conceded that he had never met, spoken to, or physically examined the Petitioner. Dr. Castle also testified that he no longer does examinations for black lung, and has not done so since 2014. Dr. Castle is retired from his active medical practice Dr. Castle testified that it would be fair to say that similarly qualified physicians can, and do, disagree as to the findings on chest x-rays. Dr. Castle testified that the only possible cause of pneumoconiosis is exposure to coal dust, and that there is no cure for that condition.

Given the totality of the evidence, the Arbitrator finds Drs. Smith and Istanbouly to be more credible than Drs. Meyer and Castle. Therefore, the Arbitrator finds that Petitioner has satisfied the requirements of Section (d) of the Act. It is apparent that Petitioner's coal workers' pneumoconiosis arose out of his employment as a coal miner, and that there is a causal connection between the conditions under which Petitioner worked and coal workers' pneumoconiosis. Petitioner worked as a coal miner for 38 ½ years, which is well over the statutorily required 10 years, and he was diagnosed with coal workers' pneumoconiosis. According to Section (d), there is a rebuttable presumption that his coal workers' pneumoconiosis arose out of his employment in the coal mines. The Respondent has not credibly rebutted that presumption.

Therefore, Petitioner proved by a preponderance of the evidence that he was afflicted with coal workers' pneumoconiosis and that it arose out of his employment.

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WITH RESPECT TO ISSUE (L), WHAT IS THE NATURE AND EXTENT OF THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds Petitioner has sustained a permanent partial disability of 5% of the person as a whole.

WITH RESPECT TO ISSUE (O), THE APPLICABILITY OF SECTIONS 1(e) and 1(f) OF THE OCCUPATIONAL DISEASES ACT, THE ARBITRATOR FINDS AS FOLLOWS:

Section 1(e) of the Occupational Diseases Act states, in pertinent part, "{d}isablement" means an impairment or partial impairment, temporary or permanent, in the function of the body or any of the members of the body." 820 ILCS 310/1(e) The Arbitrator finds that Petitioner has satisfied the requirements of Section (e) of the Act. Dr. Istanbouly testified that the inhalation of coal dust that causes irritation and inflammation that will ultimately end up forming tiny scars. Dr. Istanbouly testified that there is no cure for coal workers' pneumoconiosis, and that it is a chronic condition. Dr. Castle agreed that the scarring and fibrosis that occurs in the lungs from pneumoconiosis is irreversible and permanent. Dr. Castle testified that the scarring and fibrosis is an alteration of the lung tissue, and is also an alteration of the function of the involved lung tissue.

Section 1(f) of the Occupational Diseases Act states, in pertinent part, "[n]o compensation shall be payable for or on account of any occupational disease unless disablement, as herein defined, occurs within two years after the last day of the last exposure to the hazards of the disease." 820 ILCS 310/1(f). Petitioner last worked a day of coal mine employment on May 22, 2015. Petitioner has not worked in the coal mines and has not had any other exposure to coal mine dust since that date. On June 23, 2015, Petitioner underwent an x-ray with PA & Lateral views of the chest for pneumoconiosis at Ferrell Hospital. Dr. Smith's impression was of simple pneumoconiosis, category p/p, 1/0. Since the Petitioner obtained the coal workers' pneumoconiosis diagnosis within two years of leaving Respondent's employment, he meets the requirement under Section 1(f) of the Act.

Based on the totality of the evidence, and the factual findings above, the Arbitrator finds that the Petitioner is entitled to occupational disease benefits.

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

TIFFANY GIBSON,
Petitioner,

vs.

NO: 14 WC 22403

CHICAGO TRANSIT AUTHORITY,
Respondent.

20IWCC0346

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, temporary total disability (TTD), and permanent partial disability (PPD), and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 6, 2019 is hereby affirmed and adopted.

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

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

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

DATED: JUN 26 2020

D. Douglas McCarthy
Douglas McCarthy

L. Elizabeth Coppoletti
L. Elizabeth Coppoletti

Stephen J. Mathis
Stephen Mathis

DDM/tdm
O: 6/17/20
052

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GIBSON, TIFFANY
Employee/Petitioner

Case# **14WC022403**

CHICAGO TRANSIT AUTHORITY
Employer/Respondent

20IWCC0346

On 9/6/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

1920 BRISKMAN BRISKMAN & GREENBERG
RICHARD VICTOR
351 W HUBBARD ST SUITE 810
CHICAGO, IL 60654

0515 CTA WORKERS' COMP DEPT
LAURA HARTIN
567 W LAKE ST 6TH FL
CHICAGO, IL 60661

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Tiffany Gibson
Employee/Petitioner

v.

Chicago Transit Authority
Employer/Respondent

Case # **14** WC **22403**

Consolidated cases: _____

20IWCC0346

An *Application for Adjustment 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 **July 2, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **October 2, 2013**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident ***was 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 $**61,871.68**; the average weekly wage was $**1189.84**.

On the date of accident, Petitioner was **45** years of age, ***single*** with **0** dependent children.

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

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

Respondent shall be given a credit of $**0** for TTD, $**0** for TPD, $**0** for maintenance, and $**1252.40** for other benefits, for a total credit of $**1252.40**.

Respondent is entitled to a credit of $**4611.18** under Section 8(j) of the Act.

ORDER

Denial of benefits

Because Petitioner did not sustain accidental injuries that arose out of and in the course of 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

9.5.19
Date

SEP 6 - 2019

Tiffany Gibson v. Chicago Transit Authority, No. 14 WC 22403

Preface

The parties proceeded to hearing July 2, 2019, on a Request for Hearing indicating the following disputed issues: whether Petitioner sustained accidental injuries that arose out of and in the course of employment; 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 a period of temporary total disability; and what is the nature and extent of the injury. Tiffany Gibson v. Chicago Transit Authority, No. 14 WC 22403 Transcript of Evidence on Arbitration at 4; Arbitrator's Exhibit 1. Petitioner testified at the hearing. Dr. Nitin Khanna, Dr. Mark Levin, and Dr. Frank Phillips testified via evidence deposition.

Findings of Fact

Tiffany Gibson (Petitioner), a 45 year old female, filed an Application for Adjustment of Claim July 1, 2014, alleging she suffered repetitive trauma to her back. She claimed a date of accident of October 2, 2013. Arbitrator's Exhibit 2.

Petitioner, seemingly abandoning her repetitive trauma claim, testified she was a bus operator for the Chicago Transit Authority (Respondent) on October 2, 2013. She said she was driving a bus with a broken seat that was bouncing up and down. She said the seat vibrated during the course of her shift. Petitioner said at the end of the day, she had difficulty getting up and down out of the seat, as her lower back started hurting. She testified, in testimony that strains credibility, that if there was something wrong with the bus she was driving, she had to wait until the end of the line to notify dispatch and could not call dispatch to say the bus could not be driven. Gibson at 8-11; 27-28.

Petitioner testified she continued driving the bus, drove it to the garage, and told a Mr. Shelton her back was hurting and the seat was broken. She said she filled out an accident report that day. Petitioner admitted she had submitted numerous injury reports in the past. No such report of an injury on October 2, 2013, was located or submitted into evidence. Gibson at 11-12, 13, 32-34.

Petitioner did not seek medical attention for her claimed lower back pain for three months. Petitioner continued to work. Petitioner testified she saw Dr. Lillian Deleon January 7, 2014. Gibson at 13-14.

The records of Dr. Deleon are disjointed and largely illegible; some are irrelevant. The records do contain an x-ray done January 7, 2014, of Petitioner's lumbosacral spine, indicating at L5-S1 degenerative disc disease with lower lumbar spine facet joint degenerative changes. Petitioner testified Deleon sent her for physical therapy. The initial evaluation of Petitioner by the therapist, contained in Deleon's records, indicates a referral by Deleon for degeneration of lumbar or lumbosacral intervertebral disc. The evaluation notes Petitioner reported gradually increasing low back pain beginning December 18, 2013, associated with a lifting strain.

Petitioner was diagnosed with back pain and degenerative joint disease and sent to physical therapy for treatment. Petitioner's Exhibit 1 (unpaginated); Gibson at 15.

Petitioner testified she had epidural injections on February 17, 2014, and March 11, 2014. She said she was sent to Dr. Amarjit Bhasin in April 2014. Gibson at 15.

The medical records of Bhasin and Deleon indicate Bhasin sent a letter to Deleon April 24, 2014. Bhasin indicated Petitioner reported no antecedent illness or trauma and that low back pain occurs after driving. He noted an MRI was performed March 28, 2014, of the lumbosacral spine, indicating moderately severe degenerative disc disease at L5-S1, degenerative facet arthrosis and hypertrophy, nerve compression bilaterally. Bhasin noted Petitioner had injections that were not beneficial. His impression was no hard sign of radiculopathy and that low back pain could be secondary to degenerate facet arthropathy. Clinically, there were no signs of nerve compression. Bhasin changed Petitioner's medication and recommended finishing physical therapy with weight reduction. Petitioner had an EMG on May 12, 2014. The exam was normal. There was no electrical evidence of lumbosacral radiculopathy detected. Petitioner's Exhibit 1 (unpaginated); Petitioner's Exhibit 2 (unpaginated).

Petitioner testified she was referred to Dr. Nitin Khanna. Khanna testified not recalling seeing Petitioner as a referral. Khanna testified to first seeing Petitioner in June 2014. The records of Dr. Khanna indicate Petitioner was first evaluated June 16, 2014. The Patient Information by Petitioner indicated she was seeing Khanna for low back pain; she was employed by the CTA as a bus operator. Petitioner left blank the date of injury and did not indicate a work injury. In a patient medical history completed and signed by Petitioner, she indicated her problem was not a job injury, not a car accident, and not a sports injury. She indicated her problem, back pain, started gradually. The initial evaluation by Khanna indicated a review of an MRI showing severe modic changes at L5-S1, severe foraminal stenosis bilaterally. Khanna noted Petitioner had failed physical therapy, injections, and pain management. Khanna thought minimally invasive decompression instrumented fusion was in Petitioner's best interest. Khanna planned to perform a single level MAS PLIF at L5-S1. Gibson at 16; Petitioner's Exhibit 5 at 6; Petitioner's Exhibit 4 (unpaginated).

Dr. Khanna testified surgery was performed September 4, 2014. Khanna performed a posterior lumbar fusion level L5-S1, transforaminal interbody fusion, level L5-S1, bilateral transfacet decompression L5-S1 bilateral. There is no colorable evidence Khanna was aware of what Petitioner did for a living or exactly what she did as a bus operator. Khanna thought a bus operator was like a truck driver. Khanna testified Petitioner's position as a CTA bus driver and the repetitive trauma that ensued from being a bus driver have contributed to the progressive deterioration of the L5-S1 segment, which ultimately required surgical intervention. Khanna did not explain the nature of the repetitive trauma, but did testify it was possible that without her duties as a bus operator, she could have needed the surgery. Khanna said this ". . . was not a work injury case." Khanna last saw Petitioner May 6, 2015, and did not know if she went back to work. Petitioner testified her attorney wanted to speak to Khanna about providing a causation opinion. Petitioner's Exhibit 5 at 9; Petitioner's Exhibit 4 (unpaginated); Petitioner's Exhibit 5 at 12, 13, 14, 17-18, 15, 18, 19; Gibson at 19.

Petitioner submitted to an independent medical examination with Dr. Frank Phillips, a board certified orthopedic surgeon, on May 9, 2017. Phillips testified he is a spine surgeon doing 300 surgeries a year, three to five lumbar fusions a week. Phillips testified Petitioner denied any specific injury. He testified she did not describe the activities she had to perform as a bus operator. Phillips testified Dr. Deleon documented chronic low back pain, not injury or trauma. He noted Dr. Bhasin specifically said Petitioner sustained no trauma. Petitioner's EMG was normal. Respondent's Exhibit 4 at 5-6, 11, 13, 16.

Dr. Phillips testified there was no indication Petitioner's low back symptoms were caused, aggravated, or accelerated by a work injury. He based this on Petitioner's MRI and her treating physician's documentation of chronic back pain. He found no indication Petitioner's symptoms related to repetitive trauma, saying sitting and driving is not repetitive trauma. Dr. Phillips found no indication during his examination of a work injury. He said degenerative disc disease is a chronic process over years and years, and related to aging and genetics. It is almost never caused by trauma. Respondent's Exhibit 4 at 17, 19-20.

Conclusions of Law

The decision in this case begins and ends with disputed issue **C**, did an accident occur that arose out of and in the course of Petitioner's employment, along with disputed issue **F**, is Petitioner's current condition of ill-being causally related to the injury. A claimant bears the burden of proving by a preponderance of the evidence that her injury arose out of and in the course of the employment. Both elements must be present in order to justify compensation. First Cash Financial Services v. Industrial Commission (Rios), 367 Ill. App. 3d 102, 105 (2006). In the course of employment refers to the time, place, and circumstances of the injury. If the injury occurs within the time period of employment, at a place 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 injury is deemed to have occurred in the course of employment. Eagle Discount Supermarket v. Industrial Commission, 82 Ill. 2d 331, 338 (1980). Arising out of employment pertains to the origin or cause of the claimant's injury. First Cash, supra at 105. A claimant must prove that some act or phase of employment was a causative factor in the injury. Vogel v. Illinois Worker's Compensation Commission, 345 Ill. 2d 524, 529 (1987). A repetitive trauma injury is one which has been shown to be caused by the performance of the claimant's job and has developed gradually over a period of time. Peoria County Belwood Nursing Home v. Industrial Commission, 115 Ill. 2d 524, 529 (1987). An employee alleging injury based on repetitive trauma must meet the same standard of proof as a claimant alleging a single definable accident. The difficulty in proving that injury resulting from repeated trauma arose out of and in the course of employment will pose a serious burden for a claimant. Peoria County Belwood Nursing Home v. Industrial Commission, 138 Ill App. 3d 880, 885 (1985).

I find as a conclusion of law, Petitioner failed to prove an accident occurred that arose out of and in the course of Petitioner's employment by Respondent; and that Petitioner's current condition of ill-being is not related to any workplace accident or in any way connected to her employment. I rely on the following.

Plaintiff's story of pain in her back because of a broken seat she was forced to sit in for eight hours is implausible. There is no documentary evidence of this event, the replacement or repair of the seat, or corroboration Petitioner was forced to endure driving that way by policy or practice.

Petitioner's physical therapist noted Petitioner said she reported increasing low back pain two months after the seat incident, and said it was associated with a lifting strain. No indication it was work related was noted.

Neither Dr. Deleon nor Bhasin, Petitioner's treating physicians, expressed any opinion that any condition of Petitioner was caused by her employment. In fact, Dr. Bhasin specifically noted no antecedent illness or trauma reported.

There was no testimony or evidence on what constituted the repetitive nature of Petitioner's work.

I completely reject the testimony of Dr. Khanna that Petitioner's position as a CTA bus drive and the repetitive trauma that ensues from being a bus driver contributed to the progressive deterioration of the L5-S1 segment requiring surgery. I do so because Khanna did not know what a bus operator does, had no job description, viewed no recording of a typical shift of duty, did not discuss the job and its requirements with Petitioner, and did not even know if Petitioner went back to work. Khanna had no credible basis to say anything on this issue.

In contrast, Dr. Frank Phillips, in reliance on Petitioner's MRI, the documentation of Petitioner's treating physicians of chronic back pain, as well as his rejection of sitting and driving as repetitive trauma, found no indication Petitioner's low back symptoms were caused, aggravated or accelerated by a work injury. I rely on his testimony and find it credible and essentially supported by Dr. Deleon and Dr. Bhasin.

In a workers' compensation claim, liability cannot rest upon imagination, speculation, or conjecture, but must arise from facts established by a preponderance of the evidence. Palos Electric Co. v. Industrial Commission, 314 Ill. App. 3d 920, 926 (2000). Petitioner fails to establish such evidence.

In view of the foregoing, the disputed issue of notice of the accident, of which there is no credible evidence, is moot. Because of the foregoing, Respondent is not liable for unpaid medical bills or temporary total disability and Petitioner is not entitled to permanent partial disability.

Arbitrator

9.5.19
Date

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ELIZABETH MOENS,

Petitioner,

vs.

NO: 14 WC 6527

20 IWCC0347

CITY OF CHICAGO,
DEPARTMENT OF HOUSING & ECONOMIC DEVELOPMENT,

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, causal connection, medical, temporary total disability (TTD), and permanent partial disability (PPD), and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission strikes the following sentence that is located in the second full paragraph on page 9 of the Decision: "After considering the entirety of the evidence, including Petitioner's testimony and the medical treatment records, including that from his treating physician, Dr. Murciano, the Arbitrator finds that Petitioner is not credible regarding his ongoing complaints of pain in his lower back as related to work." The sentence references the wrong doctor and incorrectly identifies the petitioner's gender. The removal of said sentence, does not, however, impact the Commission's decision.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 1, 2019 is hereby affirmed and adopted.

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

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

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 26 2020

D. Douglas McCarthy

DDM/tdm
O: 6/17/20
052

L. Elizabeth Coppoletti

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MOENS, ELIZABETH
Employee/Petitioner

Case# **14WC006527**

CITY OF CHICAGO-DEPT OF HOUSING & ECONOMIC DEVELOPMENT
Employer/Respondent

20IWCC0347

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:

2906 MACK LAW GROUP PC
JAMES J TRAGOS
20 S CLARK ST SUITE 500
CHICAGO, IL 60603

0766 HENNESSY & ROACH PC
DANIEL S WELLNER
140 S DEARBORN ST SUITE 700
CHICAGO, IL 60603

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Elizabeth Moens
Employee/Petitioner

v.

City of Chicago-Dept of Housing & Economic Development
Employer/Respondent

Case # **14** WC **06527**

Consolidated cases: _____

20IWCC0347

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

DISPUTED ISSUES

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

FINDINGS

On **December 2, 2013**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident ***was 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 $**77,021.88**; the average weekly wage was $**1,481.19**.

On the date of accident, Petitioner was **40** years of age, ***single*** with **1** dependent children.

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

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

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

Respondent is entitled to a credit of $**6,575.60** under Section 8(j) of the Act.

ORDER

The Arbitrator finds that Petitioner did not have an accident arising out of and in the course of her employment, that Petitioner did not provide proper notice and that Petitioner's condition of ill-being is causally related to the alleged accident. Benefits are hereby denied.

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

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

Signature of Arbitrator

July 30, 2019
Date

AUG 1 - 2019

STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Elizabeth Moens,	)	
	)	
Petitioner,	)	
	)	
vs.	)	No. 14 WC 06527
	)	
City of Chicago –	)	
Dept. of Housing & Economic Development,	)	
	)	20IWCC0347
Respondent.	)	

MEMORANDUM OF DECISION OF THE ARBITRATOR

The disputed issues in the above proceeding are:

(2) Accident;
(3) Notice;
(4) Causation;
(7) Medical Bills;
(8) TTD and TPD; and
(10) Nature and Extent

STATEMENT OF FACTS

Petitioner testified that on December 2, 2013, she was employed by the City of Chicago as a coordinator of economic development. (Arbitration Transcript, hereinafter "Tr." p. 9). Petitioner had been employed at Respondent in various positions since 2001.

Dr. David Brandt was Petitioner's primary care physician. She first saw him on September 3, 2013. (PX 3 at 101). Petitioner testified that she went to him for elbow pain, which she associated with lifting Divvy bikes. (Tr. 35). Dr. Brandt's assessment was that Petitioner' primary diagnosis was bicipital tendinitis of the right shoulder with a secondary diagnosis of lateral epicondylitis. (PX 3 at 102). Petitioner was instructed to follow up in two

weeks and was given a physical therapy referral but she never went. (PX 3 at 100, 102; PX 9 at 242). The next Dr. Brandt record is a memorialization of a November 25, 2013 phone call from Petitioner to Dr. Brandt's office during which Petitioner reported that her arm was worse and that if she attempted to raise her arm over her head she would suffer shooting pain down her arm and that she could not maneuver her arm to her back to fasten her bra. (PX 3 at 100) The PT referral, that Dr. Brandt had given Petitioner in September 2013 was sent to Petitioner again. (PX 3 at 100).

Over Respondent's objection, the deposition transcript of Dr. Brandt, taken as part of Petitioner's federal lawsuit in The Northern District of Illinois, was offered by Petitioner and admitted. (PX 4). The Arbitrator was confused by the caption which was styled as "In the Circuit Court of Cook County – Elizabeth Moens v. City of Chicago," but had a federal court number -17 CV 4073, and so the Arbitrator sought to find out whether the deposition of Dr. Brandt was taken in the context of a federal or state lawsuit. A simple Google search yielded an April 11, 2019 Memorandum and Order granting summary judgment to Defendant/Respondent City of Chicago on all of the myriad harassment, fraud, ADA and other discrimination claims, and thus answered this question definitively that it was federal litigation. Under the federal rules of civil procedure, all depositions are evidence depositions, so admission of the transcript was proper.

During his deposition testimony, Dr. Brandt noted a phone call from Petitioner on November 25, 2013 in which Petitioner complained of the inability to move her arm over her head. (PX 4, p. 10). He testified that it was possible Petitioner injured her shoulder from moving either files or furniture. (PX 4, 62-63).

On December 2, 2013 at 10:41 a.m., Petitioner received an email from Amy Henry, Director of Human Resources for the Department of Planning and Development at the City of Chicago. (Rx 6). The email indicated that files had been removed from Petitioner's new work station and that Petitioner should notify Ms. Henry if Petitioner needed anything to assist with moving her belongings that morning (Rx 6). Petitioner testified that subsequent to the email from Ms. Henry, she moved her belongings to a new workstation on the same floor. (Tr. 18). Files were moved from her new work station by another employee. (Tr. 20). She testified she was provided three banker type boxes to move. (Tr. 21). Petitioner testified she received no assistance moving. (Tr. 22). She had previously moved her belongings in April 2013. Petitioner testified she made 15 to 20 trips, moving files from past 10 years as well as personal items, over the course of about 4 hours. (Tr. 25). While going through a door on one of those trips, Petitioner testified she set down a box and then while she lifted it up, she felt a pull in her shoulder. (Tr. 27). In a January 21, 2014 email from Petitioner to Brad McConnell, Petitioner wrote "[t]he only boxes I have moved are the ones I carried when I moved my own desk on 11/28." (RX 13).

Petitioner testified that she did not report injury at that time. (Tr. 29). Petitioner notified Ms. Henry of the completion of the move by email on December 2, 2013 at 3:17 p.m. (RX 6). Petitioner did not report an injury to Ms. Henry in her December 2, 2013 email. (Tr. 94). Petitioner did report completing her move, that her phone did not work, and that she had been docked a day of pay on her last check. (RX 6).

Amy Henry testified at trial. Her job duties included dealing with employee absences. (Tr. 113). All absences including workers compensation injuries would come across her desk. (Tr. 114). Ms. Henry verified Petitioner moved desks in late November 2013 and was moved by December 2, 2013. (Tr. 115). The new desk was outside Ms. Henry's office. (Tr. 115). Ms. Henry was not aware of files being moved by Petitioner on December 2, 2013. (Tr. 118). After Petitioner moved, she observed personnel items such as pictures, plants, a corkboard and a tray of papers. She did not recall anyone giving Petitioner boxes to move items. (Tr. 119). Ms. Henry testified that boxes were only provided for off-site storage. Ms. Henry testified that Petitioner did not report an injury to her on December 2, 2013. (Tr. 120). On cross examination, Ms. Henry testified that she did not watch her move her belongings on December 2, 2013. Ms. Henry testified that her staff knows that heavy items are moved by laborers and that there are procedures for moving. (Tr. 133). She did not witness anyone else moving Petitioner on December 2, 2013. (Id.)

Petitioner testified that she reported her injury to Brad McConnell verbally but could not remember the exact date. (Tr. 30-31). Petitioner testified that at whatever time this was, she did not make a request to Mr. McConnell to fill out an accident report. (Tr. 31). The Report of Occupational Injury or Illness was filled out by Petitioner and dated February 7, 2014, indicates that she notified Brad McConnell of her alleged injury on December 11, 2014 at approximately 3:30pm via email. (RX 4). The Arbitrator found no such email contained in the record.

Petitioner, in a January 21, 2014 email to Brad McConnell responding to a written reprimand concerning time off from work, wrote that she had "an appointment that was an emergency" on December 4, 2013. (RX 13). Petitioner also wrote that she missed work on December 5, 2013 for medical reasons. (RX 13). No medical record in evidence exists documenting that Petitioner received any care on December 5, 2013.

On December 4, 2013, a phone conversation memorialized on an Athletico Phone Screening Form indicated Petitioner was the caller. (PX 8 at 234). On this form, tennis elbow is listed as the single diagnosis and complaint. (Id.) Dr. Brandt is listed as the referring physician and the form indicates the prescription was sent "last week." (Id.) Petitioner presented to Athletico on December 9, 2013 for physical therapy under the original and re-sent prescription that Dr. Brandt had made on September 3, 2013. (PX 8 at 234-36). Petitioner testified and the records reflect that Petitioner indicated that she was not there because of a work related injury. (Tr. 36; PX 8 at 234-36). Petitioner was given exercises related to her shoulder (PX 8 at 238), but she identified tennis elbow as the reason she was being treated. (PX 8 at 242). The symptom-specific location was Petitioner's biceps, reported mechanism of injury was biking, symptom duration of two months, and current status of symptoms was that they had stabilized. (PX 8 at 251). Petitioner testified that her referral for PT was for tennis elbow but that she also reported, when asked if she had any previous injuries, that she had hurt her shoulder moving a week ago. (Tr. 36). There is no record of moving a week ago as a listed prior injury in the Athletico records. (PX 8) The PT assessment was decreased right shoulder range of motion elbow flexion with decreased function and increased pain and demonstrated increased pain and joint tightness in her right shoulder. (PX 8 at 252). Petitioner testified that during her treatment at Athletico she was unable to complete the exercises and stretches she was asked to perform. (Tr. 37) Petitioner never returned to Athletico and did not return any phone calls from them. (PX 8 at 254).

Petitioner testified that she was referred to Millennium Wellness by a friend and went there instead for therapy. (Tr. 38). Petitioner denied that Dr. Brandt had referred her to Millennium. (Tr. 82). Dr. Brandt is listed as the referring physician on Petitioner's initial evaluation. (PX 9 at 257)

Petitioner, in the January 21, 2014 email referenced above, wrote that she missed time at work on December 11, 2013, for physical therapy. (RX 13). There is no record of Petitioner receiving physical therapy on this date in evidence.

Petitioner began treating at Millennium Wellness and Physical Therapy on December 17, 2013, a couple of weeks after her original alleged date of injury. (RX 2, PX 9). Petitioner reported to her physical therapist complaints of shoulder pain for two months. (PX9 at 257). She reported that she biked a lot and it had gotten worse. (Id.) Her bike was stolen so she was using the Divvy bikes which were heavier. (Id.). The history indicates that Petitioner reported she was no longer biking due to the pain. (Id.) Petitioner also reported that her pain had begun with a dull pain in the bicepital area and elbow which she noticed when typing. (Id.) Petitioner treated at this location until March 4, 2014. (PX 9) On February 27, 2014, the physical therapist noted that Petitioner had 11 visits and had not shown progress. (PX 9 at 258) There were no further histories of the origin of Petitioner's shoulder problem. (PX 9). Petitioner testified that Millenium saw the referral regarding tennis elbow. (Tr. 39). Petitioner testified that she gave Millennium a history of moving her belongings at work and filled out the standard forms given to her by Millennium. (Tr. 39). Regarding Millennium, neither was a history of moving belongings at work nor any standard forms found in the record. (PX 9)

Petitioner did not attend any physical therapy sessions between December 19, 2013 and January 13, 2014. (PX 9 at 261)

Petitioner called Dr. Brandt on January 8, 2014, letting him know her condition was worse and an MRI was ordered. (Tr. 39). On January 16, 2014, an MRI without contrast was done of the right shoulder, which revealed mild supraspinatus tendinopathy with bursal surface fraying. (PX 6 at 216-217). Petitioner spoke with Dr. Brandt's office by telephone on January 22, 2014 to discuss the results of the MRI, a referral to an orthopedic surgeon, schedule an appointment with Dr. Brandt, and was prescribed pain medication. (PX 3 at 98). Petitioner "wants it noted that she started to have these issues with her arm after her boss made her move desk at work by herself" and reported that she was "seeing an attorney later today to discuss work comp case.". (PX 3 at 98).

After the MRI, Petitioner followed up with Dr. Brandt, her primary care physician, on January 28, 2014. (PX 2 at 94). Dr. Brandt noted that this visit was the first since September 3, 2013, when Petitioner had reported right forearm and upper arm numbing pain that Petitioner attributed to moving a desk at work in June 2013. (PX 2 at 94). Petitioner reported waiting two weeks after the September 3 visit to take her prescribed Celebrex and reported that it provided little relief. (Id.)

Petitioner was reprimanded for unauthorized absences in January 2014. (Tr. 90; RX 13). Ms. Henry noted Petitioner had unauthorized absences in January 2014 and sent her a written reprimand. (Tr. 122, RX 8). Petitioner responded to a disciplinary document from Brad

McConnell on January 21, 2014. (Tr. 90; RX 13). Petitioner indicated that she moved some boxes when she moved her own desk on November 28. (Tr. 91, RX 13). Petitioner did not move files from the department; they were kept in her old area. (Tr. 93). Petitioner reported several instances of missing work time for medical or physical therapy appointments. (RX 13). Petitioner testified on cross examination that she did not report a work-related injury to Mr. McConnell in her January 21, 2014 email. (Tr. 95; RX 13).

Via email, Petitioner requested a form to report her alleged workplace injury on February 6, 2017 and in this email wrote that her "injury happened after I moved my desk alone to my new location." (RX 7) Ms. Henry testified that she received this email. (Tr. 123-125). The Report of Occupational Injury or Illness was filled out by Petitioner and dated February 7, 2014. (RX 4)

Petitioner followed up with Dr. Brandt on February 7, 2014, at which point Dr. Brandt noted Petitioner had significant pain and soreness in the right shoulder capsule. (PX 3 at 91). Dr. Brandt continued to recommend medication, physical therapy, seeing an orthopedic physician, as well as acupuncture specialist and suggested a two week follow-up. (PX 3 at 92).

Petitioner followed up with Dr. Brandt on February 24, 2014, at which point Dr. Brandt completed an FMLA form for Petitioner in relation to her work with the City of Chicago. (PX 3 at 87). Dr. Brandt recommended Petitioner work 2-4 hours per day, four days per week for six months pursuant to the FMLA form. (PX 5 at 212-215). Dr. Brandt continued to prescribe the same medication from February 7, 2014, physical therapy, acupuncture, and massage. (PX 3 at 88). He also referenced a visit Petitioner would have with an orthopedic, Dr. Gryzlo. (PX 3 at 88).

Dr. Brandt referred Petitioner to a shoulder specialist, Dr. Gryzlo. (Tr. 43). As of February 2014, Petitioner testified she had pain and was missing time from work. (Tr. 44). Petitioner stopped going to Millennium and saw Dr. Gryzlo. (46). Petitioner had acupuncture and swam to relieve symptoms. (Tr. 49-50). On February 27, 2014, Petitioner underwent an x-ray of the right shoulder pursuant to Dr. Gryzlo's orders. (PX 3 at 90).

Petitioner followed up with Dr. Stephen M. Gryzlo at Northwestern Department of Orthopedic Surgery on March 6, 2014. (PX 7 at 224-225). Dr. Gryzlo noted that Petitioner reported that her injury happened moving boxes at work, that Petitioner reported having no prior shoulder injuries, and that Petitioner reported gradual pain and stiffness subsequent to the December 2, 2013, reported injury. (PX 7 at 224). Dr. Gryzlo also noted Petitioner reported pain at night and decreased range of motion. (PX 7 at 224-225). Dr. Gryzlo diagnosed Petitioner with adhesive capsulitis of the right shoulder and recommended physical therapy, acupuncture, and took her off steroids. (PX 7 at 225). He recommended a follow up in six weeks and cortisone injection if no improvement. (PX 7 at 225). Petitioner testified that a cortisone shot was discussed, but she did not have it. (Tr. 47). Petitioner was seen by Dr. Gryzlo again on April 18, 2014 and August 4, 2014 where he recommended conservative management and continued therapy. (PX 7 at 222-223). At this visit, Petitioner indicated she was doing better, was not in serious pain and he did not believe that she needed a shot. (Id.) Dr. Gryzlo wanted Petitioner to continue therapy and working and hoped to see gradual improvement.

Petitioner returned to Dr. Brandt on May 6, 2014 and Dr. Brandt recommended continued range of motion exercises, physical therapy and acupuncture with a follow up in six weeks. (PX

3 at 80). Ms. Moens followed up with Dr. Brandt on May 29, 2014, with continued complaints regarding her right shoulder, but requested to be returned to work 3.5 hours per day. (PX 3 at 76). Dr. Brandt confirmed he wrote a work note for restricted work (3.5 hours per day) from June 2, 2014 through August 1, 2014. (PX 3 at 78). Ms. Moens was advised to follow up in 2 months. (PX 3 at 76).

Petitioner returned to Dr. Brandt on July 23, 2014, and Dr. Brandt noted a recurrence of Ms. Moens' right shoulder pain after her return to light duty work. (PX 3 at 73). Dr. Brandt also noted Ms. Moens used Advil for the pain, felt locking in the right shoulder, and decreased range of motion. (PX 3 at 73). In Dr. Brandt's assessment, he notes a re-aggravation of Ms. Moens' right shoulder capsule/rotator cuff pain during her return to work (PX 3 at 74). Dr. Brandt recommended Advil for pain, home exercises, orthopedic care, and acupuncture. (PX 3 at 74). He also indicated he would write a letter for Ms. Moens to remain off work from July 23, 2014 through September 22, 2014 with a follow up in six weeks. (PX 3 at 74).

On August 4, 2014, Petitioner returned to Dr. Gryzlo. (PX 7 at 222-223). He noted her strength was improving. He also recommended conservative management. He did not provide a shot, and he wanted her to continue with physical therapy. He noted she was swimming which he believed was proper. (PX 7 at 222-223).

On September 4, 2014, Petitioner presented for examination by a physician of Respondent's choice, pursuant to Section 12 of the Act ("IME"). Dr. Cole agreed that Ms. Moens suffered from right shoulder adhesive capsulitis (RX 1, p. 5 of IME Report). Dr. Cole is a board certified surgeon. (Id.). He performs 400 to 500 shoulder surgeries a year. (Id.). He was requested to perform an independent medical examination on Petitioner on September 4, 2014. (Id.). He took a history from her, which included her moving boxes and developing shoulder pain. (RX 1, p. 6 of IME Report). Dr. Cole reviewed documents including emails and photographs of her desk. (RX 1 p. 7, Dep Ex 3). Dr. Cole also reviewed Dr. Brandt's records and an MRI. (RX 1, p 8). He performed a physical examination. (RX 1, p. 9).

Dr. Cole diagnosed Petitioner with idiopathic adhesive capsulitis. (RX 1, p. 10). He opined that even if Petitioner moved things from her desk, it would not cause adhesive capsulitis. (RX 1, p. 11). He found moving files would not have caused or aggravated her condition. (RX 1, p. 12). His opinion would be supported if Petitioner had provided a history of injury a couple of weeks after December 2, 2013 that she had shoulder pain for two months associated with either riding or moving bicycles. (RX 1 p. 13). He found that at the time of his examination of Petitioner, she would be a surgical candidate but that the surgery would not be causally related to the accident. (RX 1, p. 13). Dr. Cole also opined that Petitioner could perform her full job duties without any restrictions. (RX 1 p. 14).

On cross examination, Dr. Cole testified that independent medical examinations are less the 10% of his practice. (RX 1 p. 18). Lifting boxes could cause shoulder pain. (RX 1 p. 19). If a surgery found tears they could be caused by lifting boxes, but Dr. Cole doubted she had tears as it was not part of her clinical presentation. (RX 1, p. 21). On re-direct examination, Dr. Cole testified that adhesive capsulitis could be degenerative and could progress over time with inflammation. (RX 1)

On September 25, 2014, Ms. Moens followed up with Dr. Brandt who referenced the evaluation with Dr. Cole. (PX 3 at 70-72). Dr. Brandt noted that Petitioner was considering surgery after her evaluation with Dr. Cole and Dr. Brandt indicated he would keep her off work from September 25, 2014 through October 30, 2014. (PX 3 at 72). Dr. Brandt also diagnosed Ms. Moens with microcytic anemia on this date. (PX 3 at 72). Dr. Brandt provided an additional work note on November 3, 2014 indicating Ms. Moens should return to restricted work duty (four hour days) on November 10, 2014 for four weeks. (PX 3 at 104).

On November 10, 2014, Ms. Moens was seen by her orthopedic surgeon, Dr. Gryzlo, and reported no improvement of her right shoulder pain. (PX 7 at 222). Dr. Gryzlo noted the IME completed by Dr. Cole and planned to "go after this from a surgical standpoint." (PX 7 at 222). Specifically, Dr. Gryzlo referenced arthroscopic surgery with debridement and possible manipulation. (PX 7 at 222). Dr. Gryzlo also recommended ongoing work restrictions. (PX 7 at 222).

Petitioner returned to the treating physician, Dr. Gryzlo, on June 22, 2015. (PX 7 at 221). Dr. Gryzlo wrote that Petitioner "had an insurance glitz, was unable to come back in seven months but lo and behold the adhesive capsulitis in her right shoulder has improved significantly." (Id.) He discharged her from his care and indicated that no manipulation surgery was necessary. (Id.). Petitioner testified that Dr. Gryzlo released her from his care in June 2015. (Tr. 54).

After that point Petitioner testified she had problems with her neck. (Tr. 54-55). Petitioner continued to see Dr. Brandt, who prescribed her medication. (Tr. 56). He also treated her for iron deficiency. (Tr. 57). Dr. Brandt referred her to Dr. Jain for that issue in 2016. (Tr. 58). She had an iron transfusion which relieved her symptoms. Her last treatment for her shoulder was with Dr. Gryzlo in May 2016. (Tr. 61). Petitioner stopped feeling pain in her shoulder in mid-2016 and had full range of motion by the end of 2016, early 2017. (Tr. 63).

Petitioner was off work most of 2014 and return working 3.5 hours to start in 2015. (Tr. 64). She was then moved to four hours. In 2016, prior to being terminated, she was working five to seven hours. During that period she worked for her family farm, performing paperwork. (Tr. 65). She was still working there at time of trial. (Tr. 67). Petitioner believed her iron deficiency was caused by the pain medication she was taking. (Tr. 69). She last treated for that issue in late 2016 or early 2017. (Tr. 69). Petitioner denied that she felt symptoms in her shoulder prior to December 2, 2013.

Petitioner's job was an office job that did not require any physical labor. (Tr. 98). Petitioner owns the farm she does the paperwork for. (Tr. 99). Petitioner had not received treatment since May 2016 and has had no further symptoms in her right shoulder. (Tr. 106).

The records show that the Petitioner was also seeing Dr. Brandt for anemia. (PX 3). It appears that this condition was ongoing and part of the reason an FMLA form was filled out taking her off of work. Petitioner also acknowledged that she had intermittent right shoulder pain and stiffness but that Dr. Gryzlo had noted that no further management of the condition was needed. He later referred her to Dr. Jain for treatment of the anemia. (PX 10).

CONCLUSIONS OF LAW

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

Section 1(b)3(d) of the Act provides that, in order to obtain compensation under the Act, the employee bears the burden of showing, by a preponderance of the evidence, that he or she has sustained accidental injuries arising out of and in the course of the employment. 820 ILCS 305/1(b)3(d). To obtain compensation under the Act, Petitioner has the burden of proving, by a preponderance of the evidence, all of the elements of his claim (*O'Dette v. Industrial Commission*, 79 Ill. 2d 249, 253 (1980)), including that there is some causal relationship between his employment and his injury. *Caterpillar Tractor Co. v. Industrial Commission*, 129 Ill. 2d 52, 63 (1989). An injury is accidental within the meaning of the Act when it is traceable to a definite time, place, and cause and occurs in the course of employment, unexpectedly and without affirmative act or design of the employee. *Mathiessen & Hegeler Zinc. Co. V. Industrial Board,* 284 Ill. 378 (1918).

Decisions of an arbitrator shall be based exclusively on the evidence in the record of the proceeding and material that has been officially noticed. 820 ILCS 305/1.1(e). The burden of proof is on a claimant to establish the elements of his right to compensation, and unless the evidence considered in its entirety supports a finding that the injury resulted from a cause connected with the employment, there is no right to recover. *Board of Trustees v. Industrial Commission,* 44 Ill. 2d 214 (1969).

ACCIDENT

A claimant bears the burden of proving by a preponderance of the evidence that his injury arose out of and in the course, of the employment. 820 ILCS 305/2. Both elements must be present in order, to justify compensation. *Illinois Bell Telephone Co. v. Industrial Commission*, 131 Ill. 2d 478 (1989).

The phrase "in-the course of" refers to the time, place, and circumstances under which an incident occurred. *Orsini v. Industrial Commission*, 117 Ill. 2d 38 (1987). The words "arising out of" refer to the origin or cause of the incident and presuppose a causal connection between the employment and the accidental injury. *Caterpillar Tractor Co. v. Industrial Commission,* 129 Ill. 2d 52 (1989).

"Preponderance of the evidence is evidence which is of greater weight, or more convincing than the evidence offered in opposition of it; it is evidence which as a whole shows that the fact to be proved is more probable than not." *Houck v. Nationwide Rail Service*, 11 IWCC 249, citing, *Jones v. J. Rubin*, 02 IIC 142; [Note, the compensability holding in *Houck* was overturned at the Circuit Court on other grounds] *Parro v. Industrial Commission*, 630 N.E.2d 860 (1st Dist. 1993); *Central Rug & Carpet v. Industrial Commission,* 838 N.E.2d 39 (1st Dist. 2005).

Among the factors to be considered in determining whether a claimant has sufficiently carried his burden, is the credibility of declarant. See, *Houck*, supra. Credibility is the quality of a witness which renders his evidence worthy of belief. The arbitrator, whose province it is to evaluate witness credibility, evaluates the demeanor of the witness and any external

inconsistencies with his testimony. Where a claimant's testimony is inconsistent with his actual behavior and conduct, the Commission has held that an award cannot stand. *McDonald v. Industrial Commission,* 39 Ill. 2d 396 (1968); *Swift v. Industrial Commission,* 52 Ill. 2d 490 (1972). While it is true that an employee's uncorroborated testimony will not bar a recovery under the Act, it does not mean that the employee's testimony will always support an award of benefits when considering all the testimony and circumstances shown by the totality of the evidence. *Caterpillar Tractor Co. v. Industrial Commission,* 83 Ill. 2d 213 (1980). Internal inconsistencies in a claimant's testimony, as well as conflicts between the claimant's testimony and medical records, may be taken to indicate unreliability. *Gilbert v. Martin & Bayley/Hucks,* 08 ILWC 004187 (2010).

To determine whether a claimant has met him requisite burden of proof by a "preponderance of credible evidence" it is necessary for the Arbitrator to look for consistency and corroboration between a witness's testimony and conduct and other documentary evidence to determine the truth of the matter. Where that other evidence tends to impeach or undermine a claimant's testimony, there may be sufficient cause to find that a claimant has failed to meet his requisite burden.

After considering the entirety of the evidence, including Petitioner's testimony and the medical treatment records, including that from his treating physician, Dr. Murciano, the Arbitrator finds that Petitioner is not credible regarding his ongoing complaints of pain in his lower back as related to work. The Arbitrator finds that Petitioner's testimony does not match the facts or the medical records, and his testimony cannot be believed.

Shell Oil v. Industrial Commission, 2 Ill. 2d 590 (1954), is instructive here. In that case, it was astutely observed that "declarations of an injured person to a treating physician as to his physical condition, and the cause thereof, are admitted into evidence for the reason that it is presumed that a person will not falsify such statements to a physician from whom he expects and hopes to receive medical aid." *Id.* citing *Shaughnessy v. Holt*, 236 Ill. 485 (1908).

Similar language was cited by the Supreme Court in *Jensen v. Elgin, Joliet and Eastern Railway Company*, 24 Ill. 2d 383 (1962), for the proposition that the desire for proper treatment outweighs any motive to falsify. By way of general evidentiary concepts, greater weight is ordinarily afforded to contemporaneous medical records and histories, instead of later, less reliable and self-serving histories by those who have had time to formulate statements.

There are several examples throughout Petitioner's testimony that are inconsistent with the medical record evidence. There is no formal medical documentation of an injury until she sees Dr. Brandt on January 28, 2014, almost two months after the alleged injury date (PX 3). Petitioner was seen at Athletico on December 9, a week after the alleged injury. The report notes she had shoulder pain and limitations. There is no mention of an injury at work. She indicated she had pain for two months. Petitioner was seen as Millennium Wellness on December 17, 2013, and again reported shoulder pain for two months. On December 17, 2013, Petitioner failed to provide a history of a work injury, but specifically informed the therapist of having shoulder pain after carrying Divvy bikes.

Petitioner testified that she had no shoulder injury prior to December 2, 2013, and that a visit to her doctor in September 2013, related to her elbow. This is contradicted by the September 3, 2013 record from Dr. Brandt. Petitioner treated for her elbow and forearm, but had complaints related to her shoulder as she had problems lifting her arm over her head. In addition, she had a conversation with Dr. Brandt on November 25, 2013, and complained that she had a shooting pain when she moved her arm above her head. Petitioner's lack of credibility of her condition impacts her credibility concerning her accident claim. Based upon this lack of credibility about her pre-accident condition, the Arbitrator has reason to doubt Plaintiff's credibility as to other aspects of her testimony including the testimony about the accident. See, *McDonald v. Industrial Commission*, 39 Ill. 2d 396, 403 (Ill. 1968) (When a witness is not credible as to one material point, the trier of fact may disregard the uncorroborated testimony of that witness regarding other points).

Petitioner's testimony about what she moved was also contradicted by documentation. An email from Amy Henry to Petitioner on December 2, 2013 noted that Petitioner's files had been removed from her work station and asked if she needed any assistance with moving her belongings. This email contradicts Petitioner's testimony that she had to move voluminous files by herself. The Arbitrator also notes that Petitioner responded to this email a few hours later and did not report any injury to her. Petitioner testified to being in pain, but in her emails that day to Amy Henry she did not ask for assistance or report that she was in pain. The Arbitrator notes that Petitioner's history of work injury came after she was already off unexcused for two weeks as documented by the January 30, 2014 letter from Ms. Henry. (RX 8). She was already being disciplined for this as documented by her email of January 21, 2014 to Brad McConnell. (RX 13). This email, purporting to respond to the discipline for unexcused absences, made no mention of Petitioner being injured while moving boxes, despite mentioning attendance in therapy. In addition, the email itself shows that Petitioner could not credibly identify when she was injured. Petitioner's Application and testimony alleges an accident date December 2, 2013. This email mentions November 28. This also contradicts the email of December 2, from Ms. Henry indicating that files were moved and Petitioner confirming that she was moved. It was also noteworthy that Petitioner was moving personal items from the office to her house on November 27.

In conclusion, Arbitrator finds that Petitioner's testimony was not credible. The record is clear that Dr. Brandt diagnosed a shoulder condition in September 2013 and that in the weeks following the date of the alleged accident Petitioner admitted to her therapist that she had shoulder pain for two months and associated it with her lifting Divvy bikes. Despite emails to between Petitioner and Mr. McConnell and Ms. Henry around the alleged date of injury, Petitioner did not mention she was injured while moving boxes. These emails show inconsistencies on the date of the injury and whether boxes were moved. The accident is reported in medical records and emails almost two months after the alleged date, when Petitioner was being discipline for unexcused absences. The Arbitrator finds that a preponderance of the credible evidence does not support a claim that Petitioner had an injury arising out of or in the course of her employment.

NOTICE

A preponderance of the credible evidence does not support Petitioner's contention that she provided proper notice of her injury. The Act requires notice be provided within 45 day

pursuant to Section 6(c). During her testimony Petitioner admitted that she did not immediately report the injury. She indicated that she verbally told her supervisor, but could not say the exact date. An Accident Report with the history of a work injury was not provided until February 7, 2014. This is consistent with the therapy records dated December 9, 2013 from Athletico, which contain no history of a work injury and a history of two months of symptoms. In addition, a December 17, 2013 report from Millennium Therapy specifically provides no history of a work injury and notes that Petitioner was complaining about shoulder pain for two months after lifting Divvy bikes. The Arbitrator notes that Petitioner denied that her pre-injury visit to Dr. Brandt in September 2013 was related to her shoulder. Therefore, the Arbitrator questions why Petitioner would not give her provider an accurate history of a new shoulder injury a week after it allegedly occurred when Petitioner has actively have symptoms.

The Arbitrator notes that Petitioner testified that she felt pain related to her move on December 2, 2013. However, she admits she did not report it. Emails were traded with Amy Henry on the alleged date of injury of December 2, 2013. There was no mention of an injury. The earliest written report to the City appears to be on February 6, 2014 when she emailed Ms. Henry. (RX 7). At that time she clearly stated she injured herself while moving her desk alone to a new location. Petitioner knew she had to complete paperwork for the work injury and requested it. The Arbitrator notes that if Petitioner knew to request paperwork, she would have done so earlier. The sudden mention of the work injury appears to coincide with the receipt of the January 30, 2014 letter from Ms. Henry indicating that she had been on an unauthorized absence status since January 16 and would be subject to discipline. The Arbitrator questions why earlier notice had not been provided at least beginning January 16, if Petitioner was off for a work injury. The credible evidence supports the first notice being February 6, 2014. This was over 60 days after the alleged date of injury. Therefore, the Arbitrator finds that proper notice was not provided under the Act.

CAUSATION

Petitioner bears the burden of proving by a preponderance of the evidence all of the elements of his claim. *R & D Thiel v. Workers' Compensation Comm'n,* 398 Ill. App. 3d 858, 867 (2010). Among the elements that the Petitioner must establish is that his condition of ill-being is causally connected to his employment. *Elgin Bd. of Education U-46 v. Workers' Compensation Comm'n,* 409 Ill. App. 3d 943, 948 (2011). The workplace injury need not be the sole factor, or even the primary factor of an injury, as long as it is a causative factor. *Sisbro, Inc. v. Indus. Comm'n*, 207 Ill. 2d 193, 205 (2003).

"A chain of events which demonstrates a previous condition of good health, an accident, and a subsequent injury resulting in a disability may be sufficient circumstantial evidence to prove a causal connection between the accident and the employee's injury." *Int'l Harvester v. Industrial Comm'n*, 93 Ill. 2d 59, 63-64 (1982). If a claimant is in a certain condition, an accident occurs, and following the accident, the claimant's condition has deteriorated, it is plainly inferable that the intervening accident caused the deterioration. *Schroeder v. Ill. Workers' Comp. Comm'n*, 79 N.E.3d 833, 839 (Ill. App. 4th 2017).

A preponderance of the credible evidence does not support Petitioner's claim that her condition of ill-being is causally related to the alleged incident. The Arbitrator notes that the detailed causation opinion of Respondent's Section 12 physician, Dr. Cole. The treating doctors'

records note Petitioner's history of injury but do not discuss causation. No direct rebuttal opinion to Dr. Cole was offered. Dr. Cole is a practicing orthopedic surgeon, and the Arbitrator finds he should be provided more credibly on issues of causation of shoulder injuries. Dr. Cole found that Petitioner had adhesive capsulitis. This condition can be degenerative, often has no association with trauma and has a higher preponderance in females. He found that even if Petitioner moved items from her desk, it wouldn't have caused her adhesive capsulitis. The Arbitrator finds Dr. Cole credible because he based his opinion on Petitioner's history. The doctor noted that his opinion against causal connection would be supported by a medical record from two weeks after the alleged injury in which Petitioner reported that she had shoulder pain for two months and associated it with lifting bicycles. The Arbitrator notes that this is a reference to the Millennium Wellness note of December 17, 2013.

The Arbitrator notes Dr. Brandt's opinions in his discovery deposition in the employment case, admitted over Respondent's objection. The Arbitrator declines to adopt Dr. Brandt's opinions. The opinion shows a lack of knowledge of what Petitioner was moving. The question asked, in part, about causation in terms of moving furniture which Petitioner never testified to moving. The Arbitrator notes the compound nature of the question as well as the fact that it was leading. The Arbitrator also notes that Dr. Brandt is not an orthopedic surgeon. Dr. Brandt did not have the benefit of the documents provided to Dr. Cole prior to his exam, including the Millenium Wellness records from December 2017 in which Petitioner admitted to two months of shoulder pain while lifting Divvy bikes.

The Arbitrator also notes issues with the reliability of Dr. Brandt's records and testimony. Each party offered the FMLA form completed by Dr. Brandt in February 2014. (PX 5, RX 12). In the form offered by Petitioner, the pre-accident treatment date of September 3, 2013, is not listed under the question which asks the dates that Petitioner treated for the condition. This would support an argument that Petitioner was not treating for her shoulder before the alleged injury. Respondent offered the same document. However, in the question about when Petitioner treated for the condition, September 3, 2013 is listed. This supports an argument that Petitioner was treating for her shoulder condition prior to the alleged date of injury. Based upon the inconsistency in the two forms the Arbitrator cannot rely on it to find that Petitioner was not treating for the condition.

It is undisputed that Petitioner treated with Dr. Brandt on September 3, 2013. While she had forearm issues, Petitioner complained of painful elevation of the arm above shoulder level. That treatment note certainly mentions bicipital tendinitis of the right shoulder. This notation and the November 25 phone call in which Petitioner complains about the inability to lift her arm, appear inconsistent with Dr. Brandt's later testimony about Petitioner only having a forearm and elbow condition prior to the alleged work accident. Based upon these issues of reliability, the Arbitrator chooses not to adopt Dr. Brandt's opinions.

Dr. Cole's opinion is confirmed by the record from Dr. Brandt in September 2013, in which Petitioner was diagnosed with shoulder pain. Dr. Brandt also verified that the shoulder condition was active in September 2013, when he included that date of service on the FMLA form he completed in response to being asked when he treated the shoulder condition at issue. Petitioner's own behavior following the alleged accident also supports Dr. Cole's opinion. Immediately following December 2, 2013 Petitioner did not inform anyone of the alleged trauma. On December 9, Athletico found she had shoulder complaints and limitations, but she

did not provide any history except that she had symptoms for two months. She went to Millennium Physical Therapy on December 17 and did not provide the history of a work injury and mentioned shoulder pain after lifting bicycles. On the date of the injury itself, she did not report to Ms. Henry that she hurt herself during her office move. In fact, that email casts doubt as to whether she was even moving files. In addition, Petitioner prepared a detailed response to Mr. McConnell about being disciplined for unexcused absences and did not mention an injury.

The Arbitrator notes that Dr. Brandt's records show that Petitioner called his office on November 25, 2013. She reported that she had a shooting pain when she tried to put her arm over her head and could not maneuver her arm to behind her back. The doctor noted that he had already ordered shoulder/ biceps strengthening to address the issue. The amount of pain and restriction of movement in the two weeks prior to the alleged injury also supports Dr. Cole's finding on the lack of causation between the alleged injury and her shoulder condition.

The Arbitrator notes that Petitioner offered medical records concerning treatment for iron deficiency. Even assuming that Petitioner could prove causation of the shoulder injury, Petitioner offered no evidence causally relating the iron deficiency to the shoulder injury. No doctors comment on the issue. There is only general discussion of the causes of iron deficiency. It is well-settled that the petitioner has the burden to prove all elements in her case in order to recover benefits under Workers' Compensation; that this burden of proof must be met by the preponderance of credible evidence and liability cannot be based on imagination, speculation or conjecture. *Illinois Bell Telephone Company v. Industrial Commission*, 265 Ill.App.3d 681, 638 N.E.2d 307 (1994). Therefore, the Arbitrator does not find Petitioner met her burden of proving causation between her diagnosis of iron deficiency and the alleged accident.

TTD

Based upon the Arbitrator's findings concerning accident, notice and causation, the issue of temporary total disability is moot and no benefits are awarded.

Even assuming Petitioner proved accident and causation, the Arbitrator declines to award temporary total disability. In doing so, the Arbitrator adopts the testimony of Dr. Cole. As noted in the causation section above, there are issues with the reliability of Dr. Brandt's records and testimony. Unlike Dr. Brandt, Dr. Cole reviewed a job description and noted Petitioner had a sedentary job. Petitioner also confirmed the sedentary nature of her work. Dr. Cole found that Petitioner would not have any restrictions and could perform her job with her condition.

MEDICAL BILLS

Based upon the Arbitrator's findings concerning accident, notice and causation, the issue of medical bills is moot and no benefits are awarded.

NATURE & EXTENT

Based upon the Arbitrator's findings concerning accident, notice and causation, the issue of nature and extent is moot and no benefits are awarded.

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

CHRISTINE BUTLER,

Petitioner,

vs. NO: 19 WC 19651

STATE OF ILLINOIS,
ILLINOIS VETERANS HOME OF ANNA,

20IWCC0348

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 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.

20IWCC0348

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: JUN 2 6 2020

D. Douglas McCarthy

L. Elizabeth Coppoletti

Stephen Mathis

DDM/tdm
O: 6/23/20
052

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

BUTLER, CHRISTINE
Employee/Petitioner

Case# **19WC019651**

ILLINOIS VETERANS HOME OF ANNA
Employer/Respondent

20IWCC0348

On 10/8/2019, 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 1.69% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in 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
SHANNON D RIECKENBERG
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

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

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

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

OCT - 8 2019

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

STATE OF ILLINOIS)
)SS.
COUNTY OF MADISON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Christine Butler
Employee/Petitioner

Case # 19 WC 19651

v.

Consolidated cases: n/a

Illinois Veterans Home of Anna
Employer/Respondent

20IWCC0348

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

DISPUTED ISSUES

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

FINDINGS

On the date of accident, June 18, 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 $38,483.62; the average weekly wage was $932.13.

On the date of accident, Petitioner was 49 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. The parties stipulated that all medical incurred to date had or would be paid.

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 1, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit of amounts paid for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall authorize and pay for prospective medical treatment including, but not limited to, the treatment recommended by Dr. Thomas Lee.

Respondent shall pay Petitioner temporary total disability benefits of $621.42 per week for nine and six-sevenths (9 6/7) weeks commencing June 19, 2019, through August 27, 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 6, 2019
Date

OCT 8 - 2019

Findings of Fact

Petitioner filed an Amended 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 June 18, 2019. According to the Amended Application, Petitioner sustained injuries to her ribs, left shoulder, right knee, tailbone, left elbow and the "BAW" when a chair broke causing her to fall to the floor (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. At trial, counsel for Petitioner and Respondent agreed that resolution of all issues was dependent upon the issue of accident (Arbitrator's Exhibit 1).

Petitioner worked for Respondent as a secretary. At trial, Petitioner testified she provided her own desk and office chair and had done so since July, 2012. Petitioner stated she provided her own desk and chair because a lot of the equipment used by Respondent was not in very good condition. Petitioner testified Respondent knew about the preceding and she was never informed that she was in violation of any specific rule or told she was not permitted to do so.

Petitioner testified a new laminate floor was installed in December, 2018. She stated the surface of the floor was very slick and floor mats were placed over it in various places including one adjacent to her desk. Petitioner said the formats did not have a textured backing to prevent them from moving on the laminate flooring. Because of this, the mats would slide on the floor.

On June 18, 2019, Petitioner was in the process of returning to her workstation and had just turned the corner of her desk which was adjacent to her chair. At that time, the floor mat Petitioner was walking on slid, which caused Petitioner to reach out and grab her chair. At that time, two bolts in the chair broke which caused Petitioner to fall. Petitioner stated she did not have the chance to sit in the chair because she fell over it landing on her left side.

The accident was reported to Respondent on the same day it occurred. The First Report of Injury, the Employee's Notice of Injury, the Supervisor's Report of Injury and statements of two witnesses, Brandy Eads and Donna Murray were received into evidence (Petitioner's Exhibit 7, Respondent's Exhibit 3).

According to the First Report of Injury (which was completed by Shari Williams) the employee went to sit at her desk and her chair broke which caused the employee to fall onto the floor on her left side. This report did not contain any reference to the floor mat or laminate floor (Petitioner's Exhibit 7).

The Employee's Notice of Injury (which was completed and signed by Petitioner) noted that Petitioner was going to sit in the desk chair when the chair broke apart; however, it also noted the floor mat slid which is what caused Petitioner to fall (Petitioner's Exhibit 7).

The Supervisor's Report (which was completed by Angie Simmons) noted Petitioner went to sit down in her desk chair and the chair broke, but the floor mat slid out which caused Petitioner to sustain the fall (Petitioner's Exhibit 7).

In Brandy Eads' witness statement, she noted that "Christy had walked around the desk about that time went to sit in her chair the chair came apart, bolts even dropped to the floor." The statement did not make any reference to the floor mat or laminate flooring (Petitioner's Exhibit 7).

In Donna Murray's witness statement, she noted that she was walking and heard something "drop/clink" and when she looked at Petitioner, Petitioner was sitting in her chair which continued to tip to the left which caused Petitioner to fall to the floor. Afterward, Murray and Ellis attempted to assist Petitioner. Murray also looked at the chair and observed two screws at the base of the chair were missing (Respondent's Exhibit 3).

Petitioner initially sought medical treatment at the ER of Union County Hospital on June 18, 2019. The hospital records contained two histories of the accident. In one history, it was noted Petitioner stated she was a secretary and went to sit down and her chair broke causing her to fall onto her left side. In another history contained in the hospital record, Petitioner stated she sat down in an office chair and one side broke which caused her to fall onto the hardwood floor. There was no reference to the floor mats or Petitioner slipping on one of them (Petitioner's Exhibit 3).

When seen at Union County Hospital, Petitioner complained of right knee, left rib and low back pain. Petitioner was still recovering from rib fractures she had sustained a few months prior. Petitioner was diagnosed with a right knee sprain and was directed to go to her family physician, Dr. Michael Lawler (Petitioner's Exhibit 3).

Dr. Lawler saw Petitioner on June 24, 2019. According to his record, Petitioner sustained the injury on June 18, when a "...carpet slider got caught" and when she sat down the chair broke in half which caused Petitioner to fall on her right knee. At that time, Petitioner requested a referral to Dr. George Paletta, an orthopedic surgeon (Petitioner's Exhibit 4).

Petitioner was subsequently seen by Dr. Thomas Lee, an orthopedic surgeon. At trial, Petitioner testified Dr. Lawler referred her to Dr. Lee. Dr. Lee saw Petitioner on July 2, 2019. According to his record, Petitioner fell on a laminated floor that had mats on them, but the mats did not have any type of grip on the underside because they were designed for use on carpet. The mat slid out, Petitioner started to fall to the left, reached out with her hand attempting to grab the back of her chair and two of the bolts in the chair broke. Petitioner then fell to the ground injuring her left elbow, right knee and ribs (Petitioner's Exhibit 5).

When seen by Dr. Lee, Petitioner complained of right knee, left elbow and left shoulder pain. Dr. Lee diagnosed Petitioner with a left elbow ulnar collateral ligament strain/contusion, left elbow medial epicondylar strain/contusion, right knee medial collateral ligament strain and a right knee patellofemoral chondral contusion. He authorized Petitioner to be off work and ordered MRI scans of the left elbow and right knee (Petitioner's Exhibit 5).

The MRI of Petitioner's right knee was performed on July 9, 2019. According to the radiologist, the MRI revealed the menisci and cruciates to be intact, but revealed chondral thinning of the patella and a medial chondral defect. The MRI of Petitioner's left elbow was performed on July 9, 2019. According to the radiologist, the MRI revealed no evidence of tendinitis or a ligamentous tear, but revealed chondral thinning consistent with arthritic change (Petitioner's Exhibit 6).

Dr. Lee saw Petitioner on July 12, 2019, and he reviewed the MRI scans. Dr. Lee opined the MRI of Petitioner's right knee revealed a linear cartilage fracture in the patellofemoral articulation. Dr. Lee's interpretation of the MRI of Petitioner's left elbow was consistent with that of the radiologist. He ordered physical therapy and noted cortisone injections for both the knee and elbow were possible (Petitioner's Exhibit 5).

Dr. Lee last saw Petitioner on August 20, 2019. Petitioner continued to have right knee, left elbow and left shoulder symptoms. He noted Petitioner had been in therapy, but the therapist had to "back off" the knee treatment. Dr. Lee noted he was going to order an epidural injection for both the left elbow and right knee as well as a left shoulder MRI arthrogram. He also anticipated a potential referral to Dr. Nathan Mall, an orthopedic surgeon (Petitioner's Exhibit 5).

At trial, Petitioner testified the injections ordered by Dr. Lee had not, as yet, been performed. Petitioner continues to be off work because of her ongoing symptoms.

Angie Simmons, Respondent's administrator testified for Respondent at trial. Simmons did not witness the accident but was made aware of it shortly after it occurred. Simmons testified that if there was any problem with any of the State owned equipment, a work order would be submitted and the equipment would be fixed. Simmons knew of the laminate flooring and the mats, but she had no knowledge if the mats would slide on the floor. On cross-examination, Simmons agreed there was no prohibition or policy forbidding employees from bringing in and using their own desks and chairs.

Conclusions of Law

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

The Arbitrator concludes that Petitioner sustained an accidental injury arising out of and in the course of her employment by Respondent on June 18, 2019.

In support of this conclusion the Arbitrator notes the following:

There was no dispute Petitioner's accident occurred in the course of her employment and the dispute was whether it arose out of her employment.

An injury arises out of one's employment if its origin is a risk connected with or incidental to the employment so there is a causal relationship between the employment and the accidental injury. A Petitioner must prove the risk of injury is peculiar to the work or that he/she is exposed to risk

of injury to a greater degree than the general public. *Orsini v. Industrial Commission*, 509 N.E.2d 1005 (Ill. 1987).

As noted herein, various reports, witness statements and the histories noted in the medical treatment records contained varying accounts of exactly how the accident of June 18, 2019, occurred. The primary factual dispute appears to be whether Petitioner sustained the fall because of the floor mat sliding on the laminate flooring which caused her to reach out to grab the chair or whether Petitioner was simply in the process of sitting in the chair.

The Arbitrator finds Petitioner sustained the accident because of an unsafe/hazardous condition present on the Respondent's premises, irrespective of exactly how the accident occurred.

Respondent's counsel cited the of *Dodson v. Industrial Commission*, 720 N.E.2d 275 (Ill.App. 5th Dist. 1999) Petitioner worked for Respondent as a waitress and had just finished her shift and clocked out. She proceeded to exit Respondent's building and was walking down a concrete sidewalk to her car. Petitioner decided to walk across a grassy slope because it was the most direct route to where her car was parked. While she was walking on the grassy slope, Petitioner sustained a slip/fall injuring her right foot/ankle. The Appellate Court affirmed the Commission's denial of compensation on the basis that while the accident occurred in the course of Petitioner's employment, it did not arise out of her employment. Respondent apparently knew of the use of the grassy slope by employees and did not forbid employees from using it. However, the Appellate Court held that this was a personal risk that did not arise out of the employee's employment by Respondent.

The Arbitrator finds the holding in the *Dodson* case to be factually distinct from this case. In this case, Petitioner was using her own chair and desk, but was doing so as part of her job duties for Respondent. Petitioner's use of her own chair and desk did not present a personal risk of injury. Further, Respondent had knowledge of the fact Petitioner was using her own chair and desk and acquiesced/consented in her doing so.

The Arbitrator notes the case of *Greco v. Tenant Project Services*, 14 IWCC 0558, in which the Commission affirmed an award of compensation benefits. In that case, the Petitioner was in the process of moving boxes of documents for Respondent. To do so, Petitioner used his own wheeled dolly to move the boxes. One of the tires of the Dolly was flat and when Petitioner attempted to inflate it, the tire exploded causing him to sustained injuries.

The Arbitrator finds the *Greco* case to be analogous to this case. In both instances, the injured employee provided their own equipment, the use of which was to the benefit of the employer.

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

Based upon the Arbitrator's conclusion of law in disputed issue (C) the Arbitrator concludes Petitioner's current condition of ill-being is causally related to the accident of June 18, 2019.

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

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

Based upon the Arbitrator's conclusion of law in disputed issue (C) the Arbitrator concludes Petitioner is entitled to prospective medical treatment including, but not limited to, the treatment and diagnostic studies recommended by Dr. Thomas Lee.

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

Based upon the Arbitrator's conclusion of law in disputed issue (C) the Arbitrator concludes Petitioner is entitled to temporary total disability benefits of nine and six-sevenths (9 6/7) weeks commencing June 19, 2019, through August 27, 2019.

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

WILLIAM MASON,
Petitioner,

vs.

NO: 14 WC 28383

RESOLUTE PLUMBING, INC.,
Respondent.

20IWCC0349

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, medical, temporary total disability (TTD), and permanent partial disability (PPD), and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

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

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 6 2020

D Douglas McCarthy
Douglas McCarthy

L Elizabeth Coppoletti
L. Elizabeth Coppoletti

Stephen J. Mathis
Stephen Mathis

DDM/tdm
O: 6/17/20
052

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MASON, WILLIAM
Employee/Petitioner

Case# **14WC028383**

RESOLUTE PLUMBING INC
Employer/Respondent

20IWCC0349

On 7/8/2019, 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 2.04% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0598 LUSAK & COBB
RONALD W COBB JR
221 N LASALLE ST SUITE 1700
CHICAGO, IL 60601

0210 GANAN & SHAPIRO PC
ELAINE NEWQUIST
120 N LASALLE ST SUITE 1750
CHICAGO, IL 60602-2492

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 MASON
Employee/Petitioner

v.

RESOLUTE PLUMBING, INC.
Employer/Respondent

Case # **14** WC **28383**

Consolidated cases: **n/a**

20 IWCC0349

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **DOUGLAS S. STEFFENSON**, Arbitrator of the Commission, in the city of **CHICAGO**, on **AUGUST 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. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [x] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On **AUGUST 13, 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.

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

In the year preceding the injury, Petitioner earned $**38,315.68**; the average weekly wage was $**736.84**.

On the date of accident, Petitioner was **54** years of age, ***single*** with **0** 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.

ORDER

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

The Petitioner failed to prove he sustained an accident that arose out of and in the course of his employment and that his current condition of ill-being is causally related to the accident. All other disputed issues are moot and the 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.

Signature of Arbitrator

JULY 5, 2019
Date

JUL 8 - 2019

WILLIAM MASON v. RESOLUTE PLUMBING, INC.

14 WC 28383

FINDINGS OF FACT AND CONCLUSIONS OF LAW

INTRODUCTION

This matter was tried before Arbitrator Steffenson on August 28, 2018. The issues in dispute were accident, notice, causal connection, medical bills, TTD, and the nature and extent of the injury, if any. (Arbitrator's Exhibit 1). The parties requested a written decision, including findings of fact and conclusions of law, pursuant to Section 19(b) of the Act and agreed to receipt of this Arbitration Decision via e-mail. (Arbitrator's Exhibit (*hereinafter*, AX) 1).

FINDINGS OF FACT

Petitioner was hired by Respondent April 9, 2014, signing off on their accident reporting policy at that time. He acknowledged he was to report all injuries immediately. (Respondent's Exhibit 2). Petitioner admitted he had cell phone numbers for "everybody" and could call, leave a message or text as needed. (Transcript 84) Petitioner worked for Respondent as a plumber. (Transcript (*hereinafter*, T.) 24). On August 13, 2014 he was installing copper pipe in a kitchen ceiling of a new townhouse. He had set up the ladder and was working overhead at the top of that 5-foot ladder (T. 19) with a torch held in his left hand while he unrolled the piping with his right hand (T. 29). There were 8-foot joists, and the copper piping was being installed at a 10-foot height (T. 28). Petitioner testified he was on the second to top rung of the ladder. He had set the ladder up himself and had been up and down it about 30 times already. (T. 88). He testified he leaned to peer around a joist when the ladder started to tip over (T. 30, 90). He testified he reached out to grab the joist with his right hand and slid down. (T. 31, 32). He also testified the ladder didn't fall and that he was able to steady himself by grabbing the joist. (T. 89 – 90). Petitioner testified a coworker, Mark, was nearby but had his back to Petitioner. Mark did not turn or see the claimed incident, and there was no indication he was even aware anything had occurred (T. 35).

Petitioner testified he felt a "twinge" at the top of his right shoulder but not much pain, that he shook the arm out, took a cigarette break, and then resumed work (T. 33). He didn't attempt to report the incident to anyone, claiming he did not think anything was wrong (T. 36). Petitioner testified this occurred about 1 p.m. that day. (Id.). His supervisor, Don Sonnefeldt,

returned to the job site at 2 p.m. but Petitioner did not report the incident to him. Petitioner testified: "there was nothing to tell him." (T. 91). Petitioner continued working and finished work at 3 p.m. (Id.). He admitted he continued working on the ladder with continued overhead soldering duties until the end of his shift.

Petitioner testified he left work, stopped and got something to eat, went home that night and "it was a little uncomfortable ... but nothing at time." (T. 37, 92). He testified he woke up about 3 a.m. in severe pain from the right shoulder to the right elbow. (T. 38). He took a Norco. (T. 39). He texted Don early in the morning on August 14, advising he was "running late." (T. 92). He then took two more Norco and woke up several hours later, when his phone was ringing at about 2:30 p.m. (T. 40). He retrieved a message from Shawn Rosendahl advising he had been fired "because I didn't show up for work." (T. 42, 95).

He called Shawn and told him he hadn't been in to work that day as he had injured himself the day before. (T. 43). Shawn directed him to call the office to complete a formal accident report. Petitioner called and spoke with Shawnee in the office, advising her he had hurt himself the day before, telling her "I didn't hurt myself that much and I didn't think it was that big of an injury . . ." (T. 44-45). Petitioner testified he went into work about a week later and filled out a formal accident report. (T. 46-47). Petitioner testified at trial he reported he was "on the second rung from the top of a 5-foot ladder ... started to tilt, dropped the roll and used a joist to keep from falling." (T. 97).

Petitioner first sought medical attention at Glenbrook Hospital August 15, 2014. (T. 48). Petitioner did report a work injury to his right shoulder two days earlier when the ladder he was on started to fall and he "pulled so ladder did not fall. He did not fall or directly hit the shoulder." He took leftover Norco from a prior injury. He had localized pain and decreased motion in the right shoulder. He denied any prior injuries to the right shoulder, neck or any other injuries. X rays showed mild to moderate degenerative change in the AC joint with some osseous fragmentation "raising the possibility of old trauma." No acute abnormality was detected. (Petitioner's Exhibit 1).

He sought care with Dr. Phillips, who had treated his mother. He saw the doctor August 18, 2014. Dr. Phillips' records reflect Petitioner reported he was on a ladder which leaned over when he grabbed a joist and pulled himself back up using his right arm. He finished work that day. He noticed pain and stiffness the next morning and sought medical care at Glenbrook where he was given Norco. He denied any prior problems with his right hand, elbow or shoulder but was taking Prednisone for rheumatoid arthritis. He then admitted to prior care for epicondylitis and numbness in all fingers for which he had received an injection. He reported all

activities aggravated his symptoms. He was also noted to be on Motrin and Clonazepam. He was not in any distress. He had no swelling, deformity or atrophy in the right shoulder. He had pain with movement and pain with Hawkins and Neer testing. He did have an old fracture of the distal clavicle which Petitioner reported was from an injury when he was 18. Petitioner was given a Medrol dosepak due to reported amounts of pain. Petitioner wished to have a MRI. Dr. Phillips noted "with his underlying rheumatoid arthritis, mildly difficult to interpret what is always and what is acute." He recommended therapy to address stiffness in the shoulder. Petitioner also advised he had been fired, which the doctor found "hard to believe and I will ask him if there are any other issues, which he denied." (Petitioner's Exhibit (*hereinafter,* Pet.Ex.) 2).

MRI testing done at Glenbrook August 22, 2014 showed a high-grade partial thickness insertional, underside tear of the supraspinatus and infraspinatus extending approximately 31 mm in the AP dimension, involving greater than 75% tendon thickness, with retraction of torn fibers up to 10 mm, mild spurring, tearing superimposed on moderate tendinosis with fluid into the bursa, and mild to moderate AC and mild glenohumeral degenerative changes. (Pet.Ex. 1).

Dr. Phillips offered Petitioner a cortisone injection and therapy, or surgery. Petitioner elected to undergo surgery. (Pet.Ex. 2).

Petitioner failed to appear for appointments September 9 and 16, returning to Dr. Phillips on October 2. Petitioner was noted to be wearing a sling when outside the house. Dr. Phillips noted "many people with rotator cuff tears do quite well with therapy," that Petitioner was self-limiting his shoulder motion causing an adhesive component, that Petitioner should not wear the sling and should do aggressive motion exercises. (Id.).

Petitioner was cleared to light duty October 10, 2014 but testified he did not really look for work, only contacted a couple of companies for part time work, and resumed his own plumbing business, but not until March of 2016. (T. 99).

Petitioner returned to Dr. Phillips May 7, 2015, reporting continued right shoulder issues and that he had now qualified for Medicaid. Dr. Phillips again offered Petitioner multiple treatment options and Petitioner elected to undergo surgery. An arthroscopy with debridement, a subacromial decompression and mini open rotator cuff repair was performed May 20, 2015. Petitioner was placed in physical therapy May 27, 2015. (Pet.Ex. 2).

When seen June 5, 2015 Petitioner reported that while rising from the floor at home he fell onto his right shoulder, felt a pop and had increased pain. He did not attend therapy due to

pain. He was taking Norco. X-rays were negative for any new fracture. Concurrent pain management care elsewhere was noted. (Id.).

Petitioner returned to Dr. Phillips June 18, 2015, reporting he was doing well but had occasional pain on a 7/10 scale. Dr. Phillips noted he could not tell if Petitioner had re-torn the rotator cuff when he fell at home without a new MRI. Therapy was continued, and he was directed to stop using the sling. He was transitioned into strengthening July 9, 2015. Therapy was pulled back due to reported increased symptoms August 6, 2015, but significant gains were reported September 3, 2015. Dr. Phillips noted at this time Petitioner was "doing excellently;" he was directed to resume all but overhead activities. As of November 19, 2015, Petitioner was directed to finish the remaining therapy and to return as needed. (Id.).

At trial Petitioner testified he has not returned to see Dr. Phillips since that date. (T. 64-65). He also testified he has not sought medical care for his right shoulder since that time. (T. 101). Petitioner in fact returned to Dr. Phillips September 13, 2016 reporting "various side jobs working as a plumber," with a report of right shoulder weakness, and numbness to the wrist at night for the past two months. Dr. Phillips made few findings and detected "decreased subjective input." All testing was completely negative. He concluded Petitioner was "doing well," that he "cannot find any cause for his symptoms at the present time", and that he had "no signs of cuff insufficiency." Dr. Phillips did inquire as to why Petitioner had suddenly come in, to which Petitioner replied he "has his trial coming up." Dr. Phillips released Petitioner to "all normal activities" and found that he could "function without restrictions." His again discharged Petitioner from care. (Pet.Ex. 2).

Petitioner testified he has self-limited his duties as he only feels he is at 70%. (T. 66-68). He still has a lot of pain. He is currently working for H2O plumbing and for his own plumbing business. (T. 69).

Petitioner admitted to history of vertigo for which he has been on medication for years (T. 22). Petitioner filed a workers' compensation case for a head injury sustained with working for Aqua Plumbing on November 6, 2007. The medical records suggest Petitioner first treated for dizziness and vertigo at that time. (Respondent's Exhibit (*hereinafter*, Resp.Ex.) 5).

Petitioner admitted to having symptoms when bending his head. (T. 77). He had workup in December 2007 with neurologist Dr. Shah and with Dr. Kahn at Highland Park Hospital. Dizziness was reported to be "distressing" to him and preventing him from driving in January of 2008. (Resp.Ex. 5).

Petitioner reported self-medicating his condition with alcohol at that time and admitted at trial he has continued to do so. (T. 80). The later medical records also reflect a 20-year history of cocaine and marijuana use. (Resp.Ex. 5). Petitioner testified he had been using marijuana for longer and continues using it to date. (T. 79).

Dr. Shah diagnosed vestibular neuritis or a possible brain stem infarction in May of 2008, noting Petitioner's report of worsened symptoms with head bending along with an unsteady gait. Longstanding drug use was noted. An ENG was abnormal with noted vestibular dysfunction in April of 2009. Petitioner reported being off balance even with medication to Dr. Waxman at that time. (Resp.Ex. 5).

Petitioner pursued a workers' compensation claim for a left ear injury sustained while working for Aqua Plumbing on June 2, 2009. (Resp.Ex. 6). He rear-ended a semi on August 24, 2011. (Resp.Ex. 6). He was a seen for a trip and fall he had no recall of at trial, on March 8, 2012. He reported another fall from the back of a truck on August 11, 2012. At trial, Petitioner testified "I fall all the time. Just about every day, I catch myself from falling." (T. 82).

Petitioner testified he has continued treating for vertigo to date, that he has tried different medications with only limited results, and that when he turns his head in certain ways he gets dizzy. (T. 79 – 80). A trial Petitioner denied his fall from the ladder had anything to do with his vertigo, claiming he "just lost my balance on the ladder." (T. 103).

Petitioner's past medical history is also significant for inflammatory arthritis for which he had been on ongoing medication since early 2013. (T. 82 – 83).

Petitioner admitted he missed work frequently after he was hired, including May 1 and 2, May 5, 20, 29, June 9 and 10, July 7 and 8. On July 16, 2014 he called in to report he would be late because he had overslept but never showed up. (T. 85 – 87). Petitioner admitted he received a warning from Shawn in mid-July of 2014 that if he missed more time from work he was going to be fired. (T. 87). Petitioner called in sick August 4 and 5, 2014.

Shawn Rosendahl testified he was a superintendent for Respondent in August of 2014. He is now employed elsewhere and appeared in court voluntarily on August 28, 2018. (T. 120). Respondent provided plumbing work at new residential construction sites. (T. 108). Shawn testified the overhead work Petitioner would have continued to perform after his claimed injury on August 13, 2014 would not be the type of work one could continue to do with a shoulder injury, with duties that would have included fitting the solder into the fitting and holding the hands overhead on a constant basis. (T. 111 – 112).

Shawn confirmed the company accident reporting procedure to immediately report all injuries and noted employees would be sent for medical care and undergo a mandatory drug and alcohol test. (T. 113).

Shawn testified Petitioner had missed 13 days from work from the point of hire April 9, 2014 until he was fired August 14, 2014. (T. 114 and Resp.Ex. 1). Three of those missed days had been "no call/no show" and Petitioner knew the next one would result in termination. (T. 114). On August 14, 2014 Shawn received contact from Don Sonnefeldt, one of the job foremen, that Petitioner had called to report he would be one-half hour late that morning and then never showed up for work. He called Petitioner, was unable to reach him, and left him a message notifying him he was fired. (T. 117 – 118). Shawn testified if Respondent had been aware of any ongoing dizziness/vertigo issue Petitioner would not have been hired as their work requires daily use of ladders and scaffolding. (T. 121).

Don Sonnefeldt testified he is currently employed with Respondent as a superintendent; in August of 2014 he was a job foreman over Petitioner. (T. 129). He was familiar with the work Petitioner was doing on August 13, 2014 and testified it would have required use of both hands overhead. (T. 132). On August 14, 2014 Don testified he received a text from Petitioner around 7:00 a.m. that he was running late and would be in by 7:30 a.m. Petitioner never showed up to work that day. (T. 133).

Dr. Phillips testified September 15, 2015 he first saw Petitioner August 18, 2014, with history of a work injury when he leaned over and grabbed a joist with his right arm. He noted "any motion caused him a lot of pain" with range of motion very limited and that Petitioner could not elevate his arm over his head, thus leading to concern for a possible rotator cuff injury. MRI testing showed a tear. Dr. Phillips suspected the work injury "caused the tear or at least caused the tear to get worse." However, he also noted a high riding humeral head "which you see with chronic rotator cuff tears." He noted surgery revealed a "very large tear." (Pet.Ex. 6).

On cross examination Dr. Phillips admitted Petitioner had both rheumatoid arthritis and erosive arthropathy, with those conditions leading to the development of a rotator cuff tear with or without any aggravation. He admitted that if the work incident as described aggravated the preexisting conditions in Petitioner's right shoulder he would have had immediate pain, immediate limited range of motion, and with respect to continued climbing on the ladder "he wouldn't be able to reach overhead when he climbed, or he would have had significant pain and difficulty." (Id.).

In reviewing the MRI, he noted the extent of retraction would have required "some violent force." He admitted with the tear itself it was not possible to date but "it was days or weeks." He admitted that if the incident did not occur as claimed the damage could have been caused by a fall. (Id.).

Dr. Cole examined Petitioner February 23, 2015 and testified via deposition November 17, 2015. While Petitioner testified the whole exam took 8 minutes, Dr. Cole's report reflects a thorough history and exam. Petitioner had described feeling "a pull and discomfort" in the right shoulder after grabbing a joist to keep from falling on August 13, 2014. He had been able to finish work, did not have any pain that night and awoke the next morning with shoulder stiffness. He sought emergency room care on the second day following this claimed injury. (Resp.Ex. 3).

While he concurred with the diagnosis of a rotator cuff tear for which surgical intervention was appropriate, he opined the work incident as described did not cause or contribute to Petitioner's right shoulder condition. He stated that to sustain such a tear would have required "fairly profound energy" but that this event "was innocuous." He also noted Petitioner had had no significant pain following the incident. He noted if a work-related cause Petitioner "would not have been able to work overhead." He stressed "one would expect immediate pain and difficulty working overhead with an acute rotator cuff tear." He noted Petitioner had told him "he did not have any real pain after this alleged injury. If he had a cuff tear, I would expect severe pain." (Id.).

Dr. Cole stated, "I don't think it (the claimed work injury) caused his tear at all." When asked if the work incident could have aggravated a preexisting condition Dr. Cole stated: "anything is possible, but the clinical scenario doesn't represent that." (Id.).

CONCLUSIONS OF LAW

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

Issue C: *Accident*

A claimant bears the burden of providing every element of his claim by a preponderance of the evidence; Baldwin v. Illinois Workers' Compensation Commission, 409 Ill.App.3d 472, 949 N.E.2d 1151 (2011) Witness credibility determinations are made at the trial and Commission levels, and not on later review; O'Dette v. Industrial Commission, 79 Ill.2d 249, 403 N.E.2d 221 (1980), Hosteny v. Illinois Workers' Compensation Commission, 387 Ill.App.3d 665, 928 N.E.2d 474 (2009). Petitioner claims he sustained an injury to his right shoulder when he grabbed a joist to keep from falling from a ladder while working on August 13, 2014. The incident was not witnessed and while Petitioner variously described hanging from the joist before dropping down to the floor, sliding down the ladder to the floor, and/or that the ladder he was standing on fell, a nearby co-worker with his back turned did not react or appear to be aware any such incident had occurred. Petitioner by his own admission knew to immediately report all such injuries, yet did not do so, either by contacting any of Respondent's employees via cell phone call or text, or in telling his immediate foreman Don about any such injury when Don arrived back on the job site about an hour later.

Petitioner by his own admission felt no pain and maybe just a "pull" but continued working for the next two hours, performing the same duties which included moving the ladder, climbing up and down the five-foot ladder, and performing soldering work overhead. Following work, he did not seek medical attention, rather, went to get something to eat and then went home.

Petitioner claims the next morning he woke up around 3 a.m., felt severe pain in his right shoulder, and took Norco he had from a prior medical condition. He contacted his employer sometime around 7 a.m., not to report the work injury the day before or that he was in pain, rather, than he would be late for work. He did not then come in to work. Petitioner's attendance for Respondent over his four-month work history with them was very poor and Petitioner had been told if he failed to show up for work again he would be fired. Petitioner was in fact fired by Shawn Rosendahl around 2 p.m. that afternoon. Petitioner then claimed a work injury sustained the day before.

The Arbitrator notes that Petitioner's description of leaning his head to peer around the joist to continue soldering is the type of symptom Petitioner has been reporting causes his vertigo symptoms, a condition he has been under active medical care for over the past several years and which, by his own admission, is only partially controlled with use of medications. Petitioner by his own admission self-medicates with alcohol and drugs. The Arbitrator also notes that this condition, if known by Respondent, would have prevented Petitioner from being hired by Respondent, given the amount of ladder, scaffold and overhead work required.

The Arbitrator also notes Petitioner's admission he falls frequently, to quote Petitioner at trial "every day." Dr. Cole did not feel the description of grabbing the joist provided enough force to have resulted in the rotator cuff tear diagnosed and treated, thus he concluded the incident as described did not cause the condition. Dr. Phillips thought the work incident was the cause because he also believed Petitioner had immediate pain and could no longer do overhead work. He likewise admitted an injury with the arm outstretched, such as would be offered by falling down, could have caused the condition. The claimant bears the burden of proving his injury arose out of his employment and not due to any other cause; Sisbro v. Industrial Commission, 207 Il.2d 193 (2003).

Petitioner did not report any work injury at all, not to any personnel with Respondent he could have reached via cell phone that day, not to his foreman who was at the job site just an hour later, not the next morning when he notified his foreman he would be a half hour late to work, and not until after he had been fired. He also did not seek any medical attention until after he had been fired, and even then, not until the next day.

A portion of any arbitrator's task is to assess witness credibility, and to determine whether what someone claims is possible or probable given the circumstances. Here, we have a Petitioner should not have been working on heights but by not disclosing his vertigo condition was, who admitted he fell every day, who developed vertigo when tipping his head and per his testimony at trial was doing just that when he fell from the ladder at work that day, now claiming his resulting injury is work related. Petitioner denied his injury was caused by the vertigo yet offered no real explanation as to why he then failed to report the work injury until after he had been terminated by his employer.

Petitioner's claim is not that he fell from the ladder, rather, that the ladder started to tip, he grabbed the joist and hurt his right shoulder. Dr. Phillips stated this would be the cause of Petitioner's rotator cuff injury if he had immediate pain and could no longer perform overhead work. Dr. Cole agreed Petitioner would have had immediate symptoms and stated simply grabbing the joist would not have offered sufficient force to cause the rotator cuff injury diagnosed. Dr. Phillips admitted Petitioner's pre-existing conditions in that shoulder including

the rheumatoid arthritis and erosive arthropathy could have caused the rotator cuff tear. Dr. Phillips felt the work incident could have aggravated a pre-existing condition but to sustain that conclusion, that Petitioner would have had immediate pain and would have been unable to continue working.

For the foregoing reasons the Arbitrator finds that Petitioner has failed to prove he sustained an accidental injury in the workplace on August 13, 2014. The preponderance of the evidence supports multiple possible non-work-related explanations, and Petitioner's trial testimony was simply not corroborated by his immediate and subsequent conduct. Claim for all compensation is therefore denied.

Issue E: *Notice*

Based upon the findings regarding **Issue A**, above, the issue of *Notice* is moot.

Issue F: *Causal connection*

Petitioner testified that following his claimed injury he continued working for the next two hours, work that included moving and climbing a ladder and overhead soldering activities. By his own admission he had no immediate pain, rather, just a "pulling" sensation. He did not require or seek immediate medical attention. He finished his work day, went to get something to eat, and went home.

Dr. Cole testified the force offered by grapping the joist to stop from falling, as claimed by Petitioner, did not provide enough force to cause the rotator cuff injury found. He also testified had Petitioner sustained some injury to the right shoulder he would have had immediate pain and would not have been able to continue working, particularly overhead work. Dr. Phillips in effect agreed, testifying his "causation" opinion was predicated on the assumption Petitioner had immediate pain and was not able to continue working. Dr. Phillips also testified the Petitioner's preexisting conditions which included rheumatoid arthritis and erosive arthropathy could have caused the rotator cuff injury.

The Arbitrator makes the additional finding that Petitioner failed to establish causal connection in this matter.

Issue J: *Medical bills*

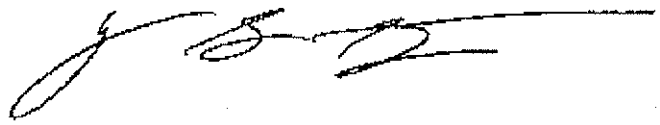
Based upon the findings regarding **Issues A and F**, above, the issue of *Medical bills* is moot.

Issue K: *TTD*

Based upon the findings regarding **Issues A and F**, above, the issue of *TTD* is moot.

Issue L: *Nature and Extent*

Based upon the findings regarding **Issues A and F**, above, the issue of *Nature and Extent* is moot.



Signature of Arbitrator

JULY 5, 2019
Date

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Sherry Ramsey,

Petitioner,

vs.

NO: 18 WC 0550

20 IWCC0350

Illinois Emergency Management Agency,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issues of notice, accident, causal connection, medical expenses, and temporary total disability, and being advised of the facts and law, modifies the Decision of the Arbitrator and corrects two scrivener's errors. The Commission otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission agrees with the Arbitrator's conclusion that Petitioner failed to meet her burden of proving she provided timely notice of her work accident pursuant to the Act. Notice is a jurisdictional issue and a claimant's failure to provide timely notice bars her claim. Pursuant to Section 6(c) of the Act, a claimant must give notice of a work accident to the employer "…as soon as practicable, but not later than 45 days after the accident…" Furthermore, the Act requires the claimant "…place the employer in possession of the known facts within the statutory period, but…a defect or inaccuracy in the notice is not a bar unless the employer is unduly prejudiced thereby." *Tolbert v. Ill. Workers' Comp. Comm'n*, 2014 IL App (4th) 130523WC ¶ 66. Petitioner bears the burden of proving by a preponderance of the evidence that she reported her alleged work injury to Respondent within the notice period established in Section 6(c) of the Act. After carefully considering the totality of the evidence, the Commission finds Petitioner failed to provide timely notice of her alleged work accident.

A close review of the evidence reveals that by December 1, 2016, Petitioner was diagnosed with osteoarthritis of the bilateral CMC joint and possible bilateral carpal tunnel syndrome. After suffering from ongoing symptoms in both hands and elbows since 2011, Petitioner told Dr. Young, her treating orthopedic surgeon, that most of her symptoms were attributable to her history of 20 years of "regular and habitual" computer work. (PX 2). It is indisputable that by the date of accident, Petitioner not only knew about her symptoms and potential diagnoses, but also believed

20 IWCC0350

her condition of ill-being was work-related. However, Petitioner was unable to provide credible evidence that she gave the required notice of her alleged work-related injury to Respondent within 45 days of that date.

Petitioner provided only vague testimony that Respondent knew about her complaints and their connection to her work duties. She testified that she wore hand braces every day while at work. However, she provided no details about when she allegedly provided Respondent notice not only of her complaints, but that those complaints might be work-related. Petitioner's witness, Mr. Pulley, testified that he saw Petitioner wearing soft spandex braces for her thumbs while in the office; however, he was unaware that Petitioner's underlying condition was related to her work duties. In fact, he testified that he was unaware that Petitioner's condition might be work-related until he received the January 2, 2018, letter from Petitioner's attorneys. (RX 4).

The Appellate Court has stated that "an employer's mere knowledge of 'some type of injury' does not establish statutory notice." *White v. Workers' Comp. Comm'n*, 374 Ill. App. 3d 907, 911 (2007). Thus, the fact that her supervisor and colleagues observed Petitioner wearing hand or thumb splints does not qualify as notice of an alleged work injury. On the date of accident, Petitioner was very aware of Respondent's injury reporting policies. As the office coordinator at least one person had previously reported a work-related injury to Petitioner. Petitioner also sustained an unrelated work injury in December 2016 after being bitten by a spider and immediately provided both oral and written notice of the work accident. Yet, during this same time period, she informed no one at work that she believed her bilateral hand and thumb complaints were work-related. Once she began treatment with Dr. Young on December 1, 2016, Petitioner informed no one at work that her doctor suspected her complaints were related to her work duties. This is clearly not a case involving a claimant who provided defective or inaccurate notice to her employer within the statutory notice period. Thus, Respondent does not have to prove it suffered undue prejudice due to Petitioner's failure to provide timely notice. For the foregoing reasons, the Commission finds Petitioner did not provide timely notice of her alleged work accident.

Finally, the Commission corrects certain errors in the Decision of the Arbitrator. On the Arbitration Decision Form, the Arbitrator mistakenly wrote that timely notice of this accident **was** given to Respondent. The Commission hereby modifies the above-referenced sentence to read as follows:

> Timely notice of this accident **was not** given to Respondent. (Decision Form)

On page one (1) of the Decision, the Arbitrator mistakenly refers to an EMG performed by Dr. Daniel Phillips on **August 22, 2011**. The Commission hereby strikes that entire sentence 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 July 16, 2019, is modified as stated herein.

20IWCC0350

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

DATED: JUN 26 2020

o: 5/5/20
TJT/jds
51

Thomas J. Tyrrell

Maria E. Portela

Kathryn A. Doerries

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

RAMSEY, SHERRY
Employee/Petitioner

Case# **18WC000550**

ILLINOIS EMERGENCY MANAGEMENT AGENCY
Employer/Respondent

20IWCC0350

On 7/16/2019, 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 2.01% 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:

4075 FISHER KERKHOVER COFFEY ET AL
JASON E COFFEY
600 STATE ST
CHESTER, IL 62233

0499 CMS RISK MANAGEMENT
801 S SEVENTH ST 8M
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KENTON J OWENS
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CARBONDALE, IL 62901

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

0502 STATE EMPLOYEES RETIREMENT
2101 S VETERANS PARKWAY
PO BOX 19255
SPRINGFIELD, IL 62794-9155

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

JUL 16 2019

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

20IWCC0350

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

SHERRY RAMSEY
Employee/Petitioner

v.

ILLINOIS EMERGENCY MANAGEMENT AGENCY
Employer/Respondent

Case # **18** WC **000550**

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 **5/14/19**. 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 **12/1/16** Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**48,732**; the average weekly wage was $**937.15**

On the date of accident, Petitioner was **59** years of age, ***married*** with **0** dependent children.

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

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

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

Respondent is entitled to a credit of $**any benefits paid through group** under Section 8(j) of the Act.

ORDER

Petitioner failed to give timely notice of accident to Respobdent. 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.

Edint Lee
Signature of Arbitrator

7/14/19
Date

JUL 16 2019

The Arbitrator makes the following findings of fact:

This is a decision on a repetitive trauma claim. The issues in dispute are accident, notice, causation, medical care and prospective medical care.

The petitioner, a 59-year-old employee from the Illinois Emergency Management Agency, alleges accidental injuries to her bilateral thumbs and elbows stemming from repetitive work activities with an effective date of loss of December 1, 2016. (Arb. Ex. 2) The Petitioner has worked for the State of Illinois for 15 years for various agencies. At that time of the alleged injury, Petitioner was working for the Illinois Emergency Management Agency as an office coordinator.

Petitioner's job duties included data entry which could be two to four hours a day. Petitioner admitted that her job duties at the office varied.

On January 8, 2018, Petitioner filed her Application for Adjustment of Claim in this matter.

On December 1, 2016, Petitioner was examined by Dr. Steven Young (Px. 2, pg. 41) Petitioner had complaints of thumb and elbow pain. (Id.) Nerve conduction studies were ordered. (Id.) The nerve conduction studies were normal. (Id.)

Following the nerve conduction studies, Petitioner returned to Dr. Young. (Id.) Petitioner was diagnosed as having bilateral thumb CMC primary degenerative arthritis and bilateral medial epicondylitis. (Id.)

On August 22, 2011 Petitioner had electrical diagnostic studies done with Dr. Daniel Phillips. (Px. 4) Dr. Phillips noted that the study showed very mild demyelinative ulnar neuropathies across the elbows. (Id.)

Petitioner was treated conservatively with injections and splints. (Id.) Petitioner's condition improved and by March 2017 she was told to follow up as needed. (Id.) Petitioner returned to Dr. Young in September 2017 and January 2018. (Id.)

At the January 4, 2018 visit, Petitioner told Dr. Young she could no longer live with her symptoms and Dr. Young recommended right thumb surgery. (Id.) Dr. Young performed ligament reconstruction and tendon interposition of the right thumb on March 12, 2018. (Id.)

Dr. Young last saw Petitioner in August 2018. (Px. 3, pg. 21) At that time, Petitioner had complaints of hand pain and loss of strength. (Id., pg. 22) Dr. Young testified that both those complaints would improve with time. (Id.) Following surgery, Dr. Young state Petitioner had a good outcome. (Id.)

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D. What was the date of the accident?

Petitioner's date of accident was December 1, 2016, when she saw Dr. Young and he told her that her condition was work related.

E. Was timely notice of the accident given?

Petitioner failed to provide notice of her injury within 45 days of December 1, 2016. Petitioner testified that she first told her employer in January 2018 about her condition. Holley v. IDOT, 19 IWCC 264(Petitioner claim barred due to lack of notice)

Based upon the above, all other issues are moot and compensation is denied.

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 up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Angela R. Williams

Petitioner,

vs. NO: 18 WC 8403

Amazon,

Respondent.

20IWCC0351

DECISION AND OPINION ON REVIEW

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

I. FINDINGS OF FACT

The Commission hereby incorporates by reference the findings of fact contained in the arbitration decision, which delineate the relevant facts and analyses. However, as it pertains to causal connection, the Commission modifies the decision as stated below.

The record reflects that Petitioner had no history of low back injuries or treatment prior to the accident date. On December 10, 2017, Petitioner was lifting boxes in accordance with her job duties weighing 25-30 pounds. While lifting a box she noticed a pull in the middle of her low back. She reported the accident to her supervisor and, after waking up the following morning with back pain and numbness and tingling in her right leg, she sought treatment at Memorial Hospital in Belleville. Petitioner then underwent medical treatment over the next several months, including hydrotherapy and manual therapy. Petitioner's right leg symptoms persisted in the interim, and she remained off work for the remainder of the year while receiving

Referencias

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temporary total disability (TTD) benefits. Subsequently, a combination of off work and restricted work releases littered Petitioner's medical records.

On March 30, 2018, Petitioner presented to Ms. Holthaus requesting a return to work with restrictions, which was ordered. However, Respondent was unable to offer modified duty to Petitioner. Petitioner then underwent an orthopedic evaluation with Dr. Raskas on April 17, 2018. An exam by a Physician's Assistant was grossly normal. X-rays revealed a slight collapse of disc space at L5-S1 along with mild foraminal stenosis. Petitioner was diagnosed with low back pain, a lumbar strain and spasm of lumbar paraspinous muscle. An MRI was ordered, and Petitioner was taken off work in the interim. The lumbar MRI on April 27, 2018 indicated minimal disc bulging at L1-2 and L4-5, without herniation, stenosis or root impingement. As of May 8, 2018, Dr. Raskas reviewed the MRI results and opined that Petitioner's disc looked pretty healthy overall and had no significant pathology. Dr. Raskas ordered additional physical therapy for two weeks, followed by two weeks of work conditioning and a functional capacity evaluation. He also prescribed Celebrex and Tizanidine. On May 14, 2018, Petitioner reported to her physical therapist that she attempted to return to work but was unable to do so without pain.

Petitioner then underwent a Section 12 examination at Respondent's request with Dr. DeGrange on May 15, 2018. Dr. DeGrange examined Petitioner and reviewed various medical records finding that Petitioner's subjective complaints were not in line with objective findings. He also found that the MRI was normal without any facet arthropathy. Dr. DeGrange diagnosed a work-related lumbar strain and unrelated chronic pain syndrome. He opined medical treatment to date had been appropriate, but that Petitioner had reached maximum medical improvement on December 24, 2017 and could return to work full duty. Dr. DeGrange also offered an AMA impairment rating of zero percent based on the body as a whole. TTD benefits were subsequently discontinued.

Petitioner received TTD benefits from December 11, 2017 through June 18, 2018, but then did not return to work for Respondent. She testified that she had been looking for work, but not with Respondent because it hurt her lower back.

Both Dr. Raskas and Dr. DeGrange testified at evidence depositions. Dr. Raskas opined that Petitioner's condition was causally related to the hyperextension injury that she suffered at work and believed that she may have had a bit of facet joint syndrome. Dr. Raskas testified that facet joint syndrome does not necessarily show up on an MRI and often responds to therapy and exercise. Absent such a response, facet blocks or rhizotomies may be needed, but Dr. Raskas was unable to determine if these measures were necessary for Petitioner.

Dr. DeGrange opined that there was a nonorganic component to Petitioner's subjective complaints, which he attributed to a possible somatization disorder. However, Dr. DeGrange did not diagnose Petitioner with the foregoing, rather he diagnosed unrelated myofascial or chronic pain. Dr. DeGrange disagreed that Petitioner suffered from facet joint syndrome and, further,

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that the condition even exists. To that end, Dr. DeGrange strongly disagreed with an article from his alma mater, UCLA, corroborating the existence of facet joint syndrome.

II. CONCLUSIONS OF LAW

The Arbitrator found that, although Petitioner did sustain an accident on the date in question, the opinions of Dr. DeGrange regarding causal connection to Petitioner's current condition were more credible than those of Dr. Raskas. Accordingly, the Arbitrator found that causal connection terminated on December 24, 2017 as opined by Dr. DeGrange. The Commission views the evidence somewhat differently and finds that Petitioner reached maximum medical improvement as of June 18, 2018.

It has been held that, "[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." *Shafer v. Illinois Workers' Compensation Comm'n*, 2011 IL App (4th) 100505WC, ¶ 39, 976 N.E.2d 1 (quoting *International Harvester v. Industrial Comm'n*, 93 Ill.2d 59, 63-64, 442 N.E.2d 908, 911 (1982). During his Section 12 examination on May 15, 2018, Dr. DeGrange found Petitioner's MRI to be normal. However, Petitioner's symptomatology had been ongoing and Dr. Raskas believed that Petitioner suffered from facet joint syndrome. Disagreeing, Dr. DeGrange opined that Petitioner's symptoms were not in line with objective findings but diagnosed her with myofascial or chronic pain unrelated to the accident.

Both Dr. Raskas and Dr. DeGrange agreed that Petitioner was suffering from a symptomatic condition after her unrefuted work accident that could not be confirmed by her MRI. Despite finding that Petitioner's condition was no longer related to the accident at work, Dr. DeGrange opined that Petitioner's medical treatment through the date of his examination had been appropriate. Moreover, Dr. DeGrange's response when presented with an article supporting the facet joint syndrome diagnosis failed to explain why, despite some support in the medical community, the diagnosis was erroneous as to Petitioner based on his knowledge of scholarly debate. Dr. DeGrange dismissed Dr. Raskas's facet joint syndrome diagnosis out of hand, but nonetheless acknowledged that Petitioner suffered from ongoing symptoms agreeing that the recommended treatment had been reasonable. Given the foregoing, the Commission is not persuaded by Dr. DeGrange's opinion regarding Petitioner's diagnosis or when she reached maximum medical improvement in this case.

The medical evidence also establishes that Petitioner's condition had stabilized by the time that Respondent discontinued Petitioner's TTD benefits and that she could have returned to her job at that time. Petitioner's symptoms had not significantly changed despite treatment. Petitioner did not claim any prospective medical treatment recommended by Dr. Raskas. Indeed, the parties proceeded to a hearing including the nature and extent of Petitioner's condition and Petitioner testified that she did not return to work for Respondent.

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Thus, the Commission finds the opinions of Dr. Raskas to be more persuasive overall given the facts of this case and finds that Petitioner reached maximum medical improvement as of June 18, 2018 at which point her condition had stabilized and was no longer temporary.

The Commission also finds that, as the causal connection termination date has been modified, so too must the award for medical expenses. In keeping with the causal connection ruling, the Commission modifies the medical expenses award and finds Respondent liable for all reasonable and necessary expenses through June 18, 2018.

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 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), Dr. DeGrange provided an AMA impairment rating of 0%. The Commission gives significant weight to this factor.

With regard to factor (ii), Petitioner was employed as a Sorter/Picker for Respondent. She testified that her back condition has forced her to seek employment elsewhere. However, objective tests indicate no substantial pathology. The Commission gives some weight to this factor.

With regard to factor (iii), Petitioner was 23 years old at the time of the accident. She will have to live with any residual symptoms as a result of her accident for a longer work life expectancy. She testified to increased pain with lifting groceries and other activities of daily living and takes extra-strength Tylenol when she suffers a flare up of pain. The Commission gives significant 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 significant weight to this factor.

With regard to factor (v), Petitioner suffered a work-related lumbar strain with minimal disc bulging at L1-2 and L4-5, and underwent physical therapy (both hydrotherapy and manual), was prescribed pain medications and a Medrol Dosepak. The record reflects that Petitioner has reached maximum medical improvement but is not symptom-free. The Commission gives moderate weight to this factor.

Based on the above, the Commission finds Petitioner sustained a 7.5% loss of use of her person as a whole under section 8(d)(2) of the Act.

All else is affirmed and adopted.

Introduction

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IT IS THEREFORE FOUND BY THE COMMISSION that Petitioner's condition was causally related to the instant accident through June 18, 2018.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner is entitled to all reasonable and necessary medical expenses through June 18, 2018.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner sustained permanent injuries to the extent of a 7.5% loss of use of her person as a whole under section 8(d)(2) of the Act, thus she is entitled to permanent disability benefits of $237.07/week for a period of 37.5 weeks.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $14,400.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

JUN 26 2020

DATED:
O: 5/7/20
BNF/wde
045

Barbara N. Flores

Deborah L. Simpson

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WILLIAMS, ANGELA R
Employee/Petitioner

Case# **18WC008403**

AMAZON
Employer/Respondent

20IWCC0351

On 5/22/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.34% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

0000 WIEDNER & McAULIFFE LTD
JULIE M TENUTO
8000 MARYLAND AVE SUITE 550
ST LOUIS, MO 63105

STATE OF ILLINOIS)
)SS.
COUNTY OF Madison)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Angela R. Williams
Employee/Petitioner

v.

Amazon
Employer/Respondent

Case # **18** WC **008403**

Consolidated cases: _____

20IWCC0351

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Collinsville**, on **March 28, 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 [1]
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 _____

[1] Respondent notes Petitioner incorrectly listed TTD benefits as a disputed issue in its Proposed Arbitration Decision. At trial, the parties did not place TTD benefits at issue. Respondent stipulated Petitioner is entitled to TTD benefits for 27 weeks from 12/11/17 through 6/18/18. At Petitioner's stipulated TTD rate of $263.41, Petitioner would be entitled to a total of $7,112.07 in TTD benefits. The parties also stipulated Respondent is entitled to a credit of $7,112.07 for TTD benefits already paid. Therefore even if TTD benefits were at issue, no additional benefits would be owed.

FINDINGS

On **12/10/17**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**20,546.24**; the average weekly wage was $**395.12** [2].

On the date of accident, Petitioner was **23** years of age, ***single*** with **0** dependent children.

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

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

Respondent shall be given a credit of $**7,112.07** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**7,112.07**.

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

ORDER

Petitioner sustained a lumbar strain as a result of the December 10, 2017 accident and reached maximum medical improvement on December 24, 2017. Because Petitioner failed to prove her current condition of ill-being is causally related to the accident, all benefits beyond December 24, 2017 are denied.

Respondent shall pay all related, reasonable and necessary medical bills pursuant to the Illinois Medical Fee Schedule or the negotiated rate, whichever is lower, for services rendered through December 24, 2017 that are submitted with an itemized bill and accompanying medical record.

Respondent shall pay Petitioner permanent partial disability benefits of $237.07/week for 0 weeks, because the injuries sustained caused the 0% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

Signature of Arbitrator

5/19/19
Date

MAY 22 2019

[2] Respondent notes Petitioner listed the incorrect average weekly wage in its Proposed Arbitration Decision. At trial, the parties stipulated to an average weekly wage of $395.12.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

This case proceeded to Arbitration on March 28, 2019 in Collinsville. The disputed issues at trial included: causal connection of Petitioner's current lumbar condition; medical benefits; and nature and extent. Petitioner testified and was represented by Mr. Keith Short. Respondent was represented by Ms. Julie Tenuto.

The Arbitrator Finds:

On December 10, 2017 Ms. Angela Williams ("Petitioner") was 23 years old and employed by Amazon ("Respondent") in Edwardsville, Illinois. Petitioner worked as a sorter, picker, slammer and forklift associate. Her job duties included picking up things with a forklift, sorting items, getting items from totes, and driving a forklift. Petitioner denied any injury or treatment to her low back prior to December 10, 2017. She denied any lost time related to her low back prior to December 10, 2017.

On December 10, 2017, Petitioner testified she was working as a sorter and picker which consisted of picking up boxes. Petitioner felt the middle of her lower back pull when she picked up a box weighing approximately 25 to 30 pounds. She stopped working and reported the incident to her supervisor. Petitioner was provided with ice and thereafter completed her shift. Later that night, she was encouraged to use ice, heat, and take an Epsom salt bath.

Petitioner testified that when she awoke the next day on December 11, 2017. she was still in pain and her lower back and right leg felt numb and tingly. She presented to the emergency room at Memorial Hospital later that day and complained of bilateral low back pain which began one day prior after she lifted a heavy box (PX6). Petitioner denied localized numbness and weakness (PX6). She was diagnosed with a back strain (PX6). The physician suspected a muscular strain and pain which was mechanical in nature (PX6). Petitioner was prescribed Mobic and Flexeril and released to return to work in two days (PX6).

Two days later on December 13, 2017 Petitioner returned to the emergency room at Memorial Hospital for continued low back pain (PX6). She denied radiation of pain, numbness, or tingling into her lower extremities (PX6). Petitioner was diagnosed with acute low back pain without sciatica and instructed to follow-up with her primary care physician (PX6).

On December 14, 2017 Petitioner presented to SIHF Healthcare and was evaluated by Brandy Holthaus, NP-C (PX5). Petitioner reported she picked up a heavy box on December 10th and felt a pull in her mid to low back (PX5). She denied radiation of pain (PX5). Ms. Holthaus diagnosed a low back strain and prescribed ibuprofen 600 mg, a Medrol dose pack, and physical therapy (PX5). Petitioner participated in physical therapy including aquatic therapy at Memorial Hospital (PX6). At the Arbitration hearing Petitioner testified during her course of therapy, her right leg condition never went away.

Petitioner followed-up at SIHF Healthcare on January 18, 2018 and her exam remained essentially unchanged. Petitioner once again denied radiation of pain (PX5). On February 5, 2018, Petitioner reported her back was slowing getting better with physical therapy but she was still having daily pain which did not radiate (PX5). As of March 7, 2018 Petitioner described throbbing pain and a pulling sensation from her upper lumbar to thoracic spine. Ms. Holthaus ordered a thoracic MRI (PX5). On March 30, 2018 Petitioner returned and reported she was unable to complete the thoracic MRI due to a positive at home pregnancy test (PX5). She reported no change in her back pain but felt she would be able to work with lifting and bending restrictions (PX5).

Petitioner was thereafter referred for an orthopedic evaluation with orthopedic spine surgeon Dr. David Raskas. She presented to him on April 17, 2018 and reported she hyperextended her back while using a forklift at work on December 10, 2017 (PX1, 2). Dr. Raskas testified Petitioner did not report any symptoms of pain radiating down her legs (PX1).

Petitioner's examination was predominately normal and non-focal with negative straight leg testing (PX1). Dr. Raskas diagnosed a lower lumbar strain and low back pain (PX1). He ordered a lumbar MRI, prescribed physical therapy, Meloxicam and Tizanidine, and kept Petitioner off work (PX1).

The lumbar MRI was completed at MRI Partners of Chesterfield on May 1, 2018 and was interpreted by the radiologist to demonstrate minimal disc bulging at L1-2 and L4-5 without herniation, stenosis, or root impingement (PX3).

Petitioner followed-up with Dr. Raskas on May 8, 2018 to review her MRI. Dr. Raskas testified Petitioner's disc profiles were healthy overall and there was no significant pathology (PX1). He did not find anything in Petitioner's examination or diagnostic studies to suggest she was a surgical candidate (PX1). He diagnosed lumbar pain and facet joint syndrome (PX1). Dr. Raskas also switched Petitioner's Tizanidine to Celebrex (PX1). He recommended two weeks of physical therapy, followed by two weeks of work conditioning and a functional capacity evaluation. He kept Petitioner off work (PX1).

Dr. Raskas testified that facet joint syndrome is an injury to the joints in the back and would not necessarily show up on an MRI scan (PX1). Facet joint syndrome may respond to therapy and exercises, but if those failed, Petitioner may require facet blocks or rhizotomies (PX1). At his deposition on September 10, 2018, Dr. Raskas testified he was not able to determine whether Petitioner will require those interventions (PX1).

Petitioner initiated physical therapy at Apex Network Physical Therapy on May 14, 2018 (PX4). She reported severe low back pain after lifting a box at work on December 10, 2017 (PX4). The therapist noted four of seven Waddell Signs were positive and petitioner had at least one sign in three or more categories which may indicate a non-organic basis to her low back pain

(PX4). Additionally, Petitioner reported herself to be 65% disabled on the Oswestry Low Back Pain Questionnaire which indicated she perceived herself to be crippled (PX4).

Petitioner thereafter attended a Section 12 examination with orthopedic spine surgeon Dr. Donald deGrange at the request of Respondent on May 15, 2018 (RX1). Petitioner reported she felt a large tug in her back while lifting a box at work on December 10, 2017 (RX1). Her complaints at the time of the IME were low back pain with occasional lower extremity tingling into the feet, but no associated pain or numbness (RX1). Dr. deGrange testified the radiation pattern Petitioner described was not consistent with any specific dermatome pattern but was quite diffuse and vague (RX1). On examination, Petitioner demonstrated some mild tenderness throughout the lumbar spine but no spasm was detected (RX1). Dr. deGrange also did not detect any significant tenderness over the sacroiliac joints (RX1). Overall Dr. DeGrange found Petitioner's neurologic examination was normal with no focal motor or sensory deficits (RX1).

Dr. deGrange reviewed Petitioner's lumbar MRI films and testified the study was normal (RX1). Although the MRI report suggested minimal bulging at L1-2 and L4-5, Dr. deGrange saw no such pathology and testified those two disc levels looked exactly like all the other levels in Petitioner's spine (RX1).

Dr. deGrange diagnosed a lumbar strain related to the December 10, 2017 work injury (RX1). He also testified Petitioner's symptoms could not be explained and were not attributable to any known medical diagnosis (RX1). Rather. Dr. deGrange felt Petitioner's clinical presentation may in fact represent somatization disorder (RX1). Dr. deGrange did not find Petitioner's subjective complaints correlated with her objective findings (RX1). Based on her DRAM assessment, he felt there was a significant nonorganic component to Petitioner's subjective complaints (RX1). Dr. deGrange opined Petitioner's continued symptoms were not

explained by her simple mechanism of injury which would have otherwise run its course in two to four weeks in a young healthy individual (RX1).

Dr. deGrange disagreed with Dr. Raskas' diagnosis of facet joint syndrome (RX1). Dr. deGrange testified that facet joint syndrome is a "wastebasket" term when physicians cannot find anything else wrong with the spine (RX1). Regardless of his disagreement as to whether it is a supported medical diagnosis, Dr. deGrange noted Petitioner's facets were normal throughout her lumbar spine (RX1).

Dr. deGrange concluded Petitioner reached maximum medical improvement for her work-related lumbar strain as of December 24, 2017 and could return to work without restrictions (RX1). Lastly, Dr. deGrange assigned a 0% AMA impairment rating resulting from the December 10, 2017 work injury (RX1).

Two days after her IME, on May 17, 2018 Petitioner reported to the therapist at Apex Network that she had a numbness/tingling sensation which goes back and forth between her left and right legs (PX4). She also exhibited severely guarded motions while in the clinic (PX4). On May 21, 2018, the therapist noted Petitioner was very guarded with transitional movements and her lumbar range of motion was inconsistent during transitional movement when compared to during exercises (PX4). At Petitioner's physical therapy re-evaluation on May 23, 2018, she reported occasional numbness/tingling into her bilateral legs anteriorly and posteriorly to her knees (PX4). Overall the therapist noted Petitioner's high subjective pain level, low tolerance to activity, and high guarding were limiting her ability to progress in physical therapy (PX4). Petitioner was discharged from Apex Network Physical Therapy on May 25, 2018 (RX1).

Petitioner last contacted Dr. Raskas' office via telephone on May 25, 2018 (PX1). She reported worsening back pain during physical therapy and admitted she was not taking her prescribed anti-inflammatory on a daily basis as directed (PX1). At the Arbitration hearing

Petitioner testified she took her prescribed medication per Dr. Raskas' recommendations. Dr. Raskas again noted he did not see any specific pathology in the lumbar MRI (PX1). He recommended Petitioner postpone therapy, then reinitiate it again followed by work conditioning and a functional capacity evaluation (PX1). As of the date of the Arbitration hearing, Petitioner had not undergone that recommended treatment.

Dr. Raskas testified that as of the last time he saw Petitioner on May 8, 2018, she was not at maximum medical improvement (PX1). He also opined Petitioner's lumbar conditions were caused or contributed to by the hyperextension event that occurred while she was working on a forklift at Amazon on December 10, 2017. He testified Petitioner's treatment to date was reasonable and necessary to cure or treat her diagnosed lumbar condition (PX1).

Respondent paid temporary total disability benefits totaling $7,112.07 covering Petitioner's lost time beginning December 19, 2017 through June 18, 2018. Petitioner testified she has been looking for work elsewhere because her job at Amazon hurts her lower back. Specifically, she testified there is too much weight on her back to ride the forklift.

Petitioner testified she is still having problems with her right leg every day which she rates about a two out of ten. Her symptoms are worsened by sitting and walking and standing for a long time and carrying groceries. Petitioner testified her low back pain has not gotten better since she stopped treating in May of 2018. She is not taking any prescription medication for her low back but takes Extra Strength Tylenol for flare-ups.

Petitioner testified she currently has health insurance. She has not seen any other doctors and has not had any treatment to her low back since May of 2018. She testified she has not presented to the emergency room or an urgent care center for low back pain since May of 2018.

The Arbitrator Concludes:

1. **As to F, whether Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator finds as follows:**

Both Dr. Raskas and Dr. deGrange agree Petitioner sustained a lumbar strain as a result of the December 10, 2017 work accident. Both doctors also agree Petitioner's May 1, 2018 lumbar MRI demonstrated no significant pathology. Dr. Raskas did not believe petitioner reached MMI but instead recommended additional treatment in the form of physical therapy, work conditioning, and an FCE. Conversely Dr. deGrange opined Petitioner reached MMI as of December 24, 2017. Based on the objective medical evidence, the Arbitrator concludes Dr. deGrange's opinions are more credible and persuasive than Dr. Raskas' and Petitioner failed to prove that her current condition of ill-being in the lumbar spine is causally related to the December 10, 2017 work accident.

Petitioner testified at the Arbitration hearing that she experiences daily problems with her right leg rated two out of ten and that her right leg condition never resolved during her course of therapy. The Arbitrator concludes Petitioner's testimony regarding her constant radiating right leg symptoms which have allegedly been present since the date of injury, is not credible and is inconsistent with the objective medical evidence.

Petitioner testified when she woke up on December 11, 2017, the day after her accident, she was still in pain and her lower back and right leg felt numb and tingly. However the medical records confirm Petitioner presented to the emergency room at Memorial Hospital on December 11, 2017, complained of bilateral low back pain, and specifically denied localized numbness and weakness (PX6).

Similarly, two days later on December 13, 2017 Petitioner returned to the emergency room at Memorial Hospital for continued low back pain and denied radiation of pain, numbness

or tingling into her lower extremities (PX6). Petitioner was diagnosed with acute low back pain without sciatica (PX6). Likewise, when Petitioner first presented to SIHF Healthcare on December 14, 2017, she denied radiation of pain (PX5). She also denied radiation of pain on January 18, 2018, when she followed-up at SIHF Healthcare (PX5). Finally, when Petitioner presented to Dr. Raskas for an orthopedic evaluation on April 17, 2018, she did not report any symptoms of radiating pain affecting her legs (PX1). Dr. Raskas testified Petitioner's examination was predominately normal and non-focal with negative straight leg testing (PX1).

The first documentation of radiating low back pain occurred when Petitioner was evaluated by Dr. deGrange on May 15, 2018. At that time, she complained of low back pain with occasional lower extremity tingling into the feet, although there was no associated pain or numbness (RX1). Dr. deGrange testified the radiation pattern Petitioner described was not consistent with any specific dermatome pattern but was quite diffuse and vague (RX1). As Dr. Raskas did, Dr. DeGrange also noted a normal neurologic examination with no focal motor or sensory deficits (RX1).

The Arbitrator concludes Petitioner's testimony regarding her ongoing daily right leg and lumbar symptoms are wholly inconsistent with the objective medical evidence and with Petitioner's own prior statements to her medical providers. Petitioner initially consistently denied radiating pain when she presented to Memorial Hospital, SIHF Healthcare, and Dr. Raskas. It was not until Dr. deGrange's May 15, 2018 IME that she first mentioned occasional lower extremity tingling into the feet without associated pain or numbness. Just two days later on May 17, 2018 at Apex Network Physical Therapy, Petitioner described numbness/tingling which variably affected her left and right legs (PX4). Again, on May 23, 2018, Petitioner reported occasional numbness/tingling into her bilateral legs (PX4). The Arbitrator is persuaded by Dr. deGrange's opinion that Petitioner's described radiation pattern was not consistent with

any specific dermatome pattern but was instead diffuse and vague (RX1), especially in light of the fact that both Dr. deGrange and Dr. Raskas agree that Petitioner's lumbar MRI was normal.

Given Petitioner's essentially normal physical examination and normal lumbar MRI scan, Dr. deGrange felt there was a significant nonorganic component to her subjective complaints and that her clinical presentation may in fact represent somatization disorder (RX1). Dr. deGrange found Petitioner's subjective complaints did not correlate with her objective findings (RX1). Based on the record as a whole, the Arbitrator concludes Dr. deGrange's opinions are more credible and persuasive as they are corroborated by the objective medical evidence.

In support thereof, the Arbitrator notes that the physical therapist at Apex Network Physical Therapy found Petitioner was positive in four of seven Waddell Signs suggesting a non-organic basis to her low back pain (PX4). The therapist also noted Petitioner's lumbar range of motion was inconsistent during transitional movement when compared to during exercises (PX4).

Additionally, Petitioner reported herself to be 65% disabled on the Oswestry Low Back Pain Questionnaire which indicated she perceived herself to be crippled (PX4). Having observed Petitioner at the Arbitrator hearing, the Arbitrator notes she appeared to ambulate without difficultly and was able to sit. walk, and stand comfortably without any obvious signs of pain or discomfort. These findings all corroborate and support Dr. deGrange's opinion that Petitioner's clinical presentation may in fact represent somatization disorder. Indeed, Dr. deGrange did not find Petitioner's subjective complaints correlated with her objective findings and testified that her symptoms could not be explained or attributed to any known medical diagnosis (RX1). Dr. deGrange also noted Petitioner's DRAM assessment suggested there was a significant nonorganic component to her subjective complaints (RX1).

Lastly, the Arbitrator concludes that Dr. Raskas' opinions are not credible or supported by the objective medical evidence. At Petitioner's first evaluation with Dr. Raskas on April 17,

2018, her physical examination was predominately normal and non-focal with negative straight leg testing (PX1). Dr. Raskas diagnosed a lower lumbar strain and low back pain (PX1). Dr. Raskas agreed with Dr. deGrange that the May 1, 2018 lumbar MRI did not demonstrate any herniation, stenosis, or root impingement and testified Petitioner's disc profiles were healthy overall and there was no significant pathology (PX1). He did not find anything in Petitioner's examination or diagnostic studies to suggest she was a surgical candidate (PX1). Nevertheless, Dr. Raskas diagnosed lumbar pain and facet joint syndrome (PX1) seemingly based solely on Petitioner's subjective complaints.

Dr. Raskas merely testified that facet joint syndrome is an injury to the joints in the back which may not necessarily be visible on an MRI scan (PX1). He failed to provide any additional explanation to justify Petitioner's diagnosis of facet joint syndrome, other than to state that it may respond to therapy and exercises and if those failed, she may require facet blocks or rhizotomies (PX1). Conversely, Dr. deGrange testified that facet joint syndrome is a "wastebasket" term when physicians cannot find anything else wrong with the spine and noted Petitioner's facets were normal throughout her lumbar spine (RX1).

When taking into consideration the inconsistencies between Petitioner's testimony and the objective medical evidence, as well as the testimony of Dr. deGrange and Dr. Raskas, the Arbitrator concludes Petitioner has failed to establish that her current condition of ill-being in the lumbar spine is causally related back to her December 10, 2017 accident.

2. **As to J, whether Respondent has paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds as follows:**

As noted above, the Arbitrator finds the opinions of Dr. deGrange more persuasive and credible than those of Dr. Raskas. Because Petitioner reached MMI relative to her work accident on December 24, 2017, Respondent shall pay all related, reasonable and necessary medical bills

pursuant to the Illinois Medical Fee Schedule or the negotiated rate, whichever is lower, for services rendered through December 24, 2017 that are submitted with an itemized bill and accompanying medical record.

3. **As to L, the nature and extent of the injury, the Arbitrator finds as follows:**

Both Dr. Raskas and Dr. deGrange agree Petitioner sustained a lumbar strain as a result of the December 10, 2017 work accident. Both doctors also agree Petitioner's May 1, 2018 lumbar MRI demonstrated no significant pathology. At Petitioner's initial evaluation with Dr. Raskas on April 17, 2018, her examination was predominately normal and non-focal with negative straight leg testing (PX1). Her exam was unchanged at her May 8, 2018 follow-up. Similarly, at Petitioner's May 15, 2018 IME with Dr. deGrange, she had a normal neurologic examination with no focal motor or sensory deficits (RX1).

Petitioner was diagnosed with a lumbar strain and treated conservatively with physical therapy and prescription medication. She did not require injections and neither doctor found Petitioner was a surgical candidate. Further, Dr. deGrange provided an AMA impairment rating of 0%.

Petitioner is 24 years old and appeared to be a young and healthy individual. There is no evidence that the December 10, 2017 accident will have any impact on Petitioner's future earning capacity. Lastly, Petitioner's evidence of disability (or lack thereof) is corroborated by the treatment records, specifically her normal physical examination findings and the lack demonstrated herniation, stenosis, root impingement or otherwise significant findings on her MRI.

Based on the foregoing and the record as a whole, the Arbitrator concludes Petitioner failed to prove she sustained any permanent partial disability as a result of the December 10, 2017 accident.

****

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Vera Moses,

Petitioner,

vs. NO: 18 WC 13481

Chicago Transit Authority,

Respondent.

20IWCC0352

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of temporary total disability, medical, prospective medical, 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 further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 31, 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.

20IWCC0352

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: JUN 2 6 2020
o052120
BNF/mw
045

Barbara N. Flores

Deborah L. Simpson

Marc Parker

# ILLINOIS WORKERS' COMPENSATION COMMISSION
# NOTICE OF ARBITRATOR DECISION
8(a)

MOSES, VERA
Employee/Petitioner

Case# **18WC013481**

CTA
Employer/Respondent

20IWCC0352

On 7/31/2019, 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:

4128 RUBENS KRESS & MULHOLLAND
134 N. LASALLE STREET
134 N LASALLE ST SUITE 444
CHICAGO, IL 60602

0515 CHICAGO TRANSIT AUTHORITY
ELIZABETH MEYER
567 W LAKE ST 6TH FL
CHICAGO, IL 60661

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
8(a)

VERA MOSES
Employee/Petitioner

v.

CTA
Employer/Respondent

Case # **18** WC **13481**

Consolidated cases: **N/A**

20 IWCC0352

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Tiffany Kay**, Arbitrator of the Commission, in the city of **Chicago**, on **February 19, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ 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, **04/12/2018**, 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 $**68,268.20**; the average weekly wage was $**1,312.85**.

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

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

Respondent shall be given a credit of $**30,757.43** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**2,500.00** for other benefits, for a total credit of $**33,257.43**.

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

ORDER

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $875.23/week for 44 5/7 weeks, commencing April 13, 2018 through February 19, 2019, as provided in Section 8(b) of the Act.

Medical benefits

Respondent shall pay reasonable and necessary medical services of $11,233.77, as provided in Section 8(a) of the Act.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $336.74 to ION, $3,711.03 to Midwest Specialty Pharmacy, $4,850.00 to Neuropsychological Services and $2,336.00 to Molecular Imaging, as provided in Sections 8(a) and 8.2 of the Act. All bills shall be paid directly to the providers of the awarded treatment.

Prospective Medical

Respondent shall authorize and pay for the surgery as recommended by Dr. Giannoulias.

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

07/30/19
Date

ICArbDec19(b)

JUL 31 2019

PROCEDURAL HISTORY

This matter was heard before Arbitrator Tiffany Kay (hereinafter "Arbitrator Kay") on February 19, 2019 in Chicago, Illinois. The submitted records have been examined and the decision rendered by Arbitrator Kay.

The parties proceeded to hearing on February 19, 2019, with disputed issues as to whether Mrs. Vera Moses's (hereinafter "Petitioner") current condition of ill-being is causally connected to her injury, whether the Chicago Transit Authority (hereinafter "CTA") has paid all appropriate charges for all reasonable and necessary medical services, and whether Petitioner is entitled to TTD for the period of 4/13/18 through 10/17/18 representing 26 6/7 weeks or 4/13/18 through 9/6/18 representing 21 weeks. In addition, Petitioner claims she is owed maintenance for the period of 10/18/18 through 2/19/19 representing 17 6/7th weeks. Also, whether the Respondent is due any credit. (Arb.X1)

The parties stipulated that Petitioner sustained an accident on 4/12/18 that arose out of and in the course of her employment with Respondent, that Petitioner gave Respondent notice of the accident within the time limits stated in the Act, and the average weekly wage pursuant to Section 10 of the Act was $1312.85. (Arb.X1) The parties also stipulated that Petitioner was 56 years of age, married and had 0 dependents at the time of the incident. (Arb.X1)

SUMMARY OF FACTS AND EVIDENCE

The parties stipulate that on April 12, 2018, Petitioner was working for Respondent, as a full-time bus operator. Petitioner testified that she was hired by Respondent on April 9, 2007, as a part-time bus operator, and became full time on December 16, 2012. (T. 12) Petitioner explained that as a bus operator her job duties included operating a commercial vehicle to pick up passengers at designated areas. (T.12) Specifically, she had to pick up passengers at assigned bus service stops, pick them up, and drop them off. (T.13) For the physically handicapped passengers, there was some assistance getting them on the bus. (T.13) That assistance may include standing behind them, balancing, making sure that they don't fall because they may be on canes and lowering the lift of the bus. (T. 13) The Petitioner explained that, at times, she would have to lower the lift of the bus. She testified that the lift can be automatically lowered but if by great chance it did not work, the operators have to pull up the lift and lower the lift manually by hand. The Petitioner testified that this would require an operator to bend over, pull a section of the floor up by hand, fold it out and then allow the wheel chair or a person on a walker to enter into the bus. Once the passenger entered, the operator would exit the bus to pick up the lift off the ground, fold it back up, and bring it back in and lower it back into the floor. The Petitioner testified that she would have to perform this exercise up to five or six times per route. (T.14)

With regard to the operation of the bus itself, the Petitioner testified that city buses do not have a standard-sized steering wheel. (T.15) Instead, they have a 21-inch steering wheel that requires considerable upper body strength and movement to maneuver. She testified that all turns require a hand-over-hand motion that force the upper extremities to be extended to the fullest when making a full turn in the bus. The Petitioner also explained that at times she would use the hand brake. This was difficult because a driver has to pull up with extreme force to get the brake to work. (T.15) The Petitioner testified that an operator needs upper body strength for all motions, all operations of the bus. (T.16) She explained that they have to use their hands to operate the fair box and to put the codes in for the fair box. She testified that if a bus breaks down or if passengers need to be taken off of the bus safely in a situation where the doors are inaccessible, the operators have to manually open up windows, open up doors, and extend wheelchair ramps. (T.16)

On April 12, 2018, Petitioner testified that while she was running a route on 79th and South Chicago, she had an incident of gunfire. (T.17-18) At trial, the Petitioner explained what happened while the Arbitrator viewed an on-bus video of the incident. (R.X1) Petitioner testified that she had been traveling north-bound on South Chicago. (T.19) Petitioner explained that while in the course of picking up passengers and letting them off, a situation developed in which several children had exited the back of the bus. (T.20) One of the of young men who had exited the bus came and got back on the front of the bus, which was not uncommon because people may have missed a stop. (T.20) Petitioner said she opened the door to let the young man back on the bus. However, once Petitioner opened the door to let him back on, she noticed that he was in a verbal altercation with another young man outside the bus. (T.20) She explained that once her attention was directed to the altercation, she noticed that the young man outside the bus had a gun in his hands. (T.20)

Petitioner testified that she pulled out her phone to call the police. (T.20) While she was attempting to contact the police, the young man at the door with the gun, opened fire at the young man on the bus. (T.21) Petitioner testified that the young man on the bus was standing directly next to her in the doorway. (T.21) Once the gunfire started, the young man on the bus started running towards the rear of the bus. (T.21) Petitioner testified that during the incident she was sitting forward but when the shooting started she grabbed the steering wheel, ducked, and fell over to the left. (T.23)

Directly following the incident, the Petitioner attempted to move the bus, however the intersection where the incident occurred is a six to seven lane intersection. (T.23) Accordingly, traffic was coming toward the bus on an angle so she was not able to move the bus out of the range of the gunfire without going further into traffic. (T.24) She explained that heading into traffic would have potentially caused more injuries to herself and passengers on the bus. Because she could not drive the bus through traffic, for risk of causing greater injuries to both people on the bus and in traffic, she had no choice but to sit there. (T.24) Once the light changed, Petitioner was able to move the bus into a safer place, a block ahead. (T.25) Petitioner testified that she was able to reach the Chicago Police Department by phone. (T.25)

Petitioner further testified that once exiting the bus she was able to see where the bullets had struck the bus. (T.28) The front door of the bus is made of glass and rubber, with 2 inches of rubber immediately in the middle of the two doors. (T.28) On the right side of the glass door. At the upper part of the window, right by the edge of the door, a bullet landed. (T.28) Another bulled landed at the bottom of the bus in the right side of the door. (T.28) After meeting with the police, and leaving the scene of the incident, Petitioner testified that she realized she had been injured physically from the incident. (T.30) Petitioner returned to the Respondent's office and reported the incident to her manager who instructed her to report to Concentra the next day. (T.29)

On April 13, 2018, Petitioner was seen at Concentra, the Respondent's company clinic. (P.X1) During the initial evaluation, Petitioner complained of headaches and anxiety, left shoulder pain, and left knee pain after the bus shooting. (P.X1p5) The notes also indicate that she was wearing a seatbelt and witnessed a shooting on a CTA bus. (P.X1p5) Concentra assessed the Petitioner as having a left shoulder strain and strain of the left knee. (P.X1p6) Concentra recommended Petitioner perform physical therapy for her left shoulder and left knee strains. (P.X1p7) No medication was prescribed or dispensed. (P.X1p7) In addition, they referred Petitioner see a psychologist for anxiety and a panic attack secondary to being a shooting witness. (P.X1p7) The records indicate that the Petitioner had three sessions of physical therapy at Concentra through April 20, 2018.

On April 17, 2018, Petitioner returned to Concentra for a follow-up visit. (P.X1) Concentra's notes state that Petitioner was placed off work by her primary care medical provider and was unable to participate in any essential job functions. Concentra noted that Petitioner reported full engagement in community and life events.

(P.X1p9) In addition, Concentra noted that Petitioner rated the pain in her left shoulder as a 0/10 and 5/10 in her knee. (P.X1p10)

On April 21, 2018, the Petitioner had an initial evaluation with Dr. Nicholas Jasinski (hereinafter "Dr. Jasinki") at Neuropsychological Services. (P.X.3, p15). Petitioner provided a history of the events that occurred on April 12, 2018 while operating her bus along her bus route. (P.X.3p15) Petitioner told Dr. Jasinki that the idea of the incident made her distraught. In addition to leaving work that day she has not returned. (P.X3, p15) The Petitioner indicated that since this incident she has manifested intrusive memories of the incident, nightmares, avoidance behavior (has not left house, avoided buses, etc.), and hyperarousal to loud sounds. (Id.) She reported depressive symptoms and intense anxiety and fear. (Id.) She reported difficulties sleeping due to ruminative thinking. (Id.) Additionally, she reported that she has a history of dealing with gun violence in her family. (Id.) Her son was killed by a police officer 1998. (Id.) She indicated that she had similar symptoms at that time as well as ongoing isolative behavior and depressive symptoms. (Id.) She noted that her granddaughter was shot five times in September 2017 and has had ongoing complications from that incident. (Id.) The Petitioner noted that she has been unable to return to work due to her symptoms. (Id.)

Dr. Jasinski noted that Petitioner had mild levels of agitation, indecisiveness, reduced energy/fatigue, decreased sleep, low libido, sadness, feelings of guilt and pessimism, negative self-image, and tearfulness. (P.X. 3, P.16). The Petitioner also completed the Beck Hopelessness Scale (BHS), on which she reported a severe level of hopelessness. (Id). Petitioner completed the State-Trait Anxiety Inventory (STAI), a measure of current anxiety and general, long-standing anxiety. (Id). She reported a severe level of both current and long-standing anxiety. (Id).

Petitioner completed the Trauma Symptom Inventory-2nd Edition (TSI-2). (Id). She reported a severe level of overall symptoms. (Id). Her responses indicated that she is having severe difficulties with intrusive re-experiencing of the traumatic event, dissociation/withdrawal, avoidance of triggering environments or situations, and interpersonal withdrawal/fears of rejection. (Id). She also reported less severe, though significant anxiety, hyperarousal, depression, and anger. (Id). Overall, results of psychological testing indicated that The Petitioner was manifesting marked emotional distress related to the shooting on April 12, 2018. (Id). Her scores on testing are common in individuals with Post-Traumatic Stress Disorder (PTSD). (Id). Though she was having an acute stress reaction to the shooting, given her history with traumatic gun violence, a diagnosis of PTSD appears warranted at the current time. (Id). Her symptomatology appeared to be at the moderate to severe level. (Id).

Dr. Jasinski recommended individual psychotherapy to help Petitioner process her recent traumatic experience. (Pet. Ex. 3, P. 16). Also, to help her develop coping skills to reduce her anxiety and distress with the goal of returning to work. (Id). Dr. Jasinski recommended that the Petitioner should not currently return to work as a bus operator, and not until she was medically cleared to do so. (Id).

On April 23, 2018, the Petitioner had an initial evaluation with Dr. Sajjad Murtaza (hereinafter "Dr. Murtaza") at Illinois Orthopaedic Network ("ION"). (Pet. Ex. 2, P. 9-10). Dr. Murtaza noted that the Petitioner had decreased range of motion in her left shoulder and decreased strength. (P.X.2. p.10). For that reason, he recommended an MRI for the Petitioner's shoulder. (Id.) On April 27, 2018, Petitioner had an MRI of her left shoulder at Advantage MRI. (P. X. 4, p. 4). The MRI revealed a full-thickness tear of her left shoulder. (Id).

On May 2, 2018, the Petitioner returned to ION, this time she was evaluated by Dr. Christos Giannoulias (hereinafter "Dr. Giannoulias"). (P.X.2,p.17). Dr. Giannoulias noted that the Petitioner was seeing him on that date for a consultation regarding her left shoulder. (Id.) She was involved in an unfortunate incident on

04/12/2018 when someone assaulted her bus. (Id.) There were multiple gun shots that were at the bus. (Id.) She had to duck and turn and twist her body to avoid getting shot. (Id.) She states that she hurt her right knee and left shoulder. (Id.) The right knee is getting better but the shoulder persists. (Id.) She felt immediate pain after the injury and the pain continues to bother her. (Id.) Dr. Giannoulias noted that he had reviewed the Petitioner's MRI. (Id.) He concluded that the Petitioner had a full-thickness rotator cuff tear that appeared to be acute in nature. (Id.) Dr. Giannoulias diagnosed a left shoulder traumatic rotator cuff tear. (Id.) He recommended surgical repair if she had a normal functioning shoulder before this incident. (Id.) Dr. Giannoulias noted that he would try to get the surgery scheduled at the earliest mutual convenience pending authorization. (Id.)

On June 13, 2018, Petitioner saw Dr. Giannoulias for follow-up visits where he reiterated that Petitioner was pending a left shoulder rotator cuff repair and subacromial decompression due to a full thickness rotator cuff tear. (P.X.2,p.18). Additionally, he noted that Petitioner has remained off work during her treatment. On July 18, 2018, Petitioner was seen again by Dr. Giannoulias. He restated in his plan that they would continue to wait for authorization and he would see Petitioner for surgical intervention. (P.X2,p.21)

On August 13, 2018, Petitioner was seen by Dr. Pietro Tonino (hereinafter "Dr. Tonino") for an Independent Medical Examination (hereinafter "IME"). Dr. Tonino stated in his notes that he reviewed Petitioner's molecular imaging, Concentra records and the incident on the video. (R.X2 p.1) Dr. Tonino stated in his notes that Petitioner reported no prior history of injuries to her left shoulder, at the examination she explained the accident that occurred on the bus to him, it was caught on camera, an injury report was filled out, the incident reported to her employer and Petitioner was seen at Concentra the next day complaining of left shoulder pain. In addition, an MRI on 4/27/18, revealed a rotator cuff tear of the left shoulder. (Id.) In Dr. Tonino's notes he stated that the diagnosis did not present an exacerbation or temporary exacerbation of a pre-existing condition since no prior condition exists. In addition, he noted no significant pre-existing conditions. Based upon his review of the video of the incident, Dr. Tonino opined that the Petitioner's need for surgery was unrelated to the incident on the bus because the bus was stationary, Petitioner was stopped and was on the phone with the incident occurred, with no apparent incident involving her left shoulder. (R.X2, p2) Dr. Tonino also stated that a left shoulder arthroscopy with possible rotator cuff repair was reasonable, regardless of causation. He also stated that Petitioner was capable of returning to work light duty with no use of her left arm and modification of her work activities until she has recovered from a rotator cuff repair, following surgery. In addition, he noted that Petitioner was not at maximum medical improvement and that the typical recovery time was six to nine months after a rotator cuff surgery. (R.X2,p.2)

On November 26, 2018, Petitioner was examined by Dr. Diana Goldstein (hereinafter "Dr. Goldstein") at the request of the Respondent for an IME examination with regard to her psychological condition. Petitioner provided the history of the accident to Dr. Goldstein who noted that Petitioner was seen the next day after the incident at Concentra where she was diagnosed with "depressed mood, anxious, reports she was unable to sleep last night due to nightmares". In addition, there was a diagnosis of a left shoulder and left knee strain with a treatment plan of X-rays. (R.X3p.1) It was also noted that Petitioner was to return to work after follow-up and psychology referral – that patient was too distraught to return to work." (Id.) Dr. Goldstein also reviewed the Petitioner's PCE from April 13, 2018 that provided an initial psychiatric evaluation diagnosing Petitioner with "anxiety/panic attack/ptsd" with a follow-up on June 12, 2018. Dr. Goldstein reported that after testing and examination she was unable to definitively provide a current psychiatric diagnosis of Petitioner. (R.X3, p15-16) Dr. Goldstein opined that she saw no reason Petitioner could not return to work full time, in a position outside of bus operations, ideally with minimal interaction with the public. (Id.)

CONCLUSIONS OF LAW

Arbitrator's Credibility Assessment/Summary of Testimony:

The petitioner, Mrs. Vera Moses, was the only witness that testified at trial. The Arbitrator finds the overall testimony of Petitioner to be truthful, credible and otherwise unrebutted regarding her past medical history, mechanisms of injuries, course of medical treatment and current subjective complaints.

With respect to issue (F) whether the Petitioner's current condition of ill-being is causally related to the Injury, the Arbitrator finds as follows:

The Arbitrator adopts the above findings of fact in support of the conclusions of law and set forth below. The Arbitrator finds that the Petitioner proved by a preponderance of the evidence that her current condition of ill-being related to her shoulder is casually connected to her April 12, 2018 work accident.

With regard to her physical condition, Dr. Tonino opined that the Petitioner's mechanism of injury could not have caused a full-thickness rotator cuff tear. In contrast, Dr. Giannoulias noted that he also had an opportunity to look at that video and he noted that she did strike her left shoulder when she was turning away from the gunshot. (Pet. Ex. 2, P. 39). He also noted that there is no way to tell the exact amount of force that would cause a rotator cuff tear; however, it is plausible that a rotator cuff injury can occur after that kind of an injury with an eccentric contracture. Id. For that reason, Dr. Giannoulias opined that, given the fact that she claimed no pain in the shoulder and no difficulty with driving a bus prior to this incident and immediate shoulder pain afterwards, he would relate the incident to the rotator cuff if there is no other trauma noted. Id. The Arbitrator concurs. There is nothing in the record to indicate that the Petitioner suffered anything other than an acute injury to her left shoulder that resulted in a tear that is in need of surgical repair. The medical chronology that indicated an immediate need for an MRI of the left shoulder, coupled with all indications that the tear was acute lead the Arbitrator to conclude that the Petitioner's current state of ill being is causally related to the work accident of April 12, 2018.

With regard to the Petitioner's psychological condition, the Arbitrator concludes that the Petitioner is suffering post-traumatic stress disorder as a result of an acute and specific trauma in which, but for a few feet, or better aim, she may have been shot and killed while driving a bus for the Respondent. It is axiomatic that it has been consistently held that the Act should be liberally construed to accomplish its purposes and objects. (Board of Education v. Industrial Com., 53 Ill.2d 167; Zimmerman v. Industrial Com., 50 Ill.2d 346; McDonald v. Industrial Com., 39 Ill.2d 396.). Our Supreme Court has held broadly that the term "accident" is not "a technical legal term but encompasses anything that happens without design or an event which is unforeseen by the person to whom it happens" (International Harvester v. Industrial Com., 56 Ill.2d 84, 88), and that a psychological disability is not of itself non-compensable under the Workmen's Compensation Act (Allis Chalmers Manufacturing Co. v. Industrial Com., 57 Ill.2d 257, 262-63; City of Chicago v. Industrial Com., 59 Ill.2d 284, 287). In Pathfinder Co. v. Industrial Commission, the Supreme Court found that an employee who, suffers a sudden, severe emotional shock traceable to a definite time, place and cause, which causes psychological injury or harm has suffered an accident within the meaning of the Act, though no physical trauma or injury was sustained. Pathfinder Co. v. Industrial Com., 62 Ill. 2d 556, 563, 343 N.E.2d 913, 917 (1976).

In the matter before the Arbitrator, it is abundantly clear that being shot at by an assailant while operating a city bus that was mostly unable to move from the target zone constitutes a shock traceable to a

definite time, place and cause, which causes psychological injury or harm. The Petitioner has plainly established a causal link between her accident and her psychological condition. The Respondent has disputed the causal link between the accident and the condition, presumably based upon the holding espoused in Matlock v. Industrial Comm'n, 321 Ill. App. 3d 167, 171, 746 N.E.2d 751, 755 (1st Dist. 2001) that recovery for non-traumatically-induced mental disability is limited to those employees who can establish that: (1) the mental disorder arose in a situation of greater dimensions than the day-to-day emotional strain and tension which all employees must experience; (2) the conditions exist in reality, from an objective standpoint; and (3) the employment conditions, when compared with the nonemployment conditions, were the major contributing cause of mental disorder. Northwest Suburban Special Education Organization v. Industrial Comm'n, 312 Ill. App. 3d 783, 787, 728 N.E.2d 498, 501, 245 Ill. Dec. 416 (2000).

According the third prong noted above, the Respondent could put forth an argument based upon Dr. Goldstein's Section 12 examination that the Petitioner has a psychological disability, but that the work accident was one of the contributing causes, but not the major contributing cause of that disability. Specifically, Dr. Goldstein noted that because of concerns about exaggeration, and purported intervening experiences involving community gun violence that are unrelated directly to the initial bus incident (but may represent an exacerbation of original symptoms), it is not possible to definitively assess Ms. Moses' emotional status since June of 2018. (R.X. 3, P. 16). She was therefore unable to offer an opinion regarding MMI, but it was her opinion that the Petitioner's symptom status is sufficiently stable to support a return to work *outside of bus operations*. (R. X. 3, P. 16-17, emphasis added).

With regard to a return to work Dr. Goldstein was asked by the Respondent: Is claimant capable of working full duty? Please explain in detail. If restrictions are necessary for claimant to work, as directly related to the 11/03/16 [sic.] injury, please list specific restrictions and length of time that these restrictions should apply. Dr. Goldstein wrote that she saw no reason the Petitioner could not return to work full-time presently, *in a position outside of bus operations*, ideally with minimal interaction with the public. (R.X. 3, P. 16) Then, confusingly, she wrote the following in response to the Respondent's question regarding the claimant's extent of disability as it directly relates to the stress injury: I have not been provided a definition of disability. Id. However, I do not consider the Petitioner "disabled" from the standpoint of returning to work at the CTA. Id. It is her choice not to work in bus operations; she is not disabled per se from doing so, and is capable of working in other positions. (Id.)

From a legal standpoint, the notion that the causal link between the Petitioner's inability to return to driving the bus and her traumatic psychological injury is severed because there are multiple reasons that contribute to the Petitioner's state of mental ill-being is not grounded in the case law. The Arbitrator notes that Dr. Goldstein, when asked whether the Petitioner's diagnosis represents an aggravation or a temporary exacerbation of a pre-existing condition (i.e., a flare-up that has resolved to the pre-work injury baseline), opined that the Petitioner's current claimed symptoms are unrelated to a pre-existing condition, with the exception of irritability/agitation and the interpersonal conflicts Ms. Moses has reported, aspects of her functioning that are longstanding (R. X. 3, P. 15).

The Respondent also asked Dr. Goldstein if she felt that the claimant's current complaints were the direct and proximate result of the stress injury, or due to non-related factors. (R. X. 3, P. 16). Dr. Goldstein wrote that because malingering/partial malingering cannot be ruled out in the Petitioner's case, she was unable to provide a definitive current psychiatric diagnosis. (Id.) However, by all accounts, while the Petitioner's symptoms prior to June 2018 do not appear to have risen to the level of a psychiatric disorder, *they can reasonably be attributed to the 4/12/18 bus incident.* (Id.) She added that the self-reported exacerbation in symptoms after June 2018, relevant to a more recent/current diagnosis, is nonwork-related (e.g., exposure to

gun violence in the community). (Id.)

It is obvious to the Arbitrator that the Petitioner is suffering from a psychological condition that prevents her from returning to work as a bus driver. It is also clear that the source of the Petitioner's condition is multi-factorial; however, those factors all relate to gun violence. Those factors were all triggered by the Petitioner's incident on the bus. The idea that this incident was somehow "non-traumatic" so that an analysis of non-work-related factors contributing to the condition should be considered is rejected by the Arbitrator. The Arbitrator finds a direct causal link between the Petitioner's psychological state of ill-being and her traumatic work accident.

With respect to issue (J), whether the medical services provided to Petitioner were reasonable and necessary and whether Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds as follows:

The Arbitrator adopts the above findings of fact in support of the conclusions of law and set forth below. The Arbitrator finds that the medical services provided to the Petitioner were reasonable and necessary to cure his condition of ill-being related to her accident on April 12, 2018. Petitioner claims Respondent is liable for the following unpaid medical bills:

1) Illinois Orthopedic Network - $336.74
2) Midwest Specialty Pharmacy - $3,711.03
3) Neuropsychological Services - $4,850.00
4) Molecular Imaging - $2336.00

The Arbitrator notes that in Dr. Tonino's IME report from August 13, 2018, he noted that "regardless of causation, treatment for Petitioner's left shoulder has been reasonable and necessary and appropriate for her clinical condition and none of it has been excessive. (R.X2, p.2) Furthermore, Dr. Goldstein stated in her IME report that Dr. Jasinski's treatment was reasonable and necessary and had not been excessive. (R.X3, p.16) The Arbitrator finds Respondent responsible for the aforementioned medical expenses in the amount of $11,233.77 pursuant to the fee schedule.

With respect to issue (K), whether the Petitioner is entitled to Prospective Medical Care, the Arbitrator finds as follows:

The Arbitrator adopts the above findings of fact in support of the conclusions of law and set forth below. The Arbitrator finds Petitioner's current condition of ill-being relative to her left shoulder traumatic rotator cuff tear is causally related to her accident at work for Respondent on April 12, 2018. In result, the Arbitrator also finds that Petitioner is entitled to the recommended left shoulder rotator cuff repair and subacromial decompression due to the full thickness rotator cuff tear recommended by Dr. Giannoulias and Dr. Tonino. The Arbitrator bases her finding on the Petitioner's credible testimony related to his shoulder, the video of the accident admitted into evidence, Petitioner's prior medical records and history and from her treating physicians and Respondent's IME reports. Therefore, the Arbitrator orders that Respondent authorize and pay for the recommended left shoulder rotator cuff repair and subacromial decompression inguinal surgery for Petitioner's left shoulder.

With respect to issue (L), whether Petitioner is entitled to Temporary Total Disability Benefits from 4/13/18 through 10/17/18 representing 26/7 weeks or 4/13/18 through 9/6/18 representing 21 weeks, with respect to Maintenance, whether Petitioner is entitled to maintenance from 10/18/18 through 02/19/19, representing 17 6/7 weeks, the Arbitrator finds as follows:

The issue of whether the Petitioner is entitled to temporary total disability benefits is in dispute. Because the Arbitrator has found that the Petitioner's current state of ill-being with regard to her left shoulder is causally related to her accident the Arbitrator finds that from a physical standpoint, the Petitioner is unable to work full-duty as a bus operator. The Arbitrator also found that the Petitioner's psychological condition of PTSD is causally related to her work injury; however, the Arbitrator finds that because she is still in need of medical treatment to recover from her physical injuries, ongoing maintenance with regard to her psychological condition is not an issue that is ripe for adjudication at this time. Accordingly, the Arbitrator awards the 44 5/7 weeks of temporary total disability that accrued from April 13, 2018 through February 19, 2019. The Arbitrator notes that on the request for hearing form, the Petitioner had sought temporary total disability benefits through October 17, 2018, the date of Dr. Goldstein's examination, with a claim to maintenance benefits thereafter. However, a note was made on the form that clarifies that if the Arbitrator found a causal connection to the Petitioner's left shoulder, all benefits sought would be considered temporary total disability.

Signature of Arbitrator

07/ 30 /19
Date

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Nasrin S. Mousavi,
Petitioner,

vs.

NO: 17 WC 28975

Menzies Aviation,
Respondent.

20IWCC0353

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 28, 2019, is hereby affirmed and adopted.

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

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

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

20IWCC0353

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $69,800.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUN 26 2020
o052120
BNF/mw
045

Barbara N. Flores

Marc Parker

Dissent

I respectfully dissent from the Decision of the Majority. The Majority affirmed and adopted the Decision of the Arbitrator who found Petitioner sustained her burden of proving her stipulated accident caused the condition of ill-being of her right knee. The Arbitrator awarded Petitioner 73&2/7 weeks of TTD, $3,744.44 in current medical expenses, and ordered Respondent to authorize and pay for total knee replacement of the right knee. I would have found that Petitioner did not sustain her burden of proving the condition of ill-being of her right knee was caused by the stipulated accident, reversed the Decision of the Arbitrator, and denied compensation.

Petitioner sustained an injury to her right knee when she fell while at work on September 15, 2015. She testified that she was climbing up metal stairs, missed "around three" stairs, and struck her knee with the edge of the corner of each stair as she slipped. She did not testify that she twisted her knee in the fall. In addition, Petitioner did not mention that she twisted her knee in her accident report. She went to an Emergency Room on September 19th and reported she hit her shin on metal stairs. Petitioner was diagnosed with a knee contusion. In fact, it is unclear whether Petitioner actually reported she twisted her knee to any of her medical providers, at any time.

Petitioner continued to treat and an MRI taken on October 6, 2017 showed extensive degenerative arthritis and a meniscus tear. Dr. Sompalli, referred to Petitioner by her lawyer, recommended arthroscopic surgery. Petitioner then sought a second opinion from Dr. Silver, who was also referred to her by her lawyer. Dr. Silver noted that Petitioner "struck her right knee and twisted it as she struck her right knee." This statement is contrary to all the prior medical history, contrary to Petitioner's prior statements, and contrary to her testimony. Dr. Silver opined that her meniscus tear was causally related to her work accident and accelerated her pre-existing arthritic condition. Because she was at end-stage arthritis with bone-on-bone exposure, Dr. Silver recommended total knee replacement.

Respondent sent Petitioner to Dr. Vora for a medical examination under Section 12 of the Act. He testified by deposition that when he examined Petitioner, she reported that she sustained a direct impact of her knee but that she did not know whether she twisted it. Dr. Vora noted that the MRI showed advanced chronic varus-type arthritis in the right knee which was not related to her accident. Dr. Vora concluded that the severe arthritis was the cause of her meniscus tear, that the mechanism of injury was consistent with a contusion, and a contusion cannot aggravate arthritis to cause a meniscal tear.

I find that causation opinion of Dr. Vora more persuasive than that of Dr. Silver. First, Dr. Silver's assertion that she twisted her knee, a fundamental basis for his causation opinion, was contrary to all the other medical records. Second, Dr. Silver agreed that Petitioner had pre-existing bone-on-bone arthritis, which was the reason for his recommendation for knee replacement. Third, the MRI proved that Petitioner had severe pre-existing degenerative joint disease and did not reveal any acute changes to her knee. Based on discrepancies in the reported mechanism of injury, Petitioner's extensive pre-existing degenerative arthritis, and the relative persuasiveness of Dr. Vora versus Dr. Silver, I cannot find that Petitioner sustained her burden of proving her accident caused the current condition of ill-being of her right knee.

For the reasons stated above, I would have found that Petitioner did not sustain her burden of proving the condition of ill-being of her right knee was caused by the stipulated accident, reversed the Decision of the Arbitrator, and denied compensation. Therefore, I respectfully dissent from the Decision of the Majority.

O-4/16/20
DLS/dw
46

Deborah L. Simpson
Deborah L. Simpson

Contents

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

MOUSAVI, NASRIN S
Employee/Petitioner

Case# **17WC028975**

MENZIES AVIATION
Employer/Respondent

20IWCC0353

On 5/28/2019, 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 2.34% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5125 LAW OFFICES OF JOSEPH YOUNES
166 W WASHINGTON ST
SUITE 600
CHICAGO, IL 60602

0560 WIEDNER & McAULIFFE LTD
MARY C SABATINO
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Nasrin S. Mousavi
Employee/Petitioner

v.

Menzies Aviation
Employer/Respondent

Case # **17 WC 28975**

Consolidated cases:

20IWCC0353

An *Application for Adjustment 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 **2/27/19**. 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: Motion to Compel Settlement

20 IWCC0353

FINDINGS

On the date of accident, **9/15/17**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**13,205.03**; the average weekly wage was $**520.00**.

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

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

Respondent shall be given a credit of $**10,355.70** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**10,355.70**.

Respondent is entitled to a credit of $**6,110.83** under Section 8(j) of the Act for medical benefits. (AX1, §9)

ORDER

The Arbitrator finds that Petitioner's Motion to Compel settlement is denied.

Respondent shall pay Petitioner $**346.67**/week from **10/3/17** through **2/27/19**, which represents a period of **73-2/7** weeks, because Petitioner was temporarily totally disabled during this period, pursuant to Section 8(b) of the Act.

For the medication prescribed to Petitioner for her right knee condition by Dr. Silver through RX Development Associates, Respondent shall pay Petitioner $**3,744.44**, pursuant to Section 8(a) and subject to Section 8.2 of the Act.

Respondent shall authorize and pay for the right knee replacement surgery that Dr. Silver has recommended, 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

5-24-2019

Date

ICArbDec19(b)

MAY 28 2019

STATE OF ILLINOIS)
)
COUNTY OF COOK)

20IWCC0353

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Nasrin S. Mousavi
Employee/Petitioner

v. Case # **17 WC 28975**

Menzies Aviation
Employer/Respondent

Introduction:

Petitioner filed a 19(b) motion and Respondent filed a Request for Hearing motion. The parties completed the Request for Hearing, or Stipulation Sheet (AX1), in which they placed in dispute, *inter alia*, nature and extent of the injury, but not prospective medical care. However, based on his findings of fact and conclusions of law, the Arbitrator wrote this decision as a 19(b) decision.

Findings of Fact:

Nasrin S. Mousavi (hereinafter "Petitioner") is a 52-year-old Passenger Service Agent for Menzies Aviation (hereinafter "Respondent"). The parties stipulated that she sustained an accident on September 15, 2017. (AX1) Petitioner testified that her responsibilities as a Passenger Service Agent were to check documents, issue boarding passes, and, if necessary, welcome arriving guests from international flights. (T.34) Petitioner testified that she was hired in 2015. Petitioner testified that on the date of her accident, September 15, 2017, she was working at the ticket counter in Terminal 3 when her manager asked her to go to Terminal 5 for the arrival of an international flight. (T.35) Petitioner testified that she had come off the jet bridge and had descended the iron stairs that connected the jet bridge to the ground. When she was on the ground, her manager motioned to her that she needed to go back up the stairs and onto the jet bridge. At that point, Petitioner testified, "while rushing back up from that iron stairs,

I missed some stairs, and I falling down, this is the time I hurt my knee." She testified that she missed 3 stairs and hit her knee on the "[E]dge of the corner" of all 3 stairs but used the railing to stop herself from "going down further." (T.38-40) She testified she went "brink, brink, brink, down the stairs." (T.74)

At trial, Petitioner was asked to point to where the swelling was. The Arbitrator noted that Petitioner pointed to the middle of her lower leg between her ankle and her knee. (T.46)

On cross-examination, Petitioner testified that the pain she feels now is in the medial aspect of the right knee, that "it goes down there," and that the MRI report has shown it. (T.77-78)

Petitioner testified that she reported her injury and was able to finish her shift that day. (T.47)

RX16 is a handwritten statement that Petitioner completed on September 18 or 19, 2017 (RX16, T.76). The handwritten statement is signed and dated "September 2017" by Petitioner. In the statement, Petitioner wrote:

> "I was looking for one of my co-worker [sic] and while going down the stairs, I missed few [sic] and slip down (sic). Trying to stop myself from a big injury, I tried to hold the sides of the stairs but got hit by the stairs on my knee. It was not so painful at that time but when I went home, I started feeling more pain and saw that my leg was swollen from the knee." (RX16)

Petitioner confirmed on cross-examination that the handwritten statement was accurate and "sounds almost identical to" her testimony on direct examination. (T.76-77)

Petitioner testified that she first sought treatment at Elmhurst Memorial Hospital (T.48). Both PX1 and RX11 include the Emergency Department records from September 19, 2017, when Petitioner was first seen at Elmhurst Memorial Hospital. The Arbitrator notes that the earliest entry was recorded at 8:54 p.m. Jennifer Veliz, R.N., wrote the following Initial Assessment:

> "Hit lower right shin on metal stair at work (O'Hare Airport) on Friday and has had pain and swelling since." (RX11)

The next entry in ED Notes was made at 9:30 p.m. by Karen S. Peck, R.N., and stated the following:

"Pt. fell at work while walking up stairs. Pain to L lower leg and L knee. No open wound or deformity noted." (RX11)

At 11:04 p.m., Nurse Peck noted the following:

"Ace wrap applied and crutches given with return demonstration. D/c home per wheelchair. (RX11)

At 11:41 p.m., Ira L. Sender, M.D., and Jessica Peller, P.A., made the following entries:

"**History**

Patient presents with:

Lower Extremity Injury (musculoskeletal)

Stated Complaint: Pain from fall from 4 days ago

HPI

HPI: Nasrin Mousavi is a 52 year old female who presents with chief complaint of anterior right lower leg pain. Onset 4 days ago. Patient states that she hit her right shin on the edge of a metal stair while at work. Pain scale 8 out of 10. Pain described as aching. Patient states the pain is constant. Patient denies alleviating factors. Patient states pain worsens with weightbearing. Patient denies other injury, head/neck injury or pain, open wound, decreased range of motion, swelling, ecchymosis, erythema, weakness, paresthesias. ****

Physical Exam ****

Musculoskeletal: Right lower extremity-Right lower extremity normal to inspection without acute bony deformity. Mild tenderness to palpation along mid anterior right tibia. Distal pulses intact. Capillary refill normal. Motor intact distally. Sensory in-

tact distally. No ecchymosis. No erythema. No open wounds. Full range of motion of right lower extremity. No compartment syndrome. No edema. Remainder of musculoskeletal system is grossly intact. There is no obvious deformity.

Neurological: Gross motor movement is intact in all 4 extremities. Patient exhibits normal speech.

Skin: Skin is normal to inspection and palpation. Warm and dry. No obvious bruising. No obvious rash.

Differential diagnosis to include fracture vs. Strain/sprain v. contusion ****

MDM

Radiology findings: Xr Tibia + Fibula (2 Views), Right (cpt=73590)

Result Date: 9/19/2017

CONCLUSION: No acute disease.

Patient case discussed with and patient seen by Dr. Sender.

Physical exam remained stable over serial reexaminations as previously documented.

Disposition and Plan

Clinical Impression:

Contusion of right lower leg, initial encounter (primary encounter diagnosis)

Elevated blood pressure reading

Disposition:

Discharge" (RX11)

Dr. Sender prescribed Tramadol 50 mg. and Naproxen 500 mg. for pain.

On October 3, 2017, Petitioner and her attorney signed an Attorney Representation Agreement and filed an Application for Adjustment of Claim for this matter. Petitioner testified that her attorney referred her to Dr. Sompalli.

Petitioner testified that following her visit to the Emergency Department of Elmhurst Memorial Hospital, she came under the care of Chandrasekhar Sompalli, M.D., at Elite

Orthopedic & Sports Medicine. (T.57-58) Petitioner was seen for the first time by Dr. Sompalli on October 3, 2017. Dr. Sompalli recorded the following:

> "She said on the day, there was a plane coming, and she was trying to find someone to get the stairs for the plane. There was nobody there working, so she went down to find someone and she missed a couple of steps and banged her right knee onto the railing and twisted her knee. Since that time she had pain, swelling, locking and giving away. Especially painful at night. Sometimes it will get stuck and swell on her. She had been taking Naprosyn and no therapy. Does not smoke, drink or do drugs. She did not have an MRI and x-rays were negative for fracture." (PX4, p. 152)

Dr. Sompalli ordered an MRI of the right knee. His examination revealed 0-90° flexion/extension, positive McMurray's, medial joint line tenderness, effusion, and mild patellofemoral pain. Under "Assessment," Dr. Sompalli wrote that Petitioner had a twisting injury with missing two steps and banging her knee on the medial side. He further wrote that she "will definitely most likely has contusion (sic)" and that he was concerned whether she twisted her knee and had a meniscal tear. He took Petitioner off work for 4 weeks. (PX4, p. 152)

Petitioner testified that Dr. Sompalli "offered me to some place that I have to go for physical exercises and all that stuff' and that that place was "New Life." (T.59) The Arbitrator notes that at the time Petitioner was treating with Dr. Sompalli, she was also treating at New Life Chiropractic Center with a Dr. Pandya. (PX5, RX12, RX13)

On October 5, 2017, a staff member at New Life Medical Center completed a "WORKERS' COMPENSATION FORM" with Petitioner. The handwritten form states: "Patient was climbing up the stairs when she missed some steps hurting R knee. Stairs struck hit the R knee." (PX5, p. 247) In a "CHIROPRACTIC REGISTRATION AND HISTORY" form, which Petitioner completed that same day, Petitioner handwrote the following: "Injury to Knee Right and Swelling on Sheen (sic)." (PX13, p. 11) She also wrote that the symptoms appeared on "15th September late night." (Id.)

Petitioner signed an opt-out clause for New Life Medical Center, which indicated that she chose to opt out of her employer's Preferred Provider sponsored plan and exercise her right

under Illinois State Workers' Compensation Law to seek treatment at a clinic of her own choice – that being New Life Medical Center. (RX13, p. 14)

MR images of Petitioner's right knee were taken on October 6, 2017 at Edgebrook Radiology. Radiologist George G. Kuritza, M.D., offered the following impression of the images: (1) Small joint effusion (2) Medial meniscus tear involving the posterior horn and midbody region (3) Intact collateral and cruciate ligaments as well as lateral meniscus (4) The rest of the exam is unremarkable. (PX2, PX4, p. 157)

When Dr. Sompalli saw Petitioner on October 31, 2017, he reviewed the MRI study and advised Petitioner she had a complex right knee medial meniscus tear and that she needed a right knee scope partial meniscectomy. (PX4, p. 154) Dr. Sompalli specifically stated that the mechanism of injury with Petitioner bending her knee and then twisting her knee is the cause of the meniscal tear because prior to that, she was completely asymptomatic. Dr. Sompalli took Petitioner off work for 6 weeks. (Id.)

On December 12, 2014, Petitioner circled on the Lower Extremity Functional Index at New Life that she had "Extreme Difficulty or unable to perform activity" as it related to walking two blocks or walking a mile. (RX13, p. 449) However, 2 days later, the chiropractor at New Life noted that Petitioner walked for 4 hours at Home Depot and while grocery shopping. (RX13, p. 442)

At a follow-up visit with Dr. Sompalli on January 5, 2018, Petitioner reported she was still having symptoms but wanted to return to light-duty work. Accordingly, Dr. Sompalli released her to light duty at that time and stated she should follow up in 4 weeks, "at which time if she is still doing well, we will return her to full duty." (PX4, p. 155)

The final visit with Dr. Sompalli was February 16, 2018. On that date, Dr. Sompalli still recommended a right knee scope partial medial meniscectomy. Dr. Sompalli noted that Petitioner was taking 8 Advil a day, which was driving up her blood pressure. He advised her to discontinue all the anti-inflammatory medication and instead prescribed Tylenol No. 3 for pain. He wrote: "We will keep her off because the light duties are causing her more pain." (PX4, p. 156)

Petitioner testified she then came under the care of orthopedic surgeon Ronald L. Silver, M.D., who is associated with Orthopaedic Specialists of the North Shore, LLC. Petitioner's Exhibit 6 consists of the medical records from Dr. Silver's office, where she was seen by Dr.

Silver for the first time on June 21, 2018. Per the intake forms, Petitioner was referred there by her attorney. (PX6, p. 292) Dr. Silver authored a letter to Coventry on June 21, 2018 in which he stated that Petitioner worked in ramp service for Frontier Airlines on September 15, 2017 and as she was climbing up stairs, she slipped and struck her right knee "and twisted it as she struck her right knee." (PX6, p. 288) Dr. Silver opined Petitioner had sustained a torn medial meniscus due to the aforementioned work injury as well as an exacerbation and acceleration of pre-existing asymptomatic degenerative changes of her right knee. After seeing Petitioner just one time, he opined that she was "definitely a candidate for knee replacement due to this work injury" as she had allegedly lost the articular cartilage in the medial compartment resulting in a bone-on-bone situation. Dr. Silver prescribed a host of medications for Petitioner that day, which included a topical Diclofenac, topical Lidocaine, Terocin patches, Ultram, and Protonix for her GERD symptoms. He removed her entirely from work on that date. (PX6, p. 289)

Petitioner was seen a second time by Dr. Silver on August 28, 2018. He reiterated that she required a knee replacement due to the work injury. He once again prescribed the same set of medications that he did at her first visit. There was a nearly identical letter from October 9, 2018, wherein Dr. Silver once again refilled Petitioner's prescription medication and also reiterated that she is a candidate for total knee replacement. (PX6, p. 286)

Petitioner was seen a total of 3 times by Dr. Silver; however, he did author one more letter on January 10, 2019, which he addressed to the insurance adjuster. In such letter, Dr. Silver wrote:

> "I have personally reviewed the MRI films of Nasrin's right knee performed on October 6, 2017. There is no indication whatsoever of this medial meniscus tear being a degenerative tear and my findings are consistent with the MRI radiologists as well. To reiterate my letter of October 9, 2018, Nasrin's condition of ill-being with regard to her right knee is completely causally related to her work injury of September 15, 2017, which caused a medical (sic) meniscal tear and exacerbation and acceleration of pre-existing asymptomatic degenerative changes of the right knee resulting in a complete loss of the articular cartilage of the medial compartment with a bone-on-bone situation." (PX6, p. 285)

On July 6, 2018, Petitioner was seen by Anand M. Vora, M.D. for a Section 12 examination. The doctor testified Petitioner had been scheduled to be there on May 4, 2018. However, that examination did not take place. By history, Petitioner told Dr. Vora that she had injured herself when she hit her knee against the jet bridge stairs. She recalled a direct impact to the knee but did not know if she twisted it. (RX2, p. 33) Dr. Vora diagnosed Petitioner with a resolved right knee contusion. He felt Petitioner's severity of complaints were disproportionate to the objective findings and that the location of pain in Petitioner's knee was consistent with that of underlying pre-existing degenerative arthritis but that it would have no relationship to the work-related contusion of the knee. (RX2, p. 34) Dr. Vora opined the meniscus tear seen on the MRI had no relationship to the described work accident, as Petitioner had severe, advanced degenerative changes of the right knee in the medial compartment, which were nearly identical to those of the opposite knee. He felt those findings were consistent with that of varus knee arthritis, chronic in nature, and would not have been caused by the mechanism Petitioner described. (RX2, pp. 34-35) In support thereof, Dr. Vora explained that he had taken plain x-ray films of both knees, which revealed identical bilateral, severe, medial compartment varus knee arthrosis, consistent with that of chronic degenerative changes. (RX2, p. 35) He felt a meniscus tear was inconsistent with that of an acute injury and instead was chronic and degenerative in nature.

In an addendum report dated October 3, 2018, Dr. Vora explained that following his personal review of the MRI imaging studies of the right knee, he found that the meniscal tear referred to by Dr. Sompalli and Dr. Silver was solely degenerative in nature, as was evident from the degenerative diffuse changes about the knee. He specifically stated that no acute meniscal tear or other acute pathology existed. (RX4, p. 42)

The parties deposed Dr. Vora on January 7, 2019. Dr. Vora explained that he is a board-certified orthopedic surgeon, who underwent his medical education at Northwestern University followed by training at Johns Hopkins University. He has been in private practice at Illinois Bone & Joint Institute. (RX5, p. 52) Dr. Vora explained that in addition to practicing orthopedic surgery, he teaches and is the Fellowship Director at Midwestern University. He is also the consulting physician for the Joffrey Ballet, among other organizations. (RX5, p. 53)

Dr. Vora testified that he was initially scheduled to see Petitioner for an independent medical examination on May 4, 2018. However, he did not undertake his first examination of

her until July 6, 2018. (RX5, p. 54) In preparation for authoring causation opinions in this case, Dr. Vora reviewed Petitioner's job description, the complete records of Dr. Sompalli, the MRI imaging studies, records of Dr. Pandya, and records of Dr. Silver. (RX5, p. 55) Dr. Vora testified that the appropriate diagnosis for Petitioner was that of a resolved knee contusion. He said that after reviewing the MRI studies and bilateral X-rays, and after considering Petitioner's complete medical picture, he thought it was clear that the meniscal tear shown on the MRI was solely degenerative in nature and would have had no relationship to her described mechanism of injury. (RX5, p. 59) Accordingly, he opined, he could not agree with Dr. Sompalli's recommendation for a partial medial meniscectomy since Petitioner has end-stage degenerative arthritis in her knees, and a meniscectomy would not resolve any of her pain complaints. (RX5, p. 60)

Dr. Vora testified that on an objective basis, given the severe arthritis bilaterally in her knees, he finds it questionable that Petitioner did not have any limitations prior to September 15, 2017. (RX5, pp. 49-50)

When asked why the doctor could not say that Petitioner's work accident caused an aggravation, acceleration, or exacerbation of her right knee arthritis, he explained that there were 3 reasons for the same. The doctor testified: "So the arthritis was severe, at end stage, both knees. And a contusion can't aggravate that beyond its normal progression. So, number one, the mechanism. Number two, a meniscal tear does not occur by direct impact. It's a twisting injury where the cartilage tears. And it has very typical findings if acute as opposed to a degenerative. The third reason is a contusion does not aggravate arthritis, even temporarily." (RX5, p. 61) When asked for the reason that the total knee replacement, as recommended by Dr. Silver, could not be related to the accident, Dr. Vora similarly explained: "Same reason and rationale that we just mentioned. The degenerative arthritis that's present is bilateral, severe, medial compartment degenerative arthritic changes, degenerative tear of the medial meniscus, no acute changes, no exacerbation beyond the normal progression by any contusion." (RX5, p. 65) He further testified that twisting cannot cause a degenerative meniscal tear.

When asked how to determine whether the meniscus tear is acute or degenerative in nature, Dr. Vora explained that degenerative tears have a very specific pattern. "It's like a rope that unravels, for the Arbitrator's simplicity. If the rope unravels, we know it's degenerative. If it's a tear, it's a very clear-cut – acute meniscal tear, the rope will be intact or the cartilage layer will be intact and it will be like a paper cut that is very focal in the area. It's very easy to tell the

difference on an MRI." (RX5, p. 66) Dr. Vora testified that after the MR images of Petitioner's right knee were taken, "everyone concluded" that her meniscus tear was degenerative in nature. (RX5, pp. 66-67)

When asked about the problems she has with her knee in the course of her day, Petitioner testified:

"In the course of the day when I come up from the bedroom, my bedroom is upstairs, I just come up once in the morning and I'm not able to climb in the whole day again. I don't feel like doing that because it's too painful. When my knee structure bone hit with the - - rub with the bone, it's too painful. So I come down in the morning after my - - for my breakfast and even to do cooking I need a chair. I can't stand and do my cooking. I have a stool there, when I do the cooking I have to sit. I can't stand for more than half an hour, I can't do my groceries, my kids have to go and get it for me, everything I do; and for anything I go, I make sure I don't stand for more than half an hour, because it goes through this until the end and my foot starts swelling." (T.65)

Conclusions of Law:

In support of his decision regarding issue (O) "Motion to Compel Settlement," the Arbitrator finds as follows:

As a preliminary matter, the Arbitrator will begin by addressing Petitioner's Motion to Compel Settlement. The Arbitrator notes that Petitioner's Exhibit 9 is a copy of Petitioner's filed Motion to Compel. The Motion states that, on or about January 30, 2018, the insurance adjuster for Respondent, working at Gallagher Bassett, and Petitioner's Counsel were discussing possible resolution of this matter. The discussions took place before Respondent was represented by counsel. The settlement discussions culminated with the adjuster suggesting to Petitioner's Counsel that he draw up contracts for the adjuster's review and tender those. Exhibit B attached to Petitioner's Exhibit 9 is the first page of the proposed settlement contract before the Illinois Workers' Compensation Commission. Exhibit 1 of Respondent's Exhibit 6 (the response to the Motion to Compel) contains the complete proposed settlement contract which is absent any terms on the second page of the settlement under "terms of settlement." (RX 6, p. 375)

Also contained within the record are email exchanges between Petitioner's Counsel and

the Gallagher Bassett adjuster (see PX 7 and RX 15). The email exchange outlines settlement discussions taking place between the adjuster and the Petitioner's Counsel, which culminated with the Petitioner's Counsel asking the adjuster on February 8, 2018, "I need an answer. Do we have a deal?" (RX 15, p. 477) The next response given by the adjuster on February 8, 2018 is, "Younes [Petitioner's Counsel], Dobek [Respondent's Counsel] will be in touch with you to discuss further, due to sensitive nature of the language involved, our attorney will handle the contracts." (Words in brackets added.) (RX 15, p. 477) The Arbitrator notes that contracts were never tendered, and Petitioner's Counsel then brought this Motion to Compel/Enforce Settlement before the Illinois Workers' Compensation Commission.

In Petitioner's motion (PX 9), Petitioner does not cite to any Illinois Workers' Compensation cases in support of his opinion that settlement can and should be enforced based upon settlement discussions taking place. He offers general case law suggesting that in Illinois offer, acceptance, and consideration are the basic elements of a contract and that the parties in this case had an enforceable settlement based upon the alleged meeting of the minds.

The Arbitrator notes, however, that the Illinois Workers' Compensation Commission is an entity of its own, governed strictly by the Illinois Workers' Compensation Act and the Rules Governing Practice Before the Illinois Workers' Compensation Commission.

Section 10.1 of the Illinois Workers' Compensation Act states, in pertinent part, the following:

> "The parties, by agreement and with approval of an arbitrator or the Commission, may enter into a compromise lump sum settlement in either permanent total or permanent partial disability cases which prorates the lump sum settlement over the life expectancy of the injured worker."

Section 23 of the Illinois Workers' Compensation Act states, in pertinent part, the following:

> "No employee, personal representative, or beneficiary shall have power to waive any of the provisions of this Act in regard to the amount of compensation which may be payable to such employee, personal representative, or beneficiary hereunder

except after approval by the Commission and any employer, individually or by his agent, service company or insurance carrier who shall enter into any payment purporting to compromise or settle the compensation rights of an employee, personal representative, or beneficiary without first obtaining the approval of the Illinois Workers' Compensation Commission as aforesaid shall be barred from raising the defense of limitation in any proceedings subsequently brought by such employee, personal representative, or beneficiary."

"The language in Section 23 of the Act is clear in that no settlement purporting to settle the claims under the Act can be effective unless it is approved by the Commission." *Maxit, Inc. v. Van Cleve*, 231 Ill.2d 229, 239 (2008).

Section 9 of the Illinois Workers' Compensation Act addresses commutation of compensation to an equivalent lump sum. Such section states, in pertinent part, the following:

"Any employer or employee or beneficiary who shall desire to have such compensation, or any unpaid part thereof, paid in a lump sum, may petition the Commission, asking that such compensation be so paid. If, upon proper notice to the interested parties and a proper showing made before such Commission or any member thereof, it appears to the best interest of the parties that such compensation be so paid, the Commission may order the commutation of the compensation to an equivalent lump sum ...

Section 9070.10 (b) of the Rules Governing Practice Before the Illinois Workers' Compensation Commission states, in pertinent part, the following:

"Settlement Contract forms shall be completed in full and accompanied by an appropriate signed physician's report concerning the nature and extent and probable duration of the disability resulting from the alleged accident ..."

In further support, the IWCC Handbook on Workers' Compensation and Occupational Diseases, states, in pertinent part, the following:

> "If the employer and employee reach an agreement, they should write down the terms of their agreement on the Commission's *Settlement Contract* and present it for approval to the arbitrator assigned to the case. A settlement is not legally binding unless the Commission approves it." (AX2, p. 16)

It is undisputed that the second page of the contract never had terms outlined, was never signed by Respondent or its representative, and was not submitted to, nor approved by, the Commission. (T.29) Given the statutory nature of all proceedings before the Illinois Workers' Compensation Commission, the Arbitrator need not address Petitioner's argument of offer, acceptance, and consideration, nor his alleged meeting of the minds. That said, even if the Arbitrator wanted to entertain that argument, he would still find no meeting of the minds, as the settlement negotiations seemed to stall out when the Gallagher Bassett adjuster indicated that before any additional terms can be discussed, the employer's attorney needed to be involved.

Under the Illinois Workers' Compensation Commission, the requirements for approval of a settlement contract are clear. The terms must be on the appropriate Illinois Workers' Compensation Commission settlement form, signed by both parties, and approved by the Illinois Workers' Compensation Commission. The parties acknowledge that all those stipulations were not met. (T.29)

Assuming, *arguendo*, that the parties had presented the Arbitrator with completed and signed settlement contracts. Even in that case neither the Arbitrator nor a Commissioner could be compelled to approve the contract.

Sections 9070.40 (b) and (c) of the Rules Governing Practice Before the Illinois Workers' Compensation Commission address actions to be taken by the Commission in the event an arbitrator rejects a settlement contract.

Moreover, case law has addressed this issue:

Approval of a settlement contract on behalf of an injured workman is not a required ministerial act of the Industrial Commission but is a discretionary function of the Commission. *Hall v. Archer-Daniels-Midland Co.*, App. 4 Dist.1986, 96 Ill. Dec. 600, 142 Ill.App.3d 200, 491

N.E.2d 879, appeal allowed, reversed 120 Ill. Dec. 556, 122 Ill.2d 448, 524 N.E.2d 586.

Approval of a settlement between employer and injured employee was not a required ministerial act of the Commission, and writ of mandamus could not be used to compel Commission to approve the settlement. *People ex rel. PPG Industries, Inc. v. Schneiderman*, App. 4 Dist. 1981, 46 Ill. Dec. 906, 92 Ill.App.3d 546, 414 N.E.2d 1059.

Accordingly, as a threshold issue, Petitioner's Motion to Compel Settlement is denied.

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

On September 18 or 19, 2017, Petitioner authored a handwritten statement in which she wrote that while going *down* the stairs, she missed a few stairs, slipped down, and "got hit by the stairs on [her] knee." (Italics added) (RX16)

On the evening of September 19, 2017, which was 4 days post-accident, Petitioner first sought care in the Emergency Department of Elmhurst Memorial Hospital. There, she gave an initial history of striking her lower right shin on a metal stair at work on Friday. There is also a separate chart note in which she reports pain to her *left* lower leg and *left* knee after falling while walking *up* stairs at work. Upon examination by Dr. Sender, the Emergency Department physician, he found no ecchymosis, no erythema, no edema, no open wounds, no compartment syndrome, and a full range of motion of the right lower extremity. (RX11)

Petitioner then hired an attorney, who sent her to Dr. Sompalli, where she first reported that she also twisted her right knee during the September 15, 2017 accident. (PX4) She told Dr. Silver that she twisted her right knee during the September 15, 2017 accident. Dr. Silver formulated a causation opinion. (PX6)

When she first saw Dr. Vora, she told him that she did not know if she twisted her knee. (PX2) At trial, Petitioner made no mention of twisting her right knee when she missed 3 stairs on September 15, 2017.

Petitioner also reported to Dr. Sompalli that she banged her knee *on the medial side.* (PX4)

On December 14, 2017, the chiropractor at New Life noted that Petitioner walked for four hours at Home Depot and while grocery shopping. (RX13, p. 442) That, despite the fact that Petitioner marked on the December 12, 2017 Lower Extremity Functional Index at New Life that

she had "extreme difficulty or unable to perform activity" as it related to walking 2 blocks or walking a mile. (RX13, p. 449)

Dr. Vora testified that the tear Petitioner sustained was a degenerative tear, and that such tear has a very specific pattern that is like a rope that unravels: "If the rope unravels, we know it's degenerative." According to Dr. Vora, Petitioner's meniscal tear looked like a rope that had unraveled. (RX5)

Dr. Silver wrote that he reviewed the MRI films and his interpretation is consistent with that of the radiologist. (PX6)

Dr. Vora explained that he had taken plain x-rays of both knees that revealed identical bilateral severe medial compartment varus knee arthrosis, which is consistent with chronic degenerative changes. (RX2, p. 35) He felt that a meniscus tear was inconsistent with that of an acute injury and instead was chronic and degenerative in nature.

Notwithstanding evidence to the contrary, the Arbitrator finds that Petitioner's current condition of ill-being of her right leg is causally related to the accident of September 15, 2017.

Respondent has stipulated to accident.

The Arbitrator carefully considers Petitioner's testimony and the sequence of events.

Petitioner testified that the accident occurred on Friday, September 15, 2017, and that after it occurred, she limped back to the terminal and reported the injury to her manager. Her manager instructed Petitioner to take a 15-minute break. During the break, Petitioner noted that her right knee was red and swollen. Petitioner told her co-workers that she was feeling so much pain that she wished she could go home. Petitioner was able to finish the 2 hours left in her shift, but the pain in her right knee worsened at home that night. (T.43-45) She applied ice to her right knee and took Advil.

The next morning, Saturday, September 16, 2017, she noticed that her foot was totally swollen. At 7:45 a.m. that morning, Petitioner sent a text message to her manager stating that she was unable to come to work due to her injury. At the request of her manager, Petitioner completed a handwritten statement. (RX16)

No lay witnesses testified on behalf of Respondent.

Petitioner then commenced treatment for the injury to her right leg on the evening of September 19, 2017, in the Emergency Department of Elmhurst Memorial Hospital. Dr. Sender found mild tenderness to palpation along the mid anterior right tibia and noted that Petitioner's

pain worsens with weight bearing.

Subsequently, Petitioner treated for her right knee with Dr. Sompalli, Dr. Pandya/New Life Medical Center, and Dr. Silver.

Respondent argues that Petitioner merely sustained a contusion to her right leg and that the meniscal tear/degenerative condition of her right knee was unrelated to the accident. Yet, the medical records show that since the September 15, 2017 accident, Petitioner has had continuous complaints of pain in her right lower leg and knee.

Accordingly, the Arbitrator asks at what point did the contusion to Petitioner's right leg resolve and the symptoms from the tear of her right medial meniscus begin? Was it just a coincidence that her right medial meniscus "unraveled" after she struck her right leg on the iron stairs?

After reviewing x-rays of the knees, Dr. Vora opined Petitioner had identical bilateral severe, medial compartment varus knee arthrosis, consistent with that of chronic degenerative changes, in both knees.

Dr. Vora testified that on an objective basis, given the severe arthritis bilaterally in her knees, he finds it questionable that Petitioner did not have any limitations prior to September 15, 2017. (RX5, pp. 49-50)

Yet, the Arbitrator finds Dr. Vora's opinion to be speculative. Respondent produced no evidence, documentary or testimonial, that Petitioner's right knee was symptomatic or that it limited her activities before September 15, 2017. No witness, which would include any co-worker, testified that prior to September 15, 2017, he or she observed Petitioner walking with a limp or an antalgic gait or heard her complain of right knee pain.

Petitioner testified that prior to the accident, she had none of the problems with activities of daily living, which would include ascending the stairs. (T.66) Pre-accident, Petitioner was capable of performing the physical requirements of a Passenger Service Agent, which included standing for 8 hours a day. Petitioner testified that post-accident, she was unable to stand for 8 hours. In fact, when she attempted to return to work as a cashier at Thornton's Gas Station, she found that she was only able to stand for 3 hours at a time and, consequently, was unable to do that job.

It stands to reason, given the continuity of her complaints and given that she struck only the right leg on September 15, 2017, that Petitioner did more than just contuse her right, lower

leg on that date, but aggravated the degenerative condition of the right knee thereby causing it to become symptomatic.

Dr. Silver opined: "Nasrin's condition of ill-being with regard to her right knee is completely causally related to her work injury of September 15, 2017, which caused a medical (sic) meniscal tear and exacerbation and acceleration of pre-existing asymptomatic degenerative changes of the right knee resulting in a complete loss of the articular cartilage of the medial compartment with a bone-on-bone situation."

"When an employee with a preexisting condition is injured in the course of his employment, serious questions are raised about the genesis of the injury and the resulting disability. The Commission must decide whether there was an accidental injury which arose out of the employment, whether the accidental injury aggravated or accelerated the preexisting condition or whether the preexisting condition alone was the cause of the injury. Generally, these will be factual questions to be resolved by the Commission. However, the Commission's decision must be supported by the record and not based on mere speculation or conjecture. If there is an adequate basis for finding that an occupational activity aggravated or accelerated a preexisting condition, and thereby caused the disability, the Commission's award of compensation must be confirmed." *Sisbro, Inc. v. Indus. Comm'n*, 797 N.E.2d 665 (2003)

In support of his decision regarding 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:

Respondent put chain of referral at issue as a potential defense in this case. Petitioner signed a form from New Life Chiropractic/Dr. Pandya in which she opted out of her employer's Preferred Provider Program ("PPP") and acknowledged that Dr. Pandya was her one choice for medical care. However, this is a form that was created by New Life Medical Center. Respondent did not establish that they subscribed to a PPP. There is no evidence that Respondent, in writing and on a form promulgated by the Illinois Workers' Compensation Commission, informed Petitioner of a Preferred Provider Program, as is required in Section 8(a)(4)(B) of the Act.

With regard to the medication Petitioner took, in response to the question, "And so the only medication you have been taking is Advil for the last two years?", she testified "Yes, Advil

and I'm using a lot of Ben-Gay." (T. 79-80) However, Petitioner also testified that she stopped taking the medicine that Dr. Silver and Dr. Vora gave her because it was so strong and could affect her kidneys. (T.79) So, Dr. Silver continued to prescribe the pain medication that, by Petitioner's acknowledgment, she stopped taking.

The Arbitrator notes that PX 3 is a Patient Statement from RX Development Associates, which is an onsite pharmacy run out of Dr. Silver's office. Upon reviewing Petitioner's Exhibit 3, the Arbitrator finds that Respondent is only liable for payment of the first round of medications (Tramadol, Terocin patches, Protonix, Mobic) prescribed on June 22, 2018, which total $3,744.44, pursuant to Section 8(a) and subject to Section 8.2 of the Act. Petitioner stopped taking these medications and instead took Advil and Ben-Gay, which she apparently paid for out-of-pocket.

In this case, the Arbitrator has found Dr. Silver's opinions to be more persuasive than those of Dr. Vora. No utilization review opinion was offered.

In support of his decision regarding issue (K) "Is Petitioner entitled to any prospective medical care?", the Arbitrator finds as follows:

The Arbitrator finds that given Dr. Vora's opinion that a total knee replacement is appropriate (although not related), Dr. Silver's causation opinion and surgical recommendation, and Petitioner's persistent complaints of right knee pain coupled with her wish to undergo such surgery, the Arbitrator finds that the right knee replacement surgery is a reasonable and necessary medical procedure, pursuant to Section 8(a) of the Act. The Arbitrator orders Respondent to authorize and pay for such surgery subject to Section 8.2 of the Act.

In support of his decision regarding issue (L) "What temporary benefits are in dispute? TTD," the Arbitrator finds as follows:

The Arbitrator finds that Petitioner is entitled to TTD benefits from October 3, 2017 through February 27, 2019, which is a period representing 73-2/7 weeks. Respondent is entitled to a credit for TTD benefits paid in the amount of $10,355.70.

Petitioner was first taken off work Dr. Sompalli, and then by Dr. Silver.

The Arbitrator finds, in this case, that the opinions of Dr. Silver are more persuasive than those of Dr. Vora.

Respondent scheduled a Section 12 examination for Petitioner with Dr. Vora on May 4, 2018. Respondent notified Petitioner's Counsel of such examination in a letter dated March 27, 2018. (RX9) Petitioner failed to attend such examination but did attend the re-scheduled Section 12 exam on July 6, 2018. Between May 4, 2018 and July 6, 2018, there is no evidence that Petitioner's right knee condition improved or that Petitioner sustained an intervening injury to this body part.

In support of his decision regarding issue (M) "Should penalties or fees be imposed upon Respondent?", the Arbitrator finds as follows:

The Arbitrator finds that, given the inconsistencies in the accident histories and given Dr. Vora's testimony that Petitioner sustained a degenerative tear and not an acute tear of her right, medial meniscus, Respondent had a bone fide dispute as to causation. Therefore, the Arbitrator finds that penalties and attorney's fees are not warranted in this case.

Brian T. Cronin
Arbitrator

5-24-2019
Date

STATE OF ILLINOIS)
) SS.
COUNTY OF ROCK ISLAND)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Gary Paxton,
Petitioner,
vs.

NO: 17 WC 14737

Standard Forwarding,
Respondent.

20IWCC0354

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, 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 November 25, 2019, is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $7,900.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUN 26 2020
o060420
BNF/mw
045

Barbara N. Flores

Deborah L. Simpson

Deborah L. Simpson

Marc Parker

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

PAXTON, GARY Case# **17WC014737**
Employee/Petitioner

STANDARD FORWARDING
Employer/Respondent

20IWCC0354

On 11/25/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.54% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4134 VanDERGINST LAW PC
MICHAEL J GALVIN
4950 38TH AVE
MOLINE, IL 61265

2904 HENNESSY & ROACH PC
STEPHEN J KLYCEK
2501 CHATHAM RD SUITE 220
SPRINGFIELD, IL 62704

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
CORRECTED ARBITRATION DECISION

GARY PAXTON
Employee/Petitioner

v.

STANDARD FORWARDING
Employer/Respondent

Case # **17** WC **14737**

Consolidated cases: **N/A**

20IWCC0354

An *Application for Adjustment 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 **Rock Island**, on **October 10, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ 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 29, 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 $**44,200.00**; the average weekly wage was $**850.00**.

On the date of accident, Petitioner was **51** years of age, *married*, with **0** dependent children.

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

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

Respondent shall be given a credit of $**2,657,32** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**2,657.32**.

Respondent is entitled to a credit for any payments made pursuant to Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $566.67/week for 10 weeks, commencing 1/24/17 through 4/3/17, as provided in Section 8(b) of the Act.

Respondent shall pay all outstanding, related, reasonable and necessary medical services, as provided in Sections 8(a) and 8.2 of the Act and subject to the medical fee schedule directly to the medical providers. Respondent shall also reimburse Petitioner for any related medical expenses he paid out of pocket.

Respondent shall be given a credit for medical benefits that have been paid through group health insurance, will reimburse group health insurance for any related medical expenses it has paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $510.00/week for 47.5 weeks, because the injuries sustained caused the 12.5% % loss of each hand, as provided in Section 8(e) of the Act.

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

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

Signature of Arbitrator Gerald Granada

11/25/19
Date

NOV 25 2019

FINDINGS OF FACT

20IWCC0354

This case involves Petitioner Gary Paxton, who alleges to have been injured while working for Respondent Standard Forwarding on September 29, 2016. Respondent disputes Petitioner's claims with the issues being: 1) accident and causation; 2) medical expenses; 3) TTD; and 4) nature and extent.

Petitioner testified that he began working for Respondent in 2007 as a pickup and delivery driver. He described his job activities as driving a semi with a vibrating steering wheel; using a stick shift for 10 years; moving freight with a pallet jack which involved pumping up the pallet jack, then pushing or pulling with his hands in awkward positions; and manually operating dock plates - all of which required forceful gripping. He used a forklift to move freight but, when he was making deliveries, if the customer did not have a forklift, he mostly used a manual pallet jack that had to be pumped up with his hands. Within six months prior to seeing his personal physician he noticed the gradual onset of problems with his wrists, specifically numbness and tingling that would wake him at night. He noted numbness and tingling while performing his job duties. He described it as a lot of needles sticking in his hands.

When he saw his personal physician about his symptoms, she referred him to a specialist. Medical records of Dr. Nancy Short show that she saw the Petitioner on September 8, 2016 for bilateral hand complaints including numbness and tingling in his bilateral first three fingers and bilateral forearms for the past 1 to 2 months. He reported that it used to be only at night but was now night and day, worsening and more frequent. He gave a history of working as a truck driver and moving freight with pallet jacks all day. She referred him to an orthopedist. (Pet.Ex.#1).

On September 15, 2016 Petitioner saw Dr. Jason Clark, an orthopedist with ORA, with complaints of bilateral hand and upper extremity symptoms for the past 4 to 6 weeks. He reported working as a truck driver and was noticing increased pain when shifting gears and moving pallets. Dr. Clark's assessment was possible carpal tunnel syndrome, for which he referred Petitioner for EMG/NCV testing and prescribed nighttime splints. (Pet.Ex.#5, dep.ex#6a)

On September 29, 2016, the EMG/NCV testing performed by Dr. Brian Anseeuw revealed bilateral compressive neuropathies of both median nerves at the wrist, worse on the right (Pet.Ex.#2). When Petitioner returned to Dr. Clark on October 5, 2016 to discuss the test results, the doctor's assessment was bilateral carpal tunnel syndrome, right worse than left. He recommended corrective surgery. (Pet.Ex.#5,dep.ex.#6a) Dr. Clark performed a right carpal tunnel release on January 24, 2017 (Pet.Ex.#3a) and a left carpal tunnel release on Febuary 21, 2017 (Pet.Ex.#3b). Dr. Clark restricted the Petitioner from work January 24, 2017 and released him to full duty without restrictions as of April 4, 2017. (Pet.Ex.#5, dep.ex.#6c).

Dr. Jason Clark testified by evidence deposition on February 27, 2019. (Pet.Ex.#5) He is board-certified in orthopedic surgery, specializing in sports medicine and upper extremity reconstruction (Pet.Ex.#5,p.4) Dr. Clark opined that because Petitioner's occupation involves repetition and a lot of force with lifting a lot of weight throughout the day, involving awkward postures, as well as occasional vibration, in his opinion Petitioner's work environment contributed to his condition of bilateral carpal tunnel syndrome. (Pet.Ex.#5, p.8;dep.ex.#1) He testified at his deposition that his opinion is within a reasonable degree of medical certainty, greater than 51% (Pet.Ex.#5,p.8). He further explained that with carpal tunnel syndrome, whenever a job involves some repetitive gripping or flexion-extension of the wrist, that increases the pressure across the carpal canal and indirectly puts force across the median nerve and compresses it, whether that's directly or even by

20IWCC0354

some inflammation of the synovium, or lining of the tendons, that go through that canal with the nerve, which then crowds that canal and puts pressure on the nerve. Those activities such as lifting and cranking involve a repetitive motion to the wrist that he believes contributes to carpal tunnel syndrome. Dr. Clark further opined that carpal tunnel syndrome is a multifactorial condition, in that there are a lot of different things that contribute to somebody developing carpal tunnel syndrome and one of them is an activity factor. The patients that he sees who have carpal tunnel syndrome, if their activities are not repetitive, they do involve a lot of strength, such as lifting 70 pounds or 100 pounds. Even driving a truck, people place their hands differently on the steering wheel; sometimes the way a hand is placed on the wheel puts pressure across the carpal canal. (Pet.Ex #5,p.15). Dr. Clark opined that the Petitioner's work activities will be a factor in his condition given the fact that Petitioner is a driver who did some heavy, repetitive-type lifting activities throughout the day, and did work activities which involved repetitive wrist flexion-extension and gripping. (Pet.Ex.#5,p.16).

Dr. Clark agreed with Respondent's IME Dr. Crandall that the Petitioner's obesity could contribute to his increased chance of carpal tunnel syndrome and maybe the diabetes could also be a contributing factor, but neither is the sole factor. Dr. Clark's opinion was that Petitioner's job activity is also a contributing factor (Pet.Ex.#5,pp.16-17). He further indicated that, no matter the patient's pre-existing condition, there still has to be some activity related to the hand and wrist to help precipitate or be "the last straw that breaks the camel's back" for them to get carpal tunnel (Pet.Ex.#5,p.20).

In denying Petitioner's claim, Respondent relied upon the reports and deposition testimony of Dr. Evan Crandall, a board certified plastic surgeon, who performed a records review at the request of Respondent. In Dr. Crandall's opinion the Petitioner had insufficient physical activity for that to be an aggravating factor or cause of his carpal tunnel syndrome (Resp.Ex.#2,p.10). He stated in his September 15, 2017 report that in his opinion physical activity lifting or pulling less than 10,000 pounds per day does not cause or contribute to carpal tunnel syndrome (Pet.Ex.#5,dep.ex.#2). In his report dated October 15, 2017, Dr. Crandall responded to Respondent's attorney providing him with a WorkSTEPS ergonomic evaluation of the Petitioner's job and opining that the total amount of activities for the specific job requirements as indicated in the WorkSTEPS analysis would equal the effort expended in a 5 minute gym workout (Resp.Ex.#2,dep.ex.#3). Dr. Crandall opined that the Petitioner's conditions of hypertension, Type II diabetes and obesity are the cause of his carpal tunnel syndrome (Resp.Ex.#2,dep.ex.#3). Dr. Crandall testified that operating a truck, occasionally taking a pin out of the connection to the truck, occasionally moving a dolly, or vibration from the steering wheel would not be a contributory factor in the onset of carpal tunnel syndrome (Resp.Ex.#1,pp.17-18).

The WorkSTEPS job analysis for job specific testing classifies the Petitioner's job as Heavy; that it is essential that a candidate be able to (I) lift a 70 pound box from the floor, place it on a 40 inch height, and return it to the floor 3 times; (II) release a dock plate, grasping the handles of the pulleys to provide 65 pounds of vertical force; (III) move freight with a pallet jack requiring 80 pounds of force to push/pull; push a cart or sled requiring 80 pounds of force to move 25 feet, then pull it back to the starting position; (IV) generate 130 pounds of horizontal pull force using both hands; may brace one or both feet against a stationary object; (V) inspect trailers by positioning their body fully underneath a 39 inch height surface by stooping, crouching, duck walking or bending under; (VI) climb in and out of the trailer involving a 27 inch high step; (VII) closing a dock door by reaching up and grabbing with both hands pulleys with weights sufficient to provide 50 pounds of downward vertical force from 80 inches to 40 inches. (Pet.Ex.#5, dep.ex.#4). Respondent's representative acknowledged by signing said document on October 12, 2015 that valid physical requirements of the job were lifting/carrying 70 lbs occasionally (up to 33% of the time or up to 100 times per day), capability of a maximum

pushing force of 80 pounds, and a maximum pulling force of 130 pounds. (Pet.Ex.#5,dep.ex.#4).

David Lofgren testified for Respondent that in 2016 he worked as a dispatcher for Respondent, in which he was Petitioner's supervisor and gave him his daily job assignments. Lofgren reviewed the WorkSTEPS Authorization for Job Specific Testing (Pet.Ex.#5, dep.ex.#4) and confirmed that it listed the Petitioner's job duties for Respondent, and included some of the physical requirements of the Petitioner's job were to lift/carry 70# up to 33% of the time or up to 100 times per day; exert a pushing force of 80#; and a pulling force of 130# (Pet.Ex.#5,dep.ex.#4). Lofgren also reviewed the "Physical Duties" description on the Respondent's letterhead that listed the duties of a City Driver for Respondent, including but not limited to stretching, bending, twisting, pushing, pulling, lifting up to 100 lbs plus, 8 hours per day, 5 days per week, with possible overtime (Pet.Ex.#5,dep.ex.#5). He confirmed that that document described the Petitioner's job duties and that Petitioner's testimony regarding his job duties was fairly accurate.

Petitioner testified that he works for a different employer, doing the same type of work he had performed for Respondent and earning slightly more. He still has complaints of occasional pain in his hands when he bends his wrists and he has some loss of strength.

Petitioner processed his related medical bills through his group insurance with his union and paid $1,228.73 out of pocket. The parties stipulated on the record that neither party knows if Petitioner's group health insurance through his union has paid the medical bills. Additionally, while off work, Petitioner received $2,657.32 in group lost time benefits.

CONCLUSIONS OF LAW

1. With regard to the issues of accident and causation, the Arbitrator finds that the Petitioner has met his burden of proof. In support of this finding, the Arbitrator relies on the Petitioner's unrebutted testimony and the preponderance of the medical evidence that show Petitioner began experiencing problems with both hands that was ultimately diagnosed as bi-lateral carpal tunnel syndrome, which manifested on September 29, 2016 – the date Petitioner underwent the EMG/NCV testing confirming his condition. The evidence shows that Petitioner's accident was repetitive in nature and due to the Petitioner's work activities that included pumping up pallet jacks, pushing or pulling with his hands in awkward positions, manually operating dock plates - all of which required forceful grip. There was evidence that Petitioner had complaints of numbness and tingling in both hands while performing his work duties. Although Respondent's IME points to the fact that Petitioner had other factors, such as diabetes, hypertension, and obesity that would make him predisposed to carpal tunnel syndrome, there was no evidence to show that Petitioner had complaints of this condition prior to his employment with Respondent. The Arbitrator finds persuasive the testimony of Petitioner's treating physician, Dr. Clark, who acknowledged Petitioner's other conditions that could contribute to carpal tunnel syndrome, but explained that Petitioner's work activities were a contributing factor that helped precipitate the condition of carpal tunnel for Petitioner. And while Respondent's expert Dr. Crandall relied on the WorkSTEPS job analysis report to conclude that Petitioner's job did not cause his carpal tunnel syndrome, Dr. Crandall's conclusion that Petitioner's work "would equal the effort expended in a 5 minute gym workout" does not appear to reflect a fair or accurate understanding of Petitioner's actual job activities. Dr. Crandall did not have the benefit of asking Petitioner about his actual job duties. In comparison, Petitioner's treating physician, Dr. Clark focused on the amount of forceful gripping and awkward hand positions required in Petitioner's repetitive work activities. The Arbitrator notes that Respondent's witness David Lofgren was present during Petitioner's testimony and later testified that Petitioner's description of his job activities was accurate.

20IWCC0354

Based on the findings above, the Arbitrator concludes that the Petitioner sustained accidental injuries while working for the Respondent that manifested on September 29, 2016 when his bilateral carpal tunnel syndrome diagnosis was confirmed by diagnostic testing. The Arbitrator further finds that this condition arose out of and in the course of Petitioner's employment with Respondent.

2. Consistent with the Arbitrator's conclusions regarding the issues of accident and causation, the Arbitrator further finds that the Petitioner's treatment regarding his carpal tunnel syndrome was reasonable and necessary in addressing his work-related condition. As such, Respondent shall pay all outstanding, related, reasonable and necessary medical services, as provided in Sections 8(a) and 8.2 of the Act and subject to the medical fee schedule directly to the medical providers. Respondent shall be given a credit for medical benefits that have been paid through group health insurance, will reimburse group health insurance for any related medical expenses it has paid, and 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. Furthermore, Respondent shall reimburse Petitioner for any related medical expenses that he has paid out of pocket.

3. Based on the Arbitrator's conclusions above, the Arbitrator further finds that the Petitioner was temporarily totally disabled from January 24, 2017 through April 3, 2017. In support of this finding, the Arbitrator relies on the Petitioner's testimony and the medical evidence, which show that Petitioner's treating physician, Dr. Clark restricted the Petitioner from work during this time period commencing with the date of Petitioner's surgery, and released Petitioner to full duty without restrictions as of April 4, 2017. While off work Petitioner received $2,657.32 in group lost time benefits. Therefore, Respondent shall pay Petitioner temporary total disability benefits of $566.67/week for 10 weeks, commencing January 24, 2017 through April 3, 2017, as provided in Section 8(b) of the Act. Respondent shall receive a credit for any disability payments made to Petitioner for this lost time.

4. Regarding the issue of the nature and extent of Petitioner's injuries, the Arbitrator applies the factors set forth in Section 8.1b of the Act and notes the following: (i) no AMA rating was introduced into evidence, so the Arbitrator gives this factor no weight; (ii), Petitioner was a pickup and delivery driver who did return to a similar position following his work-injury, a factor to which the Arbitrator gives considerable weight; (iii) Petitioner was 51 years old at the time of injury, a factor to which the Arbitrator gives some weight; (iv) there was no evidence regarding future earnings and the Arbitrator gives no weight to this factor; (v), there was evidence of disability which show that the Petitioner sustained bilateral carpal tunnel syndrome that required surgical treatment resulting in Petitioner's current complaints of occasional pain and loss of strength in his hands – the Arbitrator gives great weight to this factor. Based on the factors above, the Arbitrator concludes the injuries sustained by Petitioner caused a 12.5% loss of each hand as provided in Section 8(e) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Isadore McKennie,

Petitioner,

vs. NO: 12 WC 38378

City of Chicago,

Respondent.

20IWCC0355

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 penalties and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 19, 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.

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

20IWCC0355

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 26 2020
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BNF/mw
045

Barbara N. Flores

Deborah L. Simpson

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

McKENNIE, ISADORE
Employee/Petitioner

Case# **12WC038378**
12WC033432

CITY OF CHICAGO
Employer/Respondent

20IWCC0355

On 7/19/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.10% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1759 MARTAY LAW OFFICE
WILLIAM H MARTAY
134 N LASALLE ST 9TH FL
CHICAGO, IL 60602

0010 CITY OF CHICAGO ASST CORP COUN
STEPHANIE LIPMAN
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Isadore McKennie
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **12** WC **38378**

Consolidated cases: **12 WC 33432**

20 IWCC0355

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Molly C. Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **6/14/17**. 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. X Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ What temporary benefits are in dispute?
☐ TPD ☒ Maintenance X TTD
L. ☒ 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 **10/30/12**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**38,995.06**; the average weekly wage was $**749.90**.

On the date of accident, Petitioner was **76** years of age, ***married*** with **0** dependent children.

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

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

Respondent shall be given a credit of $**32,997.39** for TTD, $**0** for TPD, $**83,993.25** for maintenance, and $**0** for other benefits, for a total credit of $**116,990.64**.

Respondent is entitled to a credit of $**13,133.76 (NAMMIL payments) and $227,885.45 (BC/BS payments)** under Section 8(j) of the Act, with Respondent holding Petitioner harmless against said payments. Arb Exh 2. PX 3.

ORDER

The parties agree Petitioner was temporarily totally disabled from October 31, 2012 through August 14, 2015. Arb Exh 1. The Arbitrator finds that Petitioner was also temporarily totally disabled from August 15, 2015 through June 23, 2016 (the date of the last injection, based on the records in evidence) and was entitled to maintenance thereafter from June 24, 2016 through the hearing of June 14, 2017. The Arbitrator finds Petitioner's weekly TTD and maintenance rate to be $499.94 based on the stipulated average weekly wage. Respondent is entitled to credit in the amount of $116,990.64, per the parties' stipulation, for the temporary total disability and maintenance benefits it paid. Arb Exh 1.

For the reasons set forth in the attached decision, the Arbitrator finds Respondent acted unreasonably and vexatiously in refusing to pay weekly benefits from March 16, 2017 through June 14, 2017, a period of 91 days or 13 weeks. The Arbitrator finds Respondent liable for $2,730.00 in Section 19(l) penalties, $3,249.61 in Section 19(k) penalties and $1,299.84 in Section 16 attorney fees.

Respondent shall pay Petitioner permanent partial disability benefits at the rate of $449.44 per week for a period of 225 weeks representing 45% loss of use of the 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.

Molly C Mason

Signature of Arbitrator

7/18/17
Date

JUL 19 2017

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Isadore McKennie,

Petitioner,

vs. NO: 12 WC 33432

City of Chicago,

Respondent.

20IWCC0356

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 penalties and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 19, 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.

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

20IWCC0356

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 26 2020
o061820
BNF/mw
045

Barbara N. Flores

Deborah L. Simpson

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

McKENNIE, ISADORE
Employee/Petitioner

Case# **12WC033432**

12WC038378

CITY OF CHICAO
Employer/Respondent

20IWCC0356

On 7/19/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.10% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1759 MARTAY LAW OFFICE
WILLIAM H MARTAY
134 N LASALLE ST 9TH FL
CHICAGO, IL 60602

0010 CITY OF CHICAGO ASST CORP COUN
STEPHANIE LIPMAN
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Isadore McKennie
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **12** WC **33432**

Consolidated cases: **12 WC 38378**

20IWCC0356

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Molly C. Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **6/14/17**. 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 _____

20IWCC0356

FINDINGS

On **8/17/12**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

For the reasons set forth in the attached decision, the Arbitrator finds Petitioner failed to establish a causal connection between his undisputed accident of August 17, 2012 and his current post-fusion condition of ill-being.

In the year preceding the injury, Petitioner earned $**38,995.06**; the average weekly wage was $**749.90**.

On the date of accident, Petitioner was **76** 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.

The parties stipulated Petitioner was temporarily totally disabled from August 17, 2012 through October 25, 2012, a period of 10 weeks. Arb Exh 1.

Respondent shall be given a credit of $**4,999.60** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**4,999.60**.

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

ORDER

THE ARBITRATOR AWARDS NO PERMANENCY BENEFITS IN THIS CASE. SEE THE DECISION IN 12 WC 38378 FOR THE ARBITRATOR'S PERMANENCY AWARD.

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

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

Molly C Mason

Signature of Arbitrator

7/18/17
Date

JUL 19 2017

Isadore McKennie v. City of Chicago
12 WC 33432 and 12 WC 38378 (consolidated)

Summary of Disputed Issues Relative to Both Cases

The parties agree Petitioner sustained injuries on August 17 [12 WC 33432] and October 30, 2012 [12 WC 38378], while working as a custodian for Respondent. Petitioner was 76 years old when these injuries occurred. He ultimately underwent a two-level lumbar fusion in August 2013. His surgeon released him to sedentary duty in accordance with a valid functional capacity evaluation performed in November 2015. On May 5, 2016, Respondent provided him with job search logs and directed him to begin looking for work. He continued receiving duty disability benefits until January 20, 2017, at which point Respondent asserted his job search was invalid.

In 12 WC 33432, the disputed issues include causal connection and nature and extent. Arb Exh 1. In 12 WC 38378, the disputed issues include causal connection, medical expenses, temporary total disability, maintenance, nature and extent and penalties/fees. Arb Exh 2.

Arbitrator's Findings of Fact

Petitioner testified he lives in Chicago. He is now 81 years old. T. 19. He finished tenth grade. He did not graduate from high school or attend college. His jobs have always involved physical labor. T. 26-27. He worked at E. J. Brach for 24 years before being hired by Respondent on May 16, 2001. T. 13-14. He passed a mandatory pre-employment physical examination before he began working for Respondent. He was hired as a custodian. His duties included mopping and waxing floors, removing garbage and shoveling snow. His job required lifting, bending and walking. T. 14-15.

Petitioner testified he performed full duty custodial work for Respondent until August 17, 2012. On that date, he injured his back while moving some tables. He testified he underwent treatment with physicians at MercyWorks and Dr. Wehner following this injury. [No records from these providers are in evidence.] He was off work from August 12 through October 25, 2012, at which point he resumed his custodian job. He testified he "did not feel too good" at that point. T. 15-16.

Petitioner testified he re-injured his lower back on October 30, 2012, when he lifted a full mop bucket. T. 16. He identified PX 1 as his report concerning this accident. In this report, he indicated he lifted a full mop bucket while working at a library on October 30, 2012 and felt "a very sharp pain in [his] lower back that radiated down both legs."

Petitioner testified that, following the October 30, 2012 accident, he began a course of treatment at Elmhurst Primary Care Associates. Records in PX 2 reflect Petitioner actually underwent care at Elmhurst Memorial Hospital's Emergency Room on October 30, 2012 and did not go to Elmhurst Memorial Primary Care Associates until the following day. Petitioner

underwent lumbar spine X-rays and a thoracic spine MRI at the Emergency Room. The reports concerning these studies are not in evidence. The Emergency Room physician prescribed Valium and Tramadol and directed Petitioner to follow up with Dr. Stevens. PX 2. On October 31, 2012, Dr. Stevens noted that Petitioner complained of 8/10 low back pain secondary to lifting a bucket of water and had undergone X-rays at the Emergency Room the preceding day. Dr. Stevens described the X-rays as negative for fracture. After examining Petitioner, he prescribed Norco, Mobic and a Prednisone taper. He imposed a 20-pound lifting restriction and referred Petitioner to Dr. O'Connor, an orthopedic surgeon. A referral form in PX 2 describes Petitioner's "primary insurance" as Coventry Workcomp.

Petitioner first saw Dr. O'Connor on November 6, 2012. In his note of that date, the doctor recorded a consistent history of the two work accidents. He noted complaints of low back pain radiating into the buttocks and posterior thighs along with numbness in both legs. He also noted that Petitioner had previously undergone back surgery in the early 1980s. He described Petitioner as "in obvious distress" and exhibiting a slow, somewhat forward flexed gait. On examination, he noted diminished sensation diffusely over the left leg, positive passive straight leg raising bilaterally, left worse than right, exquisite tenderness in the sciatic notch and lumbar spine and moderate paraspinal spasm. He described Petitioner's symptoms as "suggestive of a large central disc herniation." He prescribed a lumbar spine MRI and continued medication. He found Petitioner unable to work secondary to the back injury. PX 5, pp. 13-14/25.

The lumbar spine MRI, performed without contrast on November 7, 2012, showed a previous right-sided laminectomy at L5-S1, degenerative desiccation at several disc space levels, mild multi-level degenerative spondylosis, a central disc protrusion at L4-L5 "with a question of a small superimposed central disc herniation," a left lateral disc herniation at the same level and a central annular tear at L5-S1 with a "small residual or recurrent right paracentral disc herniation with mild partial effacement of the right descending S1 nerve root." PX 5.

Petitioner returned to Dr. Stevens on November 17, 2012 and reported some relief from the Norco. The doctor reviewed the MRI, continued the Mobic and Norco and directed Petitioner to stay off work and follow up with Dr. O'Connor. PX 2.

On December 14, 2012, Dr. O'Connor prescribed physical therapy and epidural steroid injections. PX 5.

On January 9, 2013, Petitioner underwent transforaminal epidural steroid injections on the left at L4-L5 and on the right at L5-S1. Dr. Belavic administered these injections. He noted a history of both work accidents in his report. PX 5.

At Respondent's request, Petitioner underwent a Section 12 examination by Dr. An of Midwest Orthopaedics on February 5, 2013. In his report of that date, Dr. An recorded a consistent history of both work accidents. He noted current complaints of low back pain

radiating down both legs posteriorly. He also noted that Petitioner had undergone back surgery in the early 1980s but had done well for many years thereafter.

On examination, Dr. An noted tenderness to palpation in the L5-S1 area, a limited range of motion and no abnormal neurologic findings.

Dr. An found Petitioner's history to be "consistent with the injury to the low back" with a pre-existing diagnosis of disc degeneration. He viewed the injury as aggravating the underlying degenerative condition. He recommended non-narcotic medication and six more weeks of therapy. He found Petitioner capable of restricted work with no lifting over 20 pounds and no frequent bending or twisting. He anticipated that Petitioner would be able to resume full duty in six weeks but conceded there was a "small chance" that Petitioner would not improve significantly and might have residual permanent back pain. He indicated he would recommend a functional capacity evaluation "for permanent restrictions" if this proved to be the case. He did not recommend any type of surgery. Resp Group Exh 1.

On February 8, 2013, Petitioner saw Dr. Hennessy, Dr. O'Connor's partner. The doctor recorded a history of the two work accidents and subsequent care. He also recorded a history of a right L5-S1 discectomy in 1981. He indicated that Petitioner reported fully recovering from that surgery and having no back pain thereafter until August 2012. He noted that Petitioner denied any relief from a recent epidural injection. He described Petitioner as walking without an assistive device but moving very slowly. He interpreted the MRI as showing degenerative disc disease at L5-S1 and a small bulge at L4-L5. He recommended an EMG/NCV. PX 5.

Petitioner underwent the recommended EMG and nerve conduction studies on February 28, 2013. Dr. Kim, a physiatrist, performed these studies. He noted a history of an L5-S1 discectomy in 1981. He also noted a history of work accidents in August and October 2012. He indicated that Petitioner complained of back and bilateral leg pain for which he was taking Norco.

Dr. Kim described the EMG/NCV results as abnormal. He noted electrodiagnostic evidence of bilateral sensory neuropathy and bilateral mild chronic L4 to S1 radiculopathy in the lower extremities. PX 5.

On March 8, 2013, Dr. Hennessy reviewed the EMG/NCV results and indicated Petitioner would likely need an L5-S1 laminectomy and fusion. He noted that Petitioner wanted to try conservative care first. He prescribed Norco and physical therapy. PX 5.

Petitioner underwent physical therapy at Elmhurst Memorial Hospital between April 2 and May 16, 2013. The discharge summary of May 16, 2013 reflects Petitioner felt worse and complained of severe spasms and radiating leg symptoms. PX 5, 7.

On April 19, 2013, Dr. Hennessy noted that Petitioner was now using a cane and seemed worse rather than better. He again broached the subject of surgery but noted Petitioner wanted to try more therapy. He prescribed six more weeks of therapy along with X-rays. PX 5.

On May 13, 2013, Dr. Hennessy discussed the details of the proposed surgery with Petitioner and his son. He recommended a discogram "pending approval by workers' compensation." PX 5.

On May 20, 2013, Petitioner saw Dr. Gurevicius at Elmhurst Memorial Hospital's Pain Center. The doctor noted that Petitioner reported doing well following a 1980 lumbar fusion "until eight months ago, while moving heavy tables." He described Petitioner as receiving no relief from an epidural injection performed in January. He indicated Petitioner was walking with a cane with a right leg limp. On examination, he noted positive straight leg raising bilaterally. He agreed with Dr. Hennessy's recommendation of discography. PX 5.

Petitioner underwent a CT discogram at L3-L4 and L4-L5 on May 31, 2013. The CT scan showed Grade 1 anterior spondylolisthesis at L5 relative to S1 secondary to pars defects on the right at L5 with sclerotic/stress response on the left side. PX 5.

On May 3, 2013, Dr. Hennessy noted some inconsistencies in the discogram results but nevertheless recommended a laminectomy and fusion at L4 to S1. He indicated Petitioner might need a repeat MRI "once WC issues [are] cleared up." PX 5.

At Respondent's request, Dr. An re-examined Petitioner on June 18, 2013. He noted that Petitioner described his condition as worsening after the February examination. He also noted the discogram results. On re-examination, he noted significant tenderness to palpation in the L4-L5 and L5-S1 region and paraspinal muscles, along with a "quite limited" range of motion. He again recommended conservative care, with "better pain management", including facet injections, possible rhizotomy, anti-inflammatory medication and non-narcotic analgesics. At one point in his report, he found Petitioner unable to work "because of his significant pain." He later indicated Petitioner could perform sedentary duty with no lifting over 15 pounds and no frequent bending or twisting. With respect to the recommended fusion, he commented that the outcome of such a surgery "is not predictable" for Petitioner. Resp Group Exh 1.

Dr. Hennessy operated on Petitioner's back on August 8, 2013, performing a laminectomy, foraminotomy and fusion with instrumentation from L4 to the sacrum. T. 17. In his operative report, he noted scarring due to a prior right L5-S1 laminotomy. After debriding the scar tissue, he performed a TLIF at the left L5-S1 and a bilateral PLIF at L4-L5, inserting cages, rods and pedicle screws. He prescribed a brace and bone stimulator at discharge. PX 5.

At the initial post-operative visits in August, September and October 2013, Dr. Hennessy noted significant improvement, indicating Petitioner was no longer confined to a wheelchair. On December 27, 2013, he described Petitioner as reporting a "little setback" but noted Petitioner was continuing to walk on his own. He obtained repeat lumbar spine X-rays, which

demonstrated a solid fusion and no loosening of the hardware. He prescribed Mobic, refilled the Norco and recommended that Petitioner stay off work and continue attending therapy. PX 5.

On February 7, 2014, Dr. Hennessy recommended additional therapy and continued to keep Petitioner off work. PX 5.

On May 23, 2014, Dr. Hennessy prescribed a four-week course of work conditioning, to be followed by a functional capacity evaluation. He released Petitioner to light duty. PX 5.

On May 27, 2014, Petitioner's counsel sent Dr. Hennessy's May 23, 2014 records to Respondent's counsel and requested ongoing payment of temporary total disability benefits. PX 5.

On July 25, 2014, Dr. Hennessy continued the light duty restriction and recommended eight more weeks of work conditioning. PX 5.

On July 28, 2014, Petitioner's counsel sent Dr. Hennessy's July 25, 2014 note to Respondent's counsel. In his cover letter, Petitioner's counsel requested the ongoing payment of benefits "unless the City can provide restricted work." PX 5.

On August 15, 2014, Dr. Hennessy placed work conditioning on hold and took Petitioner off work due to regression. He recommended a lumbar spine CT scan and MRI, to be performed with and without contrast. PX 5.

On August 18, 2014, Petitioner's counsel sent Dr. Hennessy's August 15, 2014 records to Respondent's counsel. Petitioner's counsel requested authorization of the recommended studies and ongoing payment of temporary total disability benefits. PX 5.

On September 19, 2014, Dr. Hennessy recommended a pain management consultation and directed Petitioner to remain off work. PX 5.

On October 1, 2014, Petitioner's counsel sent Dr. Hennessy's note to Respondent's counsel. He requested that Respondent authorize the pain management consultation and continue to pay weekly benefits. PX 5.

On December 19, 2014, Dr. Hennessy again recommended a pain management consultation. He continued to keep Petitioner off work. PX 5.

On December 22, 2014, Petitioner's counsel sent Dr. Hennessy's December 19, 2014 note to Respondent's counsel. He requested authorization of the consultation and ongoing payment of benefits. PX 5.

On February 9, 2015, Dr. Katzovitz, Petitioner's internist, noted that Petitioner was still taking Gabapentin for moderate low back pain but felt the medication was making him drowsy. She adjusted his dosage. PX 9.

On March 6 and May 11, 2015, Dr. Hennessy directed Petitioner to remain off work and undergo sacroiliac injections. Petitioner's counsel requested authorization of these injections via letter on May 12, 2015. PX 5. [It appears Petitioner underwent these injections but no records are in evidence.]

At Respondent's request, Dr. An examined Petitioner a third time on August 14, 2015. He noted ongoing complaints of back pain radiating into the right buttock and down the right leg, despite the surgery and subsequent care. He noted that Petitioner recently underwent sacroiliac injections "which did not help."

On re-examination, Dr. An noted a well-healed surgical incision, some tenderness to palpation in the lumbosacral region, particularly on the right side, and a limited range of motion. He reviewed post-operative imaging studies. He indicated these studies showed good positioning of the screws and "good decompression without any evidence of hematoma."

Dr. An found Petitioner's diagnoses to be "consistent with multi-level lumbar spondylosis and spondylolisthesis, which are all pre-existing findings." He described the status of the fusion as "not certain," based on the imaging studies he reviewed. He recommended flexion-extension X-rays and a lumbar spine CT scan to better evaluate the fusion and the positioning of the pedicle screws. He indicated Petitioner could undergo a functional capacity evaluation to set permanent restrictions if these studies did not reveal any problems. He addressed permanency as follows: "I do believe that [Petitioner] will have some permanent partial disability due to his condition and chronicity of his pain." Resp Group Exh 1.

At Dr. Hennessy's recommendation, Petitioner underwent flexion-extension X-rays on September 25, 2015. The interpreting radiologist noted post-operative changes, considerable demineralization of L5 and no subluxation during flexion and extension. PX 5.

On October 19, 2015, Dr. Hennessy directed Petitioner to remain off work and undergo a pain management consultation, followed by a functional capacity evaluation. PX 5.

Petitioner underwent a functional capacity evaluation at Midwest Physical Therapy Center on November 19, 2015. T. 18. The evaluator noted that Petitioner reported 30% improvement after the fusion and was still experiencing back and bilateral leg pain ranging from 5/10 to 7-8/10 for which he was taking Norco. The evaluator also noted that Petitioner was using a cane and reported being unable to tolerate more than brief intervals of walking and sitting before requiring a position change.

The evaluator noted Petitioner's age (79). He described Petitioner as cooperative but "limited during the examination by pain." He indicated Petitioner complained of 9/10 pain with

limited material handling and that "safety issues were raised which would preclude him from safely performing his work duties." He found Petitioner capable of only sedentary work and unable to resume his former medium physical demand level job. The last sentence of his report reads as follows: "The client cannot safely return to his work duties." PX 4.

On January 8, 2016, Dr. Katzovitz noted that Petitioner had undergone three injections and was "now recommended to have nerve stimulator." She indicated Petitioner was considering this recommendation. PX 9.

On April 25, 2016, Dr. Katzovitz issued a note addressed "to whom it may concern," indicating that Petitioner was under her care for failed back syndrome, was "unable to stand for prolonged periods" or lift/push/pull any significant weight, and would be unable to work for "at least the next six months." [See attachment to PX 6,]

On May 5, 2016, Rebecca Strisko, Deputy Commissioner of Respondent's human resources division [hereafter "Strisko"], wrote to Petitioner, informing him that, per the Act, he was required to actively look for gainful employment "in order to continue receiving disability benefits." Strisko enclosed job logs. She directed Petitioner to "complete at least 10 job searches each week" and submit those logs in person on a weekly basis to an "injury on duty manager" based at 30 North LaSalle Street. Strisko also enclosed a "request for reasonable accommodation" form. She informed Petitioner that completion of this form was strictly voluntary. [See attachment to PX 6.]

On May 25, 2016, Petitioner's counsel sent a letter to Respondent's counsel, Strisko and a representative of Respondent's Committee on Finance, referencing Strisko's May 5th letter. Petitioner's counsel indicated that, in his view, the completion of job logs did not constitute vocational rehabilitation. He indicated that formal rehabilitation efforts should begin, given Petitioner's advanced age and sedentary duty restrictions. [See attachment to PX 6.]

On June 23, 2016, Petitioner underwent an injection. A note attached to PX 6 reflects that Dr. Brennan administered this injection and directed Petitioner to remain off work. Petitioner continued obtaining medication from Dr. Katzovitz thereafter.

On April 7, 24 and 28, 2017, Petitioner's counsel wrote to Respondent's counsel, enclosing updated job search logs and requesting a response to his demand for the reinstatement of weekly benefits. He indicated he planned to obtain a trial date on May 8, 2017. [See attachment to PX 6.]

On May 3, 2017, Petitioner's counsel filed a "Petition for Legal Fee and Penalties," alleging that Respondent wrongfully discontinued the payment of benefits in February 2017, despite the transmission of job logs and medical records.

On May 12, 2017, Dr. Katzovitz noted that Petitioner continued to take Meloxicam, Gabapentin and Tramadol (as needed) for chronic lower back pain. PX 9.

Petitioner testified Respondent never offered him sedentary duty or vocational rehabilitation. He never met with a vocational counselor. He received a letter from Respondent directing him to complete and turn in job logs. He regularly turned in these logs (PX 8) until June 9, 2017. T. 19. [The logs in PX 8 list employers (contacted almost exclusively via telephone) on March 16, 2017, March 23, 2017, April 6, 2017, April 20, 2017, April 28, 2017, May 12, 2017, May 19, 2017, May 26, 2017, June 2, 2017 and June 9, 2017.] Respondent stopped paying him duty disability benefits as of January 20, 2017. He has not retired. He is still employed by Respondent. He has received no benefits from Respondent since January 21, 2017. T. 20. He receives regular Social Security and Medicare benefits. T. 20.

Petitioner testified he is no longer engaged in active care such as physical therapy. He sees his personal care physician every three months for medication refills. T. 22. His back feels stiff and tired. When he gets up from a seated position, he must stand for a bit before beginning to move. His legs give out when he walks. T. 25. He takes medication for his symptoms and performs home exercises that Dr. Hennessy prescribed. T. 23.

Petitioner denied undergoing any surgery since his August 2013 lumbar fusion. T. 23. He has not sustained any injuries to his back since October 30, 2012. T. 23-24.

Petitioner testified that Blue Cross/Blue Shield paid the bills relating to his fusion. He does not want to have to repay Blue Cross/Blue Shield. T. 24.

Under cross-examination, Petitioner testified he injured his lower back at work in approximately 1980. He underwent surgery following that injury. He has not injured his back since the accident of October 30, 2012. T. 28-29. He ran the costs associated with his fusion through his HMO. He presented his HMO card to his primary care doctor. He did not go through workers' compensation. T. 29-30. He did not advise Respondent's workers' compensation adjusters of his fusion. T. 30. He is eligible to draw pension benefits from Respondent but has not applied for these benefits. He has not applied to Respondent for ordinary disability, either. T. 31. He never requested vocational rehabilitation. Nor did he ask to undergo computer training. T. 31. He has never asked Respondent for ADA accommodations. T. 31. His job logs from March and April 2017 indicate he looked for custodial positions. He signed these job logs. The logs reflect the employers he contacted were not hiring. T. 33. He cannot physically perform custodial work but he "was going to try it." T. 34. He was "looking for anything [he] could get paid on." T. 34. He did not apply to any employers who were seeking to hire someone. T. 35. He found job leads in the newspaper. He did not look for jobs in person. T. 36. He spent a couple of hours per day going through the Tribune, Times and RedEye, checking the job ads. T. 37-38. When he called the numbers listed in the ads, the employers asked him questions. When he told hem his age, they told him they were not hiring. T. 39. He does not have a computer at home. He has not thought about going to the public library to take computer classes. T. 39. He did not look for work in his neighborhood. T. 39.

On redirect, Petitioner reiterated that no vocational counselor offered him assistance. He looked at "help wanted" ads in the newspaper. No one hired him due to his age. T. 40.

No witnesses testified on behalf of Respondent. Respondent's documentary evidence consisted of Dr. An's three reports and a letter of July 21, 2015 indicating Petitioner failed to appear for an examination on that date. Resp Group Exhibit 1.

Arbitrator's Credibility Assessment

Petitioner came across as hard-working and believable. He was 65 years old when Respondent hired him in May 2001. He successfully performed custodial duties for about eleven years before his undisputed accidents in 2012.

Respondent's examiner, Dr. An, noted no symptom magnification. In his last report, Dr. An found it likely Petitioner would have "some permanent partial disability due to his condition and the chronicity of his pain." Resp Group Exhibit 1.

Petitioner's functional capacity evaluation was valid.

Arbitrator's Conclusions of Law Relative to Both Cases

In 12 WC 33432, did Petitioner establish a causal connection between his undisputed accident of August 17, 2012 and his current condition of ill-being?

Petitioner's testimony concerning his August 17, 2012 accident and subsequent treatment was credible but not supported by medical records. Petitioner did not offer any records from MercyWorks or Dr. Wehner. Petitioner acknowledged resuming full duty about five days before his second accident of October 30, 2012 but testified he did not feel good at that point. There is no evidence indicating that additional care was pending when Petitioner returned to full duty.

On this very limited record, the Arbitrator is unable to find that Petitioner established a causal connection between the August 17, 2012 accident and his current, post-fusion condition of ill-being. The fusion did not take place until 2013 and there is no evidence indicating a physician prescribed an MRI or broached the subject of surgery before the accident of October 30, 2012.

In 12 WC 38378, did Petitioner establish a causal connection between his undisputed work accident of October 30, 2012 and his current lumbar spine condition of ill-being?

In 12 WC 38378, the Arbitrator finds that Petitioner established a causal connection between his undisputed lifting-related accident of October 30, 2012 and his current post-fusion condition of ill-being. In so finding, the Arbitrator relies on the following: 1) the fact that Petitioner worked as a custodian for Respondent between 2001 and the accident (with the

exception of the period Petitioner was off work following his earlier accident of August 17, 2012; 2) Petitioner's credible description of the mechanism of injury; 3) the accident report of October 30, 2012 (PX 1), which reflects Petitioner began experiencing low back and bilateral leg pain after lifting a bucket that was full of water; 4) the histories recorded by Drs. Stevens, O'Connor, Hennessy and An; 5) Dr. Hennessy's and Dr. An's comments that Petitioner reported doing well for many years following his earlier back surgery, which took place in approximately 1980 or 1981; and 6) Petitioner's credible denial of any new back injuries after October 30, 2012. While Dr. An viewed Petitioner's spondylolisthesis as a pre-existing condition, he conceded in his first report that the accident aggravated this condition. Resp Group Exhibit 1.

In 12 WC 38378, is Petitioner entitled to medical expenses?

Petitioner placed medical in dispute in 12 WC 38378 but did not claim any unpaid expenses. Petitioner offered into evidence print-outs of amounts paid by NAMMIL ($13,204.82) and Blue Cross/Blue Shield ($230,788.10). PX 3. The parties agree Respondent is entitled to Section 8(j) credit for medical expenses paid by its group carrier. They did not agree as to a specific amount of credit. T. 5. Respondent disputes liability for medical expenses as well as Petitioner's request that he be held harmless against the payments made.

The Arbitrator finds Petitioner's treatment in 12 WC 38378, including the surgery performed by Dr. Hennessy, to be reasonable, necessary and causally related to the October 30, 2012 work accident. The surgery followed a long course of ultimately unhelpful conservative care. Dr. An had reservations about the surgery but did not deem it unreasonable. He simply indicated the outcome was "not predictable." Resp Group Exhibit 1. No surgical outcome is certain and, in fact, Petitioner initially had a good response.

The Arbitrator, having reviewed PX 3, notes that one of the NAMMIL payments, in the amount of $71.06, and one of the Blue Cross/Blue Shield payments, in the amount of $2,902.55, relate to Emergency Room care rendered on August 17, 2012, in connection with the first case, 12 WC 33432. Petitioner did not claim medical expenses or a hold harmless agreement in that case. The remaining payments clearly relate to care rendered after the second accident, which is the subject of 12 WC 38378. In 12 WC 38378, the Arbitrator finds that Respondent is entitled to Section 8(j) credit for the NAMMIL payments of $13,133.76 and the Blue Cross/Blue Shield payments of $227,885.45, with Respondent holding Petitioner harmless against said payments.

In 12 WC 38378, is Petitioner entitled to temporary total disability benefits from October 31, 2012 through October 16, 2015 and maintenance benefits from October 17, 2015 through the hearing of June 14, 2017? Is Respondent liable for penalties and fees for failing to pay weekly benefits from January 20, 2017 through the hearing?

In 12 WC 38378, the parties agree Petitioner was temporarily totally disabled from October 31, 2012 (the day after the undisputed accident) through August 14, 2015 (the date of Dr. An's last examination). Petitioner claims additional temporary total disability through

October 16, 2015 and maintenance from October 17, 2015 through the hearing of June 14, 2017. Arb Exh 2.

Respondent relies on Dr. An in arguing that Petitioner is not entitled to temporary total disability benefits after August 14, 2015. That reliance is misplaced. Dr. An did not find Petitioner to be at maximum medical improvement as of August 14, 2015. Instead, he prescribed flexion-extension X-rays and a lumbar spine CT scan to rule out arthrosis or problems with the spinal implant. He also recommended that Petitioner undergo a functional capacity evaluation if these studies revealed no problems. Resp Group Exhibit 1. Petitioner underwent the X-rays on September 25, 2015 and the evaluation on November 19, 2015. Records in PX 9 reflect Petitioner underwent additional back-related care, including injections, thereafter and was considering a spinal cord stimulator as of January 2016.

Based on the available treatment records, the Arbitrator finds that Petitioner's causally related lumbar spine condition stabilized on June 23, 2016. This appears to be the date on which Petitioner last underwent active care in the form of an injection. PX 6. Petitioner has continued to undergo medication management with his internist since then. PX 9.

The Arbitrator also finds that Petitioner is entitled to maintenance from June 24, 2016 through the hearing of June 14, 2017. Petitioner's job search efforts during this period were less than perfect but he faced the following significant barriers to re-employment: advanced age (81 as of the hearing), limited education (tenth grade), narrow work history, sedentary duty restriction and chronic leg and back pain. At no point in time did Respondent offer to help him get past those barriers. Petitioner was not legally obligated to request vocational rehabilitation to be entitled to maintenance (see Roper Contracting v. Industrial Commission, 349 Ill.App.3d 500 (5th Dist. 2004)), but did so, through his attorney, on May 25, 2016. There is no evidence Respondent responded to this request. Respondent failed to conduct a vocational assessment, as required by the Commission rules. See Ameritech Services, Inc. v. IWCC, 389 Ill.App.3d 191, 207 (1st Dist. 2009).

Based on the job logs and communications in PX 6 and PX 8, the Arbitrator further finds that Respondent is liable for penalties and fees based on its failure to pay benefits from March 16, 2017 through June 14, 2017. This is a period of 91 days or 13 weeks. The Arbitrator views Respondent's conduct in failing to pay benefits during this period as unreasonable and vexatious. Respondent's expectation (expressed during cross-examination) that Petitioner walk the streets to canvass prospective employers was not logical. Nor was it consistent with its examiner's finding of a chronic pain condition or its directive of May 5, 2016, which said nothing about job contacts having to be in person. The Arbitrator finds Respondent liable for Section 19(l) penalties in the amount of $2,730.00 ($30/day x 91 days), Section 19(k) penalties in the amount of $3,249.61 (50% of the $6,499.22 in benefits awarded from March 16, 2017 through June 14, 2017) and $1,299.84 in Section 16 attorney fees (20% of $6,499.22).

18WC02943

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

Demetrius Jackson,
Petitioner,
vs.

NO: 18 WC 02943

Harvard Janitorial Service,
Respondent.

20IWCC0357

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 5, 2019, is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $56,600.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

JUN 26 2020

DATED:
o061820
BNF/mw
045

Barbara N. Flores

Deborah L. Simpson

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

JACKSON, DEMETRIUS
Employee/Petitioner

Case# **18WC002943**

HARVARD JANITORIAL SERVICE
Employer/Respondent

20IWCC0357

On 3/5/2019, 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:

0579 FRIEDMAN & SOLMOR LTD
GARY B FRIEDMAN
200 N LASALLE ST SUITE 2750
CHICAGO, IL 60601

5001 GAIDO & FINTZEN
PETER HAVIGHORST
30 N LASALLE ST SUITE 3010
CHICAGO, IL 60602

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

DEMETRIUS JACKSON,
Employee/Petitioner

v.

HARVARD JANITORIAL SERVICE,
Employer/Respondent

Case # **18** WC **2943**

Consolidated cases: _____

20 IWCC0357

An *Application for Adjustment 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 **January 4, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **January 25, 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 $**31,150.60**; the average weekly wage was $**599.05**.

On the date of accident, Petitioner was **48** years of age, ***married*** with **2** dependent children.

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

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

Respondent shall be given a credit of $**2,225.06** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**2,225.06**.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $399.37/week for 5-4/7th weeks, commencing 1-26-18 through 3-5-18, as provided in Section (8(b) of the Act. Respondent shall receive credit for TTD it paid in the amount of $2,225.06.

Respondent shall pay reasonable and necessary medical services of $36,270.94, as found in Petitioner's exhibits 1-13, and as provided in Section 8(a) and 8.2 of the Act. Respondent shall receive credit for all amounts paid to or on behalf of Petitioner regarding payment of medical expenses.

Petitioner shall have and receive from Respondent the further sum of $359.43/week for a period of 50 weeks, as the injuries sustained caused the permanent partial disability to Petitioner to the extent of 10% 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.

Robert M. Harris

Signature of Arbitrator Robert M. Harris

March 5, 2019
Date

File No. 19773
Firm No. 579

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DEMETRIUS JACKSON,

Petitioner

V

NO. 18 WC 2943

HARVARD JANITORIAL SERVICE,

Respondent

STATEMENT OF FACTS

Petitioner, DEMETRIUS JACKSON, age 38, had been employed by Respondent, HARVARD JANITORIAL SERVICE, for six years doing maintenance work (Tr. 8-9). His duties included: cleaning Respondent's entire building inside and out; cleaning washrooms; emptying garbage cans; and general maintenance and housekeeping (Tr. 8-9). Before January 25, 2018, Petitioner's right shoulder and lower back were feeling fine, and he was working full duty (Tr. 9-10).

On January 25, 2018, at approximately 11:15 a.m., Petitioner testified he was mopping the men's washroom on the fifth floor when he slipped and fell hitting his right shoulder on the door frame as he fell to the washroom floor (Tr. 10-11). When his shoulder hit the door frame, Petitioner heard a "pop" (Tr. 10-11). While remaining on the washroom floor, feeling intense pain in his right shoulder, Petitioner called security (Tr. 11). Security arrived in the washroom, and an ambulance was called to the scene (Tr. 12). Fire department paramedics removed Petitioner on a gurney, and he was taken by ambulance to Alexian Brothers Hospital in Elk Grove Village (Tr. 12-13).

In the emergency room at Alexian Brothers Hospital, Petitioner told the emergency personnel that he was injured at work, and he told them that he slipped while washing a bathroom floor injuring his shoulder (Tr. 13, Pet. ex. 1). After examination and

x-rays at the hospital, Petitioner was discharged wearing a sling and was admonished to avoid pushing, pulling and use of his right arm (Tr. 13 -14, Pet. ex. 1). After discharge from the hospital, Petitioner remained at home for three or four days experiencing pain in both his right shoulder and lower back (Tr. 15). While at home, he took Advil, applied ice, and remained in bed as he addressed the continued pain in his right shoulder and lower back (Tr.15). Then, on January 29, 2018, Petitioner began receiving care and treatment from an orthopedist, Dr. Christos Giannoulias, at Illinois Orthopedic Network (Tr. 15, Pet. ex. 3). When first seen by Dr. Giannoulias on January 29, Petitioner related that he was injured at work while mopping a floor, and he slipped and fell injuring his right shoulder and lower back (Tr. 16, Pet. ex. 3). After exam and noting Petitioner's pain at 10/10, Dr. Giannoulis ordered an MRI of Petitioner's right shoulder, and he recommended that Petitioner undergo physical therapy (Tr. 16, Pet. ex 3). The right shoulder MRI was performed at Advantage MRI on February 8, 2018 (Pet. ex. 10). Physical therapy was performed at Fullerton Drake Medical Center from January 31, 2018 to June 30, 2018, and Petitioner received the therapy three times per week for both his right shoulder and his lower back (Tr. 16-17, Pet. ex. 5).

After review of the right shoulder MRI, Dr. Giannoulias recommended and referred Petitioner to orthopaedic surgeon Dr. Kevin Koutsky (Tr. 17-18, Pet. ex. 3). When first seen by Dr. Koutsky on March 2, 2018, Petitioner told the doctor he had slipped and fell at work injuring his right shoulder and back (Tr. 18, Pet. ex. 3). In his initial evaluation of Petitioner on March 2, 2018, Dr. Koutsky noted lower back pain with radiation to his buttocks and thighs as well as right shoulder pain (Pet. ex. 3). Also at this visit with Dr. Koutsky, his review of the right shoulder MRI revealed: tendinitis of the rotator cuff; a partial thickness tear of the rotator cuff; and some evidence of a bony contusion in the distal clavicle (Tr. 19, Pet ex 3 & 10). Dr. Koutsky recommended that Petitioner continue

with physical therapy, and he recommended that Petitioner undergo a lumbar MRI (Tr. 10, Pet. ex. 3). Dr. Koutsky also recommended a prescription (Tr. 19-20, Pet. ex. 3).

In addition, Dr. Koutsky injected Petitioner's right shoulder with Kenalog in an effort to reduce Petitioner's right shoulder pain and discomfort (Tr. 19, Pet. ex. 3). With Dr. Koutsky's order, Petitioner underwent a lumbar MRI on March 10, 2018 (Tr. 20, Pet. ex. 12). When seen again by Dr. Koutsky on March 16, 2018, Petitioner advised Dr. Koutsky that the prior shoulder injection actually helped reduce the shoulder pain (Tr. 20, Pet. ex. 3). Further, Dr. Koutsky reviewed the lumbar MRI and noted: some desiccation at L4-L5 with a focal left paracentral protrusion causing foraminal stenosis; and at L5-S1 a diffuse disc protrusion which is more left paracentral causing some foraminal narrowing (Pet. ex. 3 & 12). Dr. Koutsky further noted L4-L5 and L5-S1 radiculopathy and right shoulder impingement (Pet. ex. 3). Again, Dr. Koutsky recommended that Petitioner continue physical therapy, continue the use of medication and indicated the possibility that Petitioner may need to undergo a lumbar injection (Tr. 20-21, Pet. ex 3). Petitioner was then referred by Dr. Koutsky to a pain specialist also at Illinois Orthopedic Network (Tr. 21, Pet. ex. 3).

On March 29, 2018, Petitioner saw pain specialist, Krishna Chunduri, at the referral of Dr. Koutsky (Tr. 21, Pet. ex. 3). When first seen by Dr. Chunduri on March 29, 2018, Petitioner complained of pain in his lower back and right shoulder with back pain radiating into the back of his legs. The history was pain experienced after an injury at work on January 25, 2018, when Petitioner slipped while mopping twisting his lower back and slamming his right shoulder in a door frame. (Tr. 21, Pet. ex. 3). Petitioner also told Dr. Chunduri of his emergency care at Alexian Brothers Hospital and his care and treatment with Dr. Giannoulias and Dr. Koutsky.

On March 29, 2018, Dr. Chunduri examined Petitioner and reviewed Petitioner's lumbar MRI (Tr. 22, Pet. ex. 3 & 12). Dr. Chunduri noted the lumbar MRI revealed a 3mm disk protrusion at L4-L5 with an annular tear resulting in some mild foraminal stenosis

and 1mm protrusion at L5-S1 with some mild foraminal stenosis (Pet. ex. 3). Dr. Chunduri further indicated a diagnosis of lumbar spondylosis with bilateral radiculitis and right shoulder pain (Pet. ex. 3). Dr. Chunduri recommended and Petitioner then underwent a lumbar transforaminal epidural steroid injection under anesthesia on April 5, 2018 (Tr. 22, Pet. ex. 3).

Upon follow-up with Dr. Chunduri on May 3, 2018, the doctor noted the epidural steroid injection had helped and Petitioner's lower back was feeling better (Tr. 22-21, Pet. ex. 3).

Petitioner concluded his medical care and treatment for his claimed accident and injury on May 25, 2018, with Dr. Koutsky (Tr. 23, Pet. ex. 3). When last seen by Dr. Koutsky on May 25, 2018, Petitioner's right shoulder pain was noted as 5/10 (Pet. ex. 3).

Petitioner was off from work at the direction of his treating physicians from January 26, 2018 through March 5, 2018, and during this period the Respondent paid and Petitioner received the sum of $2,225.00 in TTD (Tr. 23, Pet. ex. 3, Resp. ex.1, and Arb. ex. 1). Upon his return to work on March 6, 2018, Petitioner returned to work on light duty (Tr. 23-24). Then, on May 3, 2018, Petitioner discontinued light duty, and he undertook his regular duties for Respondent (Tr. 24).

While Petitioner continues to work for Respondent up to the present time, Petitioner testified that as a result of continuing pain and discomfort in both his right shoulder and lower back, he is limited at work, and he avoids lifting heavy objects and performs only light work up to the present time (Tr. 26-27). Now, at home, Petitioner performs limited duties avoiding heavy lifting due to continued pain and discomfort in his right shoulder and lower back (Tr. 27).

Since his last visit with Dr. Koutsky on May 25, 2018, up to the present time, Petitioner testified his right shoulder is not the same as before his claimed accident and injury on January 25, 2018 (Tr. 25). Petitioner's right shoulder remains painful up to the present time, and he needs to use Advil and rest the shoulder in efforts to eliminate the

continued pain and discomfort in it (Tr. 25). Petitioner's lower back remains painful up to the present time, and he also uses Advil and rest for the continued lower back pain and discomfort (Tr. 25-26).

While receiving care and treatment from Dr. Giannoulias, Dr. Koutsky, and Dr. Chunduri, Petitioner was provided with therapeutic equipment from G & U Orthopedic that included: an ultrasound unit and supplies; a tens unit and supplies; a home therapy exercise kit, and an arm sling (Tr. 24). Petitioner has incurred medical expenses from various medical providers as he was recovering from injuries sustained in the claimed accident and injury of January 25, 2018 as follows:

Alexian Brothers Medical Center	$899.81	(Pet. ex. 2)
Illinois Orthopaedic Network	$6,716.12	(Pet. ex. 4)
Fullerton Drake Medical Center	$9,940.00	(Pet. ex. 6)
Metro Anesthesia	$1,961.15	(Pet. ex. 7)
Midwest Specialty Pharmacy	$5,379.22	(Pet. ex. 8)
G & U Orthopedic	$5,917.00	(Pet. ex. 9)
G & U Orthopedic	$1,221.64	(Pet. ex. 9)
Advantage MRI	$1,750.00	(Pet. ex.11)
Molecular Imaging	$2.486.00	(Pet. ex.13)
TOTAL MEDICAL EXPENSES:	$36,270.94	

CONCLUSIONS OF LAW

ISSUE C. ACCIDENT

Based on a review of the entire record, the Arbitrator finds and concludes **Petitioner proved by a preponderance of the credible evidence he sustained accidental injuries arising out of and in the course of his employment with Respondent on January 25, 2018 regarding both his right shoulder and lumbar spine/low back.**

In support of the Arbitrator's findings regarding this issue, the Arbitrator finds Petitioner was a credible witness and the records in evidence sufficiently (albeit not perfectly) corroborate his testimony. The gist of Respondent's argument Petitioner's claims is based on an attack of his credibility. The Arbitrator does not find this persuasive.

Respondent argued against finding that Petitioner injured his low back in part on an argument that Petitioner's histories to his various medical providers indicate Petitioner's "penchant for stating different versions of the mechanism of injury"; however, the Arbitrator finds this to be a weak argument, as all of the cited "different versions" actually corroborate each other in their essential history of the mechanism of injury; that is, all indicate a similar history and essentially agreeing components of the injury. This is seen as follows: Three of the four histories cited indicate Petitioner being in the bathroom; three of the four indicate a history of "slipping"; all four indicate a history of hitting his shoulder against the door; one notes also hitting the right side of his body and one notes twisting his back. **These histories are sufficiently similar in what is important to support** the position that an accident occurred on January 25, 2018 involving Petitioner's right shoulder **and** back. The Arbitrator therefore does not agree with Respondent's argument that "different accounts exist for each practitioner" has any meaningful consequence as indicated in this claim.

Further, Respondent raises an additional argument/point to attack Petitioner's credibility that is erroneous; Respondent asserts, "Finally, Petitioner testified that he had filed no other workers' compensation claims when the IWCC's records indicate Mr. Jackson settled a prior 2006 claim (case no. 06WC44367)" citing to page 32 of the trial transcript. First, this case number is not found in the record and was not an exhibit and therefore it is questionable whether evidence not in the record should be cited here; nonetheless, Respondent's assertion is erroneous. Petitioner clearly did **not** testify he filed **no** prior workers' compensation claim – to the contrary, pages 31-32 of the transcript reveal Petitioner was asked, "Have you ever had any other workers' comp lawsuits" and

Petitioner answered, **"There were one..." That answer demonstrates he was truthful**. Further, Petitioner was then asked, "And my question to you would be to find out if there are any other claims that you had that would have brought up an injury similar to the one that you have now" and Petitioner answered, "No." This answer was also truthful (and unrebutted) because Petitioner's prior filed case involved his right hand, a fact Respondent did not mention. Lastly, Respondent asked Petitioner, "And do you have any other personal injury lawsuits in the past 10 years that would have involved your back or your shoulder?" and Petitioner answered, "No." This was never rebutted.

Lastly, in this same approach, the Arbitrator does not find it significant that Petitioner did not amend his Application for Adjustment of Claim to add the lower back injury.

Petitioner's uncontradicted testimony was that on January 25, 2018, at approximately 11:15 a.m., he was mopping the men's washroom on the fifth floor of the Respondent's premises when he slipped and fell hitting his right shoulder on the door frame as he fell to the washroom floor (Tr. 10-11). At the time of this occurrence, Petitioner was performing his regular duties of maintenance that he had been doing for Respondent for the last six years (Tr. 8-9). There is no real dispute or controversy here – other than arguing over discrepancies in inconsequential details - and Respondent offered no concrete rebuttal evidence that Petitioner did not sustain this accident; **that is, there was no evidence of any other cause or mechanism or place of injury**. Respondent has contested the issue of "accident" essentially because Petitioner admittedly did not offer "identical" accident histories to multiple parties, a standard of proof not required under the Act and one unrealistically demanded; however, Respondent has not offered any contrary evidence to rebut Petitioner's substantially corroborated claims.

ISSUE F. <u>CAUSAL CONNECTION</u>

Based on a review of the entire record, the Arbitrator finds and concludes **Petitioner proved by a preponderance of the credible evidence his current condition of ill-being (right shoulder and lumbar spine/low back) is causally related to the accidental injury sustained on January 25, 2018.**

In support of the Arbitrator's finding on this issue, again, Petitioner's uncontradicted testimony of Petitioner was that prior to his slip and fall at work on January 25, 2018, his right shoulder and lower back were feeling fine (Tr. 9-10). Again uncontradicted, Petitioner has testified that as a result of his slip and fall at work on January 25, 2018, he sustained injury to his right shoulder and lower back (Tr. 10-11, 15). In addition, every medical record in evidence refers to Petitioner sustaining injury as a result of a slip and fall incident at work that occurred on January 25, 2108 (Pet. ex. 1, 3, 5, 9, 10, & 12). While Petitioner admits and the hospital emergency room record confirms that his only complaint at Alexian Brothers Hospital on January 25, 2108 involved his right shoulder (Tr. 13, 40, Pet. ex. 1), Petitioner's further testimony was that, in addition to the original shoulder pain experienced, his lower back pain began to become apparent in the three or four days while he remained at home after his slip and fall incident at work on January 25, 2108 (Tr. 15). This testimony is credible. **It is reasonable to believe Petitioner's back pain appeared in the three or four days while he remained at home; that is not a period of time which would cause suspicion or doubt.** Petitioner's testimony in this regard is corroborated by the records of Dr. Giannoulis dated January 29, 2018, in which the Petitioner's injury to both his right shoulder and lower back sustained at work on January 25, 2018 are noted (Pet. ex. 3). Thereafter, care and treatment was provided to both Petitioner's right shoulder and lower back by Dr. Giannoulis, Dr. Koutsky, and Dr. Chunduri at Illinois Orthopedic Network (Pet. ex. 3). **While Respondent contested the issue of "causal connection", a distinctly medical issue, Respondent did not offer any contrary expert medical evidence to contest the issue.**

J. MEDICAL EXPENSE 20IWCC0357

Petitioner testified uncontradicted that after his slip and fall at work on January 25, 2018, he received medical care and treatment for injury to his right shoulder and lower back at several medical facilities and several diagnostic companies (Tr. 12-23).

Initially, Petitioner was removed from the scene by ambulance to Alexian Brothers Medical Center in Elk Grove Village where he received emergency care and treatment (Tr. 12-14, Pet. ex. 1). The balance due the hospital for the emergency care and treatment Petitioner received is the sum of $899.81 (Pet. ex. 2). Upon discharge from the hospital, Petitioner received care and treatment for the injuries sustained at work from doctors Giannoulias, Koutsky, and Chunduri from January 29, 2018 to May 25, 2018 (Tr. 15-23, Pet. ex. 3). The statement of charges for the care and treatment Petitioner received at Illinois Orthopedic Network totals the sum of $6,716.12 (Pet. ex. 4). At the direction of his treating physician at Illinois Orthopedic Network, Petitioner was referred to and received physical therapy for injuries sustained at work at Fullerton Drake Medical Center from January 21, 2018 to June 20, 2018 (Tr. 16 -17, Pet ex. 5). The bill for the physical therapy Petitioner received at Fullerton Medical Center totaled the sum of $9,940.00 (Pet. ex. 6). At the direction and order of Dr. Giannoulias, Petitioner underwent a right shoulder MRI on February 8, 2018 at Advantage MRI (Pet. ex. 10). The bill from Advantage MRI for the right shoulder MRI is the sum of $1,750.00 (Pet. ex. 11). At the direction and order of Dr. Koutsky, Petitioner underwent a lumbar MRI on March 10, 2018 at Molecular Imaging MRI (Pet. ex. 12). The bill from Molecular Imaging MRI is the sum of $2,486.00 (Pet. ex. 13). On April 5, 2018, after the lumbar MRI revealed a disk protrusion and annular tear at L4-L5 and a disk protrusion at L5-S1, Petitioner underwent a transforaminal epidural steroid injection under anesthesia performed by Dr. Chunduri (Tr. 22, Pet. ex. 3 & 10). The anesthesia service for the epidural steroid injection

was provided by Metro Anesthesia, and their bill for the anesthesia service is the sum of $1,961.15 (Pet. ex. 7).

While receiving care and treatment to his right shoulder and lower back injured at work on January 25, 2018, Petitioner was prescribed medication by his treating physicians that was provided to him by Midwest Specialty Pharmacy (Tr. 19-20). The bill Petitioner incurred from Midwest Specialty Pharmacy is the sum of $5,379.22 (Pet. ex. 8). While trying to recover from injury to his right shoulder and lower back sustained at work on January 25, 2018, Petitioner was provided with home therapy equipment by G & U Orthopedic that included: an ultrasound unit and supplies; a tens unit and supplies; a home therapy exercise kit; and an arm sling (Tr. 24). The bills Petitioner incurred from G & U Orthopedic are the sums of $5,917.00 and $1,221.64 (Pet. ex. 9).

In light of Petitioner's uncontradicted testimony as to his continuing pain and discomfort to his right shoulder and lower back that required comprehensive medical care and treatment after his slip and fall at work on January 25, 2018 (Tr. 12-23) that is corroborated by a review of his treating medical records in evidence, and the fact that Respondent has not offered any contrary or even any evidence as to the issue of reasonable and necessary medical services; (however, the Arbitrator emphasizes Respondent had 3 Utilization Reviews performed as found in RX 3 as required under Sections 8.7 and 8.7(i)(3) to "deny payment of or refuse to authorize payment of medical services rendered or proposed on the grounds that the extent and scope of medical treatment is excessive and unnecessary"; Petitioner properly objected to these reports on the basis of hearsay, no depositions had been taken, and, accordingly, the Arbitrator sustained Petitioner's timely objections. The UR reports were not admitted into evidence but have been attached to the Record as "rejected exhibits, pursuant to Commission Rule Section 9030.70 b)).

The following medical bills Petitioner incurred Petitioner after his employment accident and injury sustained on January 25, 2018 are found to be reasonable and necessary:

Alexian Brothers Medical Center	$899.81	(Pet. ex. 2)
Illinois Orthopaedic Network	$6,716.12	(Pet. ex. 4)
Fullerton Drake Medical Center	$9,940.00	(Pet. ex. 6)
Metro Anesthesia	$1,961.15	(Pet. ex. 7)
Midwest Specialty Pharmacy	$5,379.22	(Pet. ex. 8)
G & U Orthopedic	$5,917.00	(Pet. ex. 9)
G & U Orthopedic	$1,221.64	(Pet. ex. 9)
Advantage MRI	$1,750.00	(Pet. ex.11)
Molecular Imaging	$2.486.00	(Pet. ex.13)

TOTAL MEDICAL: $36,270.94

Respondent shall receive credit for all amounts paid to or on behalf of Petitioner for medical treatment.

K. TTD

In support of the Arbitrator's finding on the issue of "temporary total disability benefits", the parties agreed Petitioner was off work for the period of January 26, 2018 through March 5, 2018, a period of 5-4/7 weeks, for which Respondent paid Petitioner the sum of $2,225.06, the proper sum of TTD benefits. Respondent only disputed "liability" regarding this period of TTD. This was the same period of TTD for which Petitioner claims entitlement. Based on the Arbitrator's findings in support of accident, causation and medical, the Arbitrator affirms this is the correct period to which Petitioner is entitled to TTD benefits.

Petitioner has testified he was off from work at the direction of his treating physicians from January 26, 2018 through March 5, 2018 (Tr. 23). When Petitioner did return to work on March 16, 2018, he returned to work with restrictions, and his light duty work continued until May 3, 2018 (Tr. 23-24). Petitioner's testimony in this regard is verified upon review of the records of his treating physicians at Illinois Orthopedic Network (Pet. ex. 3).

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L. NATURE AND EXTENT

Pursuant to Section 8.1b, permanent partial disability shall be established and determined using the following five factors:

With regard to subsection (i), the Arbitrator notes that no AMA Impairment Rating permanent partial disability report and or opinion was submitted into evidence. The Arbitrator therefore gives no weight to this factor.

With regard to subsection (ii), the occupation of the employee, the Arbitrator notes the record reveals Petitioner was employed doing maintenance work at the time of his accident and that he is able to return to work in his prior capacity as a result of said accident. The Arbitrator notes Petitioner continues to work in the same capacity, but he is somewhat limited in his duties at work because of his continued pain in his right shoulder and lower back. Because of his ability to return to his former position *but with continued problems, the Arbitrator gives greater weight to this* factor.

With regard to subsection (iii), the Arbitrator notes that Petitioner was 48 years old at the time of the accident. Because of his age, the Arbitrator gives little weight to this factor.

With regard to subsection (iv), Petitioner's future earnings capacity, the Arbitrator notes there was no negative impact to Petitioner's ability to earn the same or greater hourly rate in the same job, the Arbitrator gives no weight to this factor.

With regard to subsection (v), evidence of disability corroborated by the treating medical records, the Arbitrator notes the continuing residual problems experienced by the Petitioner in that he still experiences pain in his right shoulder and lower back while doing maintenance work for Respondent and his household duties at home. Because the residual problems are verified by the records of Illinois Orthopedic Network (Pet. ex. 3), the Arbitrator therefore gives greater weight to this factor.

Petitioner shall have and receive from Respondent the sum of $359.43/week for a period of 50 weeks, as the injuries sustained caused the permanent partial disability to Petitioner to the extent of 10% under Section 8(d)2 of the Act.

In addition to and in support of the Arbitrator's finding on the issue of permanent partial disability, Petitioner testified that he continues to experienced pain and discomfort in his right shoulder and his lower back up to the present time (Tr. 25-27). With reference to his right shoulder, Petitioner testified that it is not the same as it was before his injury at work on January 25, 2018 (Tr. 25). Experiencing pain in the right

20IWCC0357

shoulder at least three times per week, Petitioner tries to avoid heavy lifting at work limiting his work duties, and he avoids heavy lifting at home, also limiting his household duties at home (Tr. 25-27). To treat the continued pain and discomfort in his right shoulder, Petitioner takes Advil, and he tries to rest the shoulder at home (Tr. 25).

Petitioner's testimony of continued pain and discomfort in his right shoulder and lower back is deemed credible upon review of various medical records in evidence.

Robert M. Harris

Robert M. Harris, Arbitrator

Dated: March 5, 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 WILLIAMSON)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
		☐ PTD/Fatal denied
	☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

David Bush,

Petitioner,

vs. NO. 18WC 36460

State of IL/IL Dept. of Transportation, **20IWCC0358**

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petitions for Review having been filed by both parties herein and proper notice given, the Commission, after considering the issue of permanent disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 9, 2019 is hereby affirmed and adopted.

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

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

Pursuant to §19(f)(1) of the Act, this Decision and Opinion on Review of a claim against the State of Illinois is not subject to judicial review.

JUN 2 6 2020

DATED:
SJM/sj
o-6/23/2020
44

Stephen J. Mathis

Douglas D. McCarthy

20IWCC0358

DISSENT

I view the evidence differently with respect to Section 8.1b(b) factors (ii), and (v). Therefore, I respectfully dissent.

(ii) the occupation of the injured employee

Petitioner continues to work in his pre-injury job as a highway maintainer. The Arbitrator highlighted this job requires Petitioner to engage in significant repetitive duties and attached more weight to the factor presumably in favor of an increased permanent disability.

Petitioner was able to return to work performing heavy work activities without issue. T. 20-1. I find this factor weighs in favor of decreased permanent disability.

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

In analyzing the evidence of disability as corroborated by the treating medical records, the Arbitrator highlighted "Petitioner's complaints were consistent with the injuries sustained." What the Arbitrator failed to do is follow the dictates of the Act- compare the complaints testified to by Petitioner with those contained in the medical records. I find the medical records do not wholly support Petitioner's subjective complaints.

During Petitioner's final evaluation examination with Dr. Paletta on June 10, 2019, Petitioner voiced no complaints regarding his wrists and his cubital tunnel syndrome. Dr. Paletta noted "He [Petitioner] returns today for follow up stating both the wrists and the ulnar nerve transpositions are doing great. He is having no issues with those." PX3. On Dr. Paletta's referral, Petitioner was evaluated by Dr. Bayes who provided an injection to the left elbow. On September 9, 2019, Dr. Bayes evaluated Petitioner for a final time wherein he noted "He [Petitioner] has minimal pain to touch. He has no pain with extension, no pain with supination." PX9. I find this factor weighs in favor of decreased permanent disability.

Having weighed the evidence and analyzed the Section 8.1b(b) factors, I find Petitioner sustained a 7.5% loss of use of the right hand; 10% loss of use of the left hand; 10% loss of use of the right arm; and 15% loss of use of the left arm pursuant to Section 8(e) of the Act.

Therefore, I respectfully dissent.

L Elizabeth Coppoletti

L. Elizabeth Coppoletti

Agenda

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BUSH, DAVID
Employee/Petitioner

Case# **18WC036460**

ST OF IL/IL DEPT OF TRANSPORTATION
Employer/Respondent

20IWCC0358

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:

0969 RICH RICH COOKSEY & CHAPPELL
THOMAS C RICH
6 EXECUTIVE DR SUITE 3
FAIRVIEW HTS, IL 62208

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

0558 ASSISTANT ATTORNEY GENERAL
SHANNON D RIECKENBERG
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

1430 CMS BUREAU OF RISK MANAGEMENT
WORKERS'S COMPENSATION MANGER
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

20IWCC0358

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

David Bush
Employee/Petitioner

v.

State of IL/IL Dept. of Transportation
Employer/Respondent

Case # 18 WC 36460

Consolidated cases: n/a

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Herrin, on October 16, 2019. By stipulation, the parties agree:

On the date of accident, November 12, 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 $70,741.00; the average weekly wage was $1,360.40.

At the time of injury, Petitioner was 49 years of age, married, with 0 dependent child(ren).

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

Respondent shall be given a credit of $0.000 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $0.00.

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 temporary total disability benefits of $906.93 per week for 11 3/7 weeks, commencing March 21, 2019, through June 11, 2019, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $813.87 per week for 134.475 weeks because the injuries sustained caused 12 1/2% loss of use of the right hand; 15% loss of use of the left hand; 12 1/2% loss of use of the right arm; and 20% loss of use of the left arm, as provided in Section 8(e) of the Act.

Respondent shall pay Petitioner compensation that has accrued from September 9, 2019, through October 16, 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

October 23, 2019
Date

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged he sustained a repetitive trauma injury arising out of and in the course of his employment by Respondent. The Application alleged date of accident (manifestation) of November 12, 2018, and that, as a result of "Repetitive Duties" Petitioner sustained injuries to both upper extremities and the body as a whole (Arbitrator's Exhibit 2). At trial, counsel for Petitioner and Respondent stipulated that the only disputed issue was the nature and extent of disability. Further, counsel for Petitioner and Respondent stipulated Petitioner was entitled to payment of temporary total disability benefits of 11 3/7 weeks, commencing March 21, 2019, through June 11, 2019. For some unknown reason, Petitioner was paid sick time and non-occupational disability benefits during the aforestated period of time. Petitioner acknowledged that when he was paid the temporary total disability benefits, he would have to pay back the sick time and non-occupational disability benefits he had drawn (Arbitrator's Exhibit 1).

Petitioner worked for Respondent as a highway maintainer and, at the time he sustained the repetitive trauma injury, worked on the "drill crew." Petitioner testified the work was very hand intensive and involved a lot of forceful gripping and pulling of pipes with large pipe wrenches. Petitioner is left hand dominant and initially began to experience left elbow pain and numbness in the fourth and fifth fingers of his left hand.

Prior to the accident, Petitioner sustained a fracture of the distal radius of his right arm. For that injury he was treated by Dr. Davis (whose medical records were not tendered into evidence) who performed surgery on Petitioner's right arm/hand which consisted of an open reduction and internal fixation of the fractured radius as well as a carpal tunnel release.

Subsequent to this accident Petitioner was seen and treated by Dr. George Paletta, an orthopedic surgeon, who initially evaluated Petitioner on November 5, 2018. At that time, Petitioner complained primarily of left elbow pain and numbness/tingling in the fourth and fifth fingers of the left hand. Dr. Paletta opined Petitioner had cubital tunnel syndrome and possible associated carpal tunnel syndrome. He ordered EMG/nerve conduction studies (Petitioner's Exhibit 3).

On November 12, 2018, Petitioner was evaluated by Dr. Daniel Phillips, a neurologist, who performed EMG/nerve conduction studies. The studies were positive for bilateral ulnar neuropathies at the elbows, left greater than right, and bilateral median neuropathies at the wrist, left greater than right (Petitioner's Exhibit 4).

Petitioner was seen by Dr. Paletta on November 20, 2018. At that time, Dr. Paletta reviewed the EMG/nerve conduction studies. He recommended Petitioner undergo ulnar nerve transposition and carpal tunnel release surgeries, initially on the left because of the severity of his symptoms on the left as compared to the right (Petitioner's Exhibit 3).

Because Respondent was, at that time, disputing liability, Petitioner did not proceed with surgery. Dr. Paletta again saw Petitioner on February 6, 2019, and renewed his surgical recommendation. He also noted Petitioner had developed left tennis elbow symptoms and ordered an MRI scan to determine the severity of that condition (Petitioner's Exhibit 3).

The MRI was performed on February 11, 2019. According to the radiologist, the MRI was positive for mild lateral epicondylitis and/or partial tear (Petitioner's Exhibit 7).

Dr. Paletta reviewed the MRI on February 12, 2019. Based upon his review, he recommended Petitioner undergo an injection in the elbow and undergo physical therapy (Petitioner's Exhibit 3).

Petitioner was seen by Dr. Helen Blake, a pain management physician, on February 18, 2019. At that time, she administered an injection in Petitioner's left elbow (Petitioner's Exhibit 5).

Dr. Paletta performed surgery on March 21, 2019, on Petitioner's left elbow/wrist. The procedure consisted of an open carpal tunnel release and ulnar transposition (Petitioner's Exhibit 6).

Dr. Paletta performed surgery on April 16, 2019, on Petitioner's right elbow/wrist. The procedure consisted of an open carpal tunnel release and ulnar transposition (Petitioner's Exhibit 8).

Following the surgeries, Dr. Paletta ordered physical therapy. When he saw Petitioner on April 29, 2019, he authorized Petitioner to return to work on May 20, 2019 (Petitioner's Exhibit 3).

When Dr. Paletta saw Petitioner on June 10, 2019, Petitioner continued to have left elbow symptoms of epicondylitis. He recommended Petitioner undergo another injection and referred Petitioner to Dr. Matthew Bayes (Petitioner's Exhibit 3).

Dr. Bayes saw Petitioner on July 11, 2019. At that time, Dr. Bayes diagnosed Petitioner with an interstitial partial tear. He administered a plasma injection. When Dr. Bayes saw Petitioner on September 9, 2019, Petitioner's left elbow condition had improved. Dr. Bayes opined Petitioner was at MMI (Petitioner's Exhibit 9).

At trial, Petitioner testified he has experienced a lack of strength in both arms and hands, specifically, a diminished grip strength in both hands. Although Petitioner is left hand dominant, he still has experienced pain in his right elbow. Petitioner agreed he was able to return to work to his regular job as a highway maintainer.

Petitioner testified, prior to the accident, he was able to engage in some extra work which included tree trimming. He stated he is no longer able to perform this additional work because of his elbow/hand condition; however, he did not provide any evidence as to any income loss as a result thereof.

Conclusions of Law

The Arbitrator concludes Petitioner had sustained permanent partial disability to the extent of 12 1/2% loss of use of the right hand, 15% loss of use of the left hand, 12 1/2% loss of use of the right arm and 20% loss of use of the left arm.

In support of this conclusion the Arbitrator notes the following:

Neither Petitioner nor Respondent tendered an AMA impairment rating. The Arbitrator gives this factor no weight.

Petitioner worked as a highway maintainer, a job which required significant repetitive use of both upper extremities. While Petitioner was able to return to work to his regular job, he continues to complain of a lack of strength in both arms, specifically, diminished grip strength in both hands. The Arbitrator gives this factor significant weight.

Petitioner testified that, because of his upper extremity symptoms, he was no longer able to obtain extra work as a tree trimmer. However, no evidence was tendered as to how much of an income loss Petitioner has, in fact, sustained. The Arbitrator gives this factor minimal weight.

Petitioner was 49 years old at the time of the accident and 50 years old at the time the case was tried. He will have to live with the effects of the injury for the remainder of his working and natural life. The Arbitrator gives this factor moderate weight.

Petitioner sustained a repetitive trauma injury to both upper extremities which required open carpal tunnel release surgeries on both hands and ulnar transposition surgeries on both elbows. Petitioner agreed the surgeries relieved many of his symptoms, but he still experiences a lack of strength in both arms and hands. Petitioner was left hand dominant. In regard to his left elbow, Petitioner was also diagnosed with left epicondylitis and with an interstitial partial tear which was treated conservatively with injections and physical therapy. The Arbitrator finds Petitioner's complaints were consistent with the injuries he sustained. The Arbitrator gives this factor significant weight.

William R. Gallagher, Arbitrator

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Veronica Serna,

Petitioner,

vs.

NO. 17 WC 08130

Farmland Foods,

20IWCC0359

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, 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 November 6, 2019 is hereby affirmed and adopted.

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

No bond is required for 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.

JUN 26 2020

DATED:
SJM/sj
o-6/23/2020
44

Stephen J. Mathis

L. Elizabeth Coppoletti

Douglas D. McCarthy

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION 19IWCC0359

SERNA, VERONICA
Employee/Petitioner

Case# **17WC008130**

FARMLAND FOODS
Employer/Respondent

On 11/6/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.53% 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:

6105 REHN LAW LLC
JOHN REHN
5 E SIMMONS ST
GALESBURG, IL 61401

5354 STEPHEN P KELLY ATTY AT LAW
MATTHEW BREWER
2710 N KNOXVILLE AVE
PEORIA, IL 61604

20IWCC0359

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

Veronica Serna
Employee/Petitioner

v.

Farmland Foods
Employer/Respondent

Case # 17 WC 8130

Consolidated cases: N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Rock Island**, on **September 9, 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 _____

FINDINGS

On **October 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.

Per the stipulation of the parties, in the year preceding the injury Petitioner earned **$39,312.00**; the average weekly wage was **$756.00**.

On the date of accident, Petitioner was **40** years of age, ***married*** with **2** dependent children.

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$1,979.17** in other benefits, for a total credit of **$1,979.17.**

Respondent is entitled to a credit for medical bills paid in the amount of **$1,979.17** through its group medical plan for which credit may be allowed under Section 8(j) of the Act.

ORDER

Petitioner failed to prove that she sustained an accident that arose out of and in the course of her employment with Respondent, and that her current condition of ill-being is casually related to her alleged accident. All benefits are denied; the remaining issues are moot and the Arbitrator makes no conclusions as to those issues.

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. Bone-Gillman

Signature of Arbitrator

11/5/19

Date

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Veronica Serna
Employee/Petitioner

Case # 17 WC 8130

v.

Consolidated cases: N/A

Farmland Foods
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that she lives in Monmouth and that she no longer works for Respondent. She testified that from 2002 to 2016, she worked for Respondent. She testified that Respondent operates a meatpacking facility in Monmouth and that when she worked there, her first job was doing bottoms which included trimming fat, flipping the meat, performing more trimming, and throwing it on the belt. She testified that she cut meat with a knife in her right hand, that she flipped the meat with her left hand, and that with her left hand she threw it on another belt. She testified that when she flipped the meat the belt was above her shoulder a little, and that she would do that all day from 6:00 a.m. to 2:30 p.m. She testified that she did the bottoms job for a few years. She testified that when lifting above shoulder-level, the meat weighed no more than 5 pounds. She testified that the bottoms job was in the ham boning department, and that most of the time that she worked for Respondent she worked in the boning department.

Petitioner testified that she also did the tops job where she grabbed the ham, cut a seam in it, pulled it with her left hand, pushed it with her right hand, trimmed it a little, and threw it above shoulder-level. She testified that she was cutting with her right hand and moving the meat with her left hand. She testified that after it was cut she lifted the meat up onto a belt above her shoulder level, and that when she was cutting it was at waist level. She testified that when she was on the tops line, she did motions with her hands all day.

Petitioner testified that in addition to the bottoms and tops jobs, she also at times did the feeding the line job. She testified that when doing that job the hams fell into the chute, that she grabbed the ham and set it on a square, that she trimmed the fat, and that she turned it to put it in a certain position for next person to work on it. She testified that she did cutting with her right hand and that when turning the hams, her hands were at shoulder level. She testified that as she was feeding the line occasionally there would be jams on the line, and that she would have to either pull hard on the ham or, if there were too many, she would have to push them back and tell the other person to slow down. She testified that there were times when a few more fell than were supposed to, and that the weight of the hams varied between 20 and 30 pounds. She testified that with the feeding the line job she was cutting with her right hand and manipulating the meat with her left hand.

Petitioner testified that that in 2014, she worked in the ham boning department. She testified that in 2014 she was having problems with her shoulder and that every time she moved it, it hurt. She testified that she heard a popping sound, and that at night she was unable to sleep because it was numb. She testified

that she saw the nurse at Respondent's facility in 2014, and that at first they tried some heating pads and that later on she saw Dr. Ayers and was sent to therapy. She testified that the therapy in 2014 helped to control the pain, but that she was still doing the same job. She testified that her job at that time was that of feeding the line.

Petitioner testified that after she saw Dr. Ayers, she was switched to the loin bone job for a couple of months. She testified that she was unable to keep up and that her shoulder was the same with that job. She testified that when she left the loin bone job at the end of 2014 or early 2015 she worked in ham boning, and that she worked in that job up until October 2016. She testified that in 2015 and 2016 she was having problems with her left shoulder, and that she went to the nurse once in a while and used a heating pad. She testified that in October 2016 her left shoulder was still in pain and that she was fired. She testified that her employer wanted her to do the tops job, and that this was where she was lifting meat above her shoulder.

Petitioner testified that after she was fired, she was referred to Dr. Schierer at Cottage Orthopedics. She testified that she saw Dr. Schierer in November 2016, that she was referred there by Ms. Johnson, and that her main concern was that of her shoulder. She testified that she was also having locking of the ring finger. She testified that Dr. Schierer indicated that she needed surgery. She testified that she told him that her main concern was her shoulder. She testified that he recommended surgery on her finger first, but that she did not have it done. She testified that she went back to Dr. Schierer in February and that her complaints at that time were that her shoulder was very painful, and that he gave her an injection and some medications. She testified that this did not work, so the next step was surgery. She testified that she underwent surgery and had post-operative physical therapy. She testified that she was ultimately released without any restrictions. She testified that she did not return to work for Respondent and that she found another job. Petitioner denied having any problems now with her shoulder while working.

Petitioner denied ever having had any treatment for her left shoulder before she worked for Respondent. She further denied ever having had problems with her left shoulder before working for Respondent. She testified that in the 14 years that she worked for Respondent she did a number of jobs, but that she was working on the line all 14 years. She testified that all her jobs involved handling meat or boxes of meat throughout the day.

On cross examination, Petitioner agreed that she was claiming a repetitive trauma injury to her left shoulder. Petitioner denied ever having had any accidents or injuries to her left shoulder besides her repetitive trauma claim. When shown a note from an October 22, 2016 visit with Mary Johnson referencing a slip and fall at work 3-4 years ago and indicating that her shoulder not having been the same since, however, Petitioner agreed that she had had a prior left shoulder injury. Petitioner testified that she did not recall whether she told Dr. Schierer about this accident, but that she thought that she had told Dr. Li. Petitioner agreed that her left shoulder was never the same after her prior fall.

On cross examination, Petitioner testified that she was moved around in her jobs. Petitioner testified that her physical therapy in 2014 helped to control her pain, but that when she went back to the boning job her pain returned. She agreed that she was discharged to full duty in November 2014. She further agreed that she did not seek treatment for about two years until October 2016.

On cross examination, Petitioner agreed that in October 2016 she was not under any restrictions and that she could have worked any position they she was assigned to. She agreed that in October 2016 she had no restrictions in place that would have prevented her from doing the tops position. She testified that she was terminated three days later, that she saw Mary Lou Johnson on that date, and that she recalled talking to her. When asked if she filed her case was because she was fired from Respondent, Petitioner responded that they did not respect her.

On cross examination, Petitioner testified that it was possible that she had no shoulder complaints when she first saw Dr. Schierer. She testified that at the November 2016 visit with Dr. Schierer he did not give her any restrictions on that date, and that she did not see him for three months until February 2017. She agreed that at that point she had not worked for Respondent for 3-4 months, but testified that the pain was still there despite not working there.

On cross examination, Petitioner agreed that she saw Dr. Li for an IME. She testified that she did not understand some of the questions that he asked. She testified that she informed Dr. Li that she did work at- or above-shoulder level. As to the feeding line position, Petitioner testified that the line relative to her body height was that of near the top of her stomach area. She testified that the trimming was all done at stomach level.

On cross examination, Petitioner agreed that she was released by Dr. Schierer after surgery to full duty. She testified that her shoulder feels much better now than before surgery.

On redirect, Petitioner testified that the fall occurred at Respondent's facility and that the floor was wet. She testified that she did not have any outside treatment in 2015 or 2016, but that she was treating with the nurses for her shoulder.

Scott Collins was called as at witness by Respondent at the time of arbitration. He testified that he works for Respondent and that he is a ham boning supervisor. He testified that he has held this position for the last six years, and that he held the position in October 2014.

Mr. Collins testified that he was familiar with the different tasks on the line and that he had listened to Petitioner testify. When asked about the tops job and whether there was any at- or above-shoulder level lifting, Mr. Collins responded that it was about chest high and that the meat weighed between 3 and 8 pounds. He testified that as to the bottoms job, it was also about chest high. He testified that the highest conveyor was about four feet off the ground, and that the weights involved in the bottoms job was that of 5 to 6 pounds. He testified that there was no lifting more than 10 pounds for either the tops or bottoms job, and that one would not have to lift the meat but rather would just have to flip it over with their hand. He further testified that in his experience and as a supervisor, there was no overhead or over-shoulder work in the tops, bottoms, or feed lines positions.

On cross examination, Mr. Collins agreed that he had done these jobs himself. He testified that there were not two different conveyors for the bottoms and tops jobs. He testified that he was 5'10" and agreed that Petitioner was shorter than him. He testified that Petitioner would not have lift above her shoulder, but he agreed that her shoulder was lower than his shoulder.

On redirect, Mr. Collins testified that he had witnessed Petitioner performing the various tasks.

The medical records of OSF Occupational Medicine were entered into evidence at the time of arbitration as Petitioner's Exhibit 1. The records reflect that Petitioner was seen on October 21, 2014, at which time it was noted that she presented with "really no new injury," that she fell a year ago she thought and had pain from her right ankle and left arm from that incident, and that she had been at Farmland for 12 years. It was noted that Petitioner had pain in her left shoulder up her neck and down her arm, that she felt like it was because she was working fast and had to push the hams, and that her lower back had been bothering her. It was noted that Petitioner's ankle started bothering her last year after she slipped going to the locker rooms after work, that she had regular shoes on and she was looking for her ID, that she was in the hallway and the floor was wet, and that she ended up slipping. It was noted that Petitioner went back, that she thought she fell onto her right side at that time, and that she was able to get up and was not sure how she hurt her ankle, but that she had pain in the front of her ankle after that and had pain with steps and with standing. It was noted that Petitioner was also noticing that her wrist had been bothering her, but that

she thought it was because she had to pull, push, flip, and grip with her left hand as she held back the hams and then also fed the line. It was noted that Petitioner had been having problems with her left arm for the past 3-4 weeks, that it bothered her in her shoulder to her neck to her whole arm, that it went back to the back of her hand, and that the back of her left wrist had a sharp pain. It was noted that Petitioner had been feeding the line for about 4 years or so, that she had to hold the hams back if they got jammed up, that it was not a heavy job but that she had to push the hams back with her left arm, and that she had noticed that her shoulder had been bothering her because of that. It was noted that Petitioner could not sleep at night, that heat did help some, and that she had not been restricted. It was noted that Petitioner had a little bit of pain in her back as she pushed, that she had no radiating pain, that it just hurt, that she had to wear a brace because of the pain, and that her back had been bothering her for "awhile" but that she felt like it was worse. It was noted that given the chronicity of this there had been no new injury, that Petitioner was dating it back to a fall about a year ago, and that her left shoulder was giving her problems for the last several months. It was noted that Petitioner was to start Prednisone and to undergo physical therapy for the left shoulder. It was also noted that Petitioner wanted to be on regular work so they would keep that going. (PX1).

The records of OSF Occupational Medicine reflect that Petitioner was seen on November 21, 2014, at which time it was noted that she had been feeling a lot better, that she had some soreness but no pain at all, that she had been working cleaning tenders and was very light work, and that she had been running a ring knife. It was noted that Petitioner had been very comfortable in her current position, that she was to bid to this job but that she also ran a ring knife, and that she was having trouble keeping up. It was noted that Petitioner had no numbness, that she had no wrist problems, that her ankle had been fine standing, and that her shoulder had been doing fine. It was noted that Petitioner's back had not been bothering her. It was noted that Petitioner felt like the therapy helped, that she was no longer on any medication, and that she was off the Prednisone. It was noted that they would leave a note with "Bob" and let him know that Petitioner was okay with where she was at, that hopefully they would give her another week or so, and that she was discharged to regular work. (PX1).

Included within the records of OSF Occupational Medicine was an interpretive report for x-rays of the lumbar spine performed at OSF St. Mary Medical Center on October 21, 2014, which were interpreted as revealing the vertebral body heights and alignment are maintained; no acute osseous abnormality; the disc spaces are also maintained. The history was noted to be that of low back pain. The records reflect that Petitioner also underwent x-rays of the left wrist on October 21, 2014, which were interpreted as revealing no acute fracture or acute traumatic injury seen. The history was noted to be that of left wrist pain for one year; low back pain, no injury. Petitioner underwent x-rays of the right ankle on October 21, 2014, which were interpreted as revealing no fracture, dislocation, or significant arthritic change. The history was noted to be that of left wrist pain, ankle pain. (PX1).

The records of OSF Occupational Medicine reflect that Petitioner was a no-show for her appointment on October 30, 2014. (PX1).

The medical records of Azer Clinic were entered into evidence at the time of arbitration as Petitioner's Exhibit 2. The records reflect that Petitioner underwent physical therapy for the timeframe of October 27, 2014 through November 20, 2014. At the time of the November 3, 2014 visit, it was noted that Petitioner reported that she was still hurting from the shoulder to the elbow and in her wrist. At the time of the November 5, 2014 visit, it was noted that Petitioner reported that she had good pain relief with the trigger point release during the last treatment session. At the time of the November 6, 2014 visit, it was noted that Petitioner reported pain at 6/10 with certain movements and that she stated that her shoulder had gotten a little better. At the time of the November 10, 2014 visit, it was noted that Petitioner reported that she was seeing a little improvement and that she stated that she had just started a new job which was pushing lighter pieces of meat, so it should be better. At the time of the November 12, 2014 visit, it was noted that

Petitioner reported that her upper trap and shoulder were feeling better since starting her new job, but that her hands and forearms were sore. (PX2).

The records of Azer Clinic reflect that Petitioner was seen for physical therapy on November 13, 2014, at which time it was noted that she reported pain and soreness along the left lateral shoulder down to the elbow rating it at 5/10, and that she stated that overall she had gotten better since she was not doing the same job as before. At the time of the November 17, 2014 visit, it was noted that Petitioner reported that she was not having any shoulder pain that day, and that she stated that her new job had really helped to reduce the pain in her shoulder. At the time of the November 19, 2014 visit, it was noted that Petitioner reported that her shoulder was feeling better but that she was hurting all over from adjusting to the new job. At the time of the November 20, 2014 visit, it was noted that Petitioner stated that she was just sore from her new job and that she stated that she wanted to join the YMCA. (PX2).

The medical records of Cottage Clinic of Monmouth were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The records reflect that Petitioner was seen on October 25, 2016, at which time it was noted that she was seen for a follow-up on left shoulder pain and right wrist pain. It was noted that Petitioner stated that both were work comp injuries, that she stated that they were repetitive injuries, and that she stated that she was let go from her job. It was noted that Petitioner presented after being fired from Smithfield, that she now wanted to file a work comp case on her right-hand pain and left shoulder, and that the right wrist pain was 9/10 pain that date and had been for three months. It was noted that Petitioner's left shoulder pain was 8/10 that date and had been hurting off and on for three years, depending on the job. It was noted that Petitioner had been taking Ibuprofen on an intermittent basis, nothing continually, that she had difficulty sleeping for three years, and that she claimed she had difficulty with carrying groceries on the left side and could not lay on her left side. It was noted that Petitioner stated that she had trouble cooking and stirring, that she had pain pushing a shopping cart, and that she had a right 4th finger triggering nodule. The assessment was noted to be that of (1) left shoulder joint pain; (2) pain in right wrist; (3) acquired trigger finger. Petitioner was recommended to undergo x-rays of the left shoulder and right wrist and hand and was also recommended to continue with Mobic. It was noted that Petitioner was extremely emotional and crying, and that it was hard to separate her anger and emotions from true signs and symptoms. (PX3).

The records of Cottage Clinic of Monmouth reflect that Petitioner was seen on October 22, 2016, at which time it was noted that she stated that she got suspended from work because she did not obey her supervisor, that she stated that they moved her to a new job, that she stated that he tried to move her and that she told him "no" because her shoulders and wrist hurt, and that she would throw hams up with another person for a few hours and that was okay but when they moved her it would cause her shoulders to hurt worse. It was noted that Petitioner stated that she told them they did not listen to seniority, that they were attacking her and cutting her off when she tried to talk, and that they would not let her talk or would not listen when she tried to speak. It was noted that Petitioner stated that when they moved her she became sweaty, shaky, and nervous, and that she stated that she slipped 3-4 years ago at work and her shoulder had not been the same since. It was noted that Petitioner stated that she would like a letter requesting jobs that where she was being moved her body was unable to handle it, that she stated that her right wrist hurt all the time, and that she stated that she was unable to sleep on her left shoulder at night and that it became numb. It was noted that Petitioner stated that depending on the job her pain became worse, and sometimes was 9-10. It was noted that Petitioner was angry due to being suspended, that she had not been treated for right wrist pain and left shoulder pain, that she felt her pain was due to work, and that she only wanted to work certain jobs. It was noted that Petitioner was awarded a new job but kept getting pulled back to jobs she did not like and felt made her hands hurt and left shoulder hurt, and that she had intermittently been to medical but no work comp case had been opened. It was noted that Petitioner wanted her provider to write a restriction for one specific job, and that she was crying and very emotional. The assessment was noted to be that of (1) left shoulder joint pain; (2) pain in right wrist; (3) acquired trigger finger. Petitioner was

recommended a trial of Mobic and was also recommended to use Biofreeze or Icyhot to massage into her muscles. It was noted that Petitioner was very anxious about the potential loss of her job, that she also brought into the subject that she was being treated unfairly by management and was being discriminated against, and that another woman who was making trouble in her marriage was behind her getting moved into different jobs. Petitioner was issued work restrictions including no lifting, pushing, or pulling greater than 5 pounds bilaterally, and no above-shoulder work. It was noted that Petitioner was okay on her newly-assigned job, and that Marilou Johnson, NP tried to explain that she would not write a permanent restriction. (PX3).

The medical records of Cottage Orthopedics were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The records reflect that that Dr. Schierer issued a letter to Petitioner's attorney dated January 18, 2019, in which he indicated that Petitioner suffered from impingement syndrome of the left shoulder due to work activities at Farmland Foods requiring acromioplasty, and that it was his opinion that the injuries he treated her for were a direct result of her activities at Farmland Food based on her description of her job activities, physical findings, and MRI scan. It was noted that Dr. Schierer opined that Petitioner had a good prognosis with respect to her left shoulder, that he anticipated no further medical or surgical treatment, and that he presently had no limitations regarding work or activities. It was noted that Dr. Schierer did not feel that Petitioner had suffered any permanent injuries to her left shoulder. (PX4).

The records of Cottage Orthopedics reflect that Petitioner was seen on February 23, 2018, at which time it was noted that she had left shoulder acromioplasty on November 9, 2017, had been in therapy, and had improved, but was not 100%. It was noted that Petitioner was happy with her progress. The assessment was noted to be that of impingement syndrome of the left shoulder. It was noted that Petitioner was allowed to partake in physical therapy at home and may start to look for a job. Petitioner was instructed to return as needed. At the time of the November 1720, 2017 visit, it was noted that Petitioner had mild pain and had developed a rash and itching with the Norco. The assessment was noted to be that of impingement syndrome of the left shoulder. Petitioner was given physical and occupational therapy referrals. Petitioner was also given a prescription for Tramadol and was recommended to discontinue the sling and return in four weeks. At the time of the October 31, 2017 visit, it was noted that Petitioner was injured three years ago at Farmland, that her work comp was denied, and that she wished to schedule an acromioplasty of the left shoulder using her insurance. It was noted that Petitioner had continued pain with abduction and that she had failed a steroid injection. It was noted that Petitioner's MRI showed impingement. The assessment was noted to be that of impingement syndrome of the left shoulder and pre-surgery evaluation. (PX4).

The records of Cottage Orthopedics reflect that Petitioner was seen on July 14, 2017, at which time it was noted that she was injured three years ago at Farmland, that she was still having pain 8/10, that she had pain with abduction, and that they were waiting for approval to proceed with left acromioplasty. It was noted that the MRI scan showed partial tearing and impingement of the rotator cuff, and that no complete rotator cuff tear was seen. The assessment was noted to be that of impingement syndrome of the left shoulder. It was noted that Petitioner needed acromioplasty of the left shoulder and that they were awaiting work comp authorization. At the time of the April 7, 2017 visit, it was noted that Petitioner was injured three years ago at Farmland, that she had received a steroid injection to the left shoulder on March 7, 2017, that her pain with abduction was no better, and that she complained of 8/10 pain in the left shoulder and was unable to sleep on her left side. It was noted that Petitioner's MRI showed partial tearing, tendinosis, and impingement. The assessment was noted to be that of impingement syndrome of the left shoulder. It was noted that Petitioner needed acromioplasty of the left shoulder and that they were awaiting work comp authorization. (PX4).

The records of Cottage Orthopedics reflect that Petitioner was seen on March 7, 2017, at which time it was noted that she was seen for the results of the left shoulder MRI. It was noted that Petitioner had no improvement, that her shoulder felt the same, and that she was injured on the job at Farmland three years

ago. The assessment was noted to be that of (1) impingement syndrome of the left shoulder; (2) acquired trigger finger, right ring finger. Petitioner was given an injection to the shoulder joint and was given a note taking her off work until re-evaluation by Dr. Schierer. Petitioner was also recommended to continue Meloxicam and to return in four weeks. It was noted that if Petitioner was not improved that she would need left shoulder acromioplasty and right fourth trigger finger release. At the time of the February 17, 2017 visit, it was noted that Petitioner had injured her left shoulder at work but had been fired since the injury, that she was fired four months ago, that it was a disputed work comp case, that she previously worked at Farmland for 14 years, and that she still suffered from a work-related right fourth trigger finger. The assessment was noted to be that of pain in the left shoulder. Petitioner was recommended to undergo an MRI of the left shoulder and to return to the clinic when completed. (PX4).

The records of Cottage Orthopedics reflect that Petitioner was seen on November 11, 2016, at which time it was noted that she had been referred by Marilou Johnson for a right fourth trigger finger. It was noted that Petitioner had been getting pain that shot up into her elbow, that she had been using a wrist support, and that she had x-rays of the right hand at Galesburg Cottage Hospital within normal limits. It was noted that Petitioner's pain was a 9/10 at time, that she was fired by Farmland a few weeks ago, and that she was seeing a work comp attorney. The assessment was noted to be that of acquired trigger finger, right ring finger. It was noted that Petitioner needed a right fourth trigger finger release, and that she wanted to speak with an attorney before she scheduled her case. (PX4).

The medical records of Galesburg Cottage Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. The records reflect that on November 9, 2017, Petitioner underwent left shoulder acromioplasty by Dr. Schierer for a pre- and post-operative diagnosis of chronic impingement syndrome, left shoulder. The records reflect that Petitioner underwent an MRI of the left shoulder on March 1, 2017, which was interpreted as revealing (1) extensive partial-thickness articular and bursal surface tearing of the supraspinatus tendon; small full-thickness communicating defect between the two tears is best seen on the axial proton density fat-saturated sequence; no tendon retraction or muscle atrophy; (2) suspected subtle non-displaced SLAP tear of the labrum; (3) mild amount of fluid in the subacromial/subdeltoid bursa. (PX5).

The medical records of Cottage Rehab & Sports Medicine were entered into evidence at the time of arbitration as Petitioner's Exhibit 6. The records reflect that a Discharge Summary was issued on February 26, 2018, which noted that Petitioner was discharged to a home exercise program. At the time of the February 26, 2018 visit, it was noted that Petitioner reported that the left shoulder continued to be weak and stiff with overhead motions. At the time of the February 22, 2018 visit, it was noted that Petitioner reported that the left shoulder continued to be stiff and sore, and that she had a doctor's appointment scheduled for the next day. At the time of the February 20, 2018 visit, it was noted that Petitioner reported that the left shoulder felt like it had gotten stiffer over the last week, and that it was more sore at all end ranges. At the time of the February 15, 2018 visit, it was noted that Petitioner reported that the left shoulder was still sore and felt like it was getting stiffer, and that she reported that she was still having difficulty reaching overhead and behind the back. At the time of the February 13, 2018 visit, it was noted that Petitioner stated that she felt like she was about 80% better. At the time of the February 9, 2018 visit, it was noted that Petitioner stated that she was doing okay but stated that she knew she was still limited with shoulder flexion. (PX6).

The records of Cottage Rehab & Sports Medicine reflect that Petitioner was seen for physical therapy on February 7, 2018, at which time it was noted that she reported that she slept much better and experienced less left shoulder discomfort the last two nights, and that she was reporting less shoulder discomfort overall. At the time of the February 5, 2018 visit, it was noted that Petitioner reported that she had the stomach flu over the weekend so her shoulder had been more stiff than normal due to her not having moved around too much, that she stated overall she was using it more with her activities of daily living but

stated that she still had limited range of motion at all end ranges, and that she reported increasing overall strength but stated that overhead was still weak. At the time of the February 2, 2018 visit, it was noted that Petitioner reported that her left shoulder felt good when she was warmed up, but that she stated that the soreness returned when she cooled back down. At the time of the January 31, 2018 visit, it was noted that Petitioner reported that she had been experiencing increased left shoulder joint soreness since the last session stating that it felt like it was stretched too far, and that she stated that it felt like it needed to "pop." (PX6).

The records of Cottage Rehab & Sports Medicine reflect that Petitioner was seen for physical therapy on January 29, 2018, at which time it was noted that she reported that she had been consistently stretching at home, that she stated that she was sleeping better and with less pain, and that she also reported less soreness throughout the day and could see improvements. At the time of the January 25, 2018 visit, it was noted that Petitioner stated that she was feeling less soreness daily. At the time of the January 23, 2018 visit, it was noted that Petitioner stated that she was still sore in the shoulder but less than the previous session. At the time of the January 22, 2018 visit, it was noted that Petitioner stated that she noticed she was greatly improved and stated that she was able to do all activities of daily living with greater ease and was having less difficulty with reaching overhead. It was noted that Petitioner stated that most complaints of pain were at night after a day of activity and difficulty with sleeping. At the time of the January 19, 2018 visit, it was noted that Petitioner reported that the left was not feeling too bad that day and that she got tired quickly when performing overhead motions. (PX6).

The records of Cottage Rehab & Sports Medicine reflect that Petitioner was seen for physical therapy on January 17, 2018, at which time it was noted that she reported that her left shoulder was much better overall but that she stated that she continued to struggle with getting comfortable at night, that she tossed and turned and could not seem to get more than four hours at a time of sleep, and that she stated that her left shoulder was usually stiff and sore in the mornings but eventually loosened up as the day progressed. At the time of the January 15, 2018 visit, it was noted that Petitioner reported that the left shoulder was not hurting as much that day but that she was really stiff, especially with overhead motions. At the time of the January 11, 2018 visit, it was noted that Petitioner stated that she was not feeling too bad that day and that she had some soreness, but that it was not as bad as the last visit. At the time of the January 10, 2018 visit, it was noted that Petitioner stated that she was doing okay and that she stated that some of her life stresses were causing her more aggravation in the shoulder. At the time of the January 9, 2018 visit, it was noted that Petitioner stated that she was noticing improvements and that the shoulder was not too sore. (PX6).

The records of Cottage Rehab & Sports Medicine reflect that Petitioner was seen for physical therapy on January 5, 2018, at which time it was noted that she reported that she had been a little more sore from trying to use the arm more during the day and doing more overhead motions. At the time of the January 3, 2018 visit, it was noted that Petitioner reported that the left shoulder was more sore on that date from trying to stretch it a little more during yesterday's appointment. At the time of the January 2, 2018 visit, it was noted that Petitioner reported that the left shoulder felt "achy" that day, but that she did not remember doing anything differently over the weekend to get it irritated. At the time of the December 29, 2017 visit, it was noted that Petitioner reported that the left shoulder continued to be feeling better and that she was a "good sore" (in the muscles) after yesterday's appointment. At the time of the December 28, 2017 visit, it was noted that Petitioner reported that the left shoulder was not feeling too bad after yesterday's appointment. At the time of the December 27, 2017 visit, it was noted that Petitioner reported that the left shoulder continued to be getting better and that she reported she could reach and lift lighter objects with greater ease, but that it was still weak with overhead motions. (PX6).

The records of Cottage Rehab & Sports Medicine reflect that Petitioner was seen for physical therapy on December 22, 2017, at which time it was noted that she reported that the left shoulder continued to be feeling and moving better, but that it was still pretty sore if she pushed it too hard. At the time of the

December 20, 2017 visit, it was noted that Petitioner reported that she was using her left upper extremity more with her daily activities and that she stated that the pain was lessening. It was noted that Petitioner continued to report tightness/weakness with any activity over shoulder height. At the time of the December 18, 2017 visit, it was noted that Petitioner stated that she was sore over the weekend, that she stated that she had pain with resting in the left shoulder, and that she stated that her soreness and pain were "letting up" that day. At the time of the December 15, 2017 visit, it was noted that Petitioner stated that she was doing well, that she stated that she had a "pop" in the shoulder the night before which she stated released pressure, and that the shoulder felt better. At the time of the December 13, 2017 visit, it was noted that Petitioner reported that the shoulder was not too sore after the appointment on December 11th and that she continued to be doing a little better every day. (PX6).

The records of Cottage Rehab & Sports Medicine reflect that Petitioner was seen for physical therapy on December 11, 2017, at which time it was noted that she reported that the shoulder was feeling and moving a little better, but that it was still really weak and sore with all motions. At the time of the December 7, 2017 visit, it was noted that Petitioner stated that she had no pain while not using her shoulder and that she continued to have pain with movement. At the time of the December 6, 2017 visit, it was noted that Petitioner stated that she was doing well and that she was feeling stiff that morning, but overall good since the weekend. At the time of the November 30, 2017 visit, it was noted that Petitioner reported that the left shoulder was not feeling too bad that day and that it continued to be moving better. At the time of the November 28, 2017 visit, it was noted that Petitioner reported that the left shoulder was a little more sore upon waking that morning after yesterday's appointment, but that "it was a good soreness and [was] moving better." At the time of the November 24, 2017 visit, it was noted that Petitioner stated that she had difficulty with her shoulder mobility since surgery. At the time of the November 27, 2017 visit, it was noted that Petitioner reported that the shoulder was moving better than it was last week, but was still "pretty sore." It was noted that Petitioner reported compliance with the home exercise program. (PX6).

The transcript of the deposition of Dr. Gregory Schierer dated April 25, 2019 was entered into evidence at the time of arbitration as Petitioner's Exhibit 7. Dr. Schierer testified that he is an orthopedic surgeon and that he is board-certified in orthopedic surgery. (PX7).

Dr. Schierer testified that he first saw Petitioner in November 2016, and that she was referred for triggering of her right fourth finger. He testified that he did not recall if Petitioner mentioned anything about her shoulder, and that he did not document anything about the shoulder at that visit. He testified that Petitioner returned on February 17, 2017, at which time she had left shoulder pain with abduction for three years and that she was still suffering from the trigger finger that he had seen her for in November. He testified that Petitioner told him that she had worked at Farmland for 14 years, that she had been fired four months prior to this visit, that she mentioned a dispute of a workman's comp claim, and that she thought that her shoulder pain was due to the repetitive range of motion and lifting she had to do on her job. He testified that on physical examination Petitioner had tenderness of her greater tuberosity and her biceps tendon, that she had tenderness of her subacromial bursa, that she had normal range of motion with pain with abduction, that she had positive Hawkins and Neer's tests, and that there was some muscle weakness mainly involving the rotator cuff, specifically with abduction. He testified that he did not make a diagnosis after taking a history and performing an examination because he was concerned about the possibility of a rotator cuff tear, so he ordered an MRI scan. (PX7).

Dr. Schierer testified that Petitioner had the MRI on March 1, 2017, and that it showed partial-thickness tearing, tendinosis, and impingement of the rotator cuff, that there was no complete rotator cuff tear seen, and that there was a small labral tear. He testified that when he performed surgery, he did not find a full-thickness tear. He testified that Petitioner returned on March 7, 2017, and that she reported that her left shoulder was no better. He testified that Petitioner added that she might have injured it at work three years prior to that, and that she had pain with range of motion of the shoulder. He testified that he

rendered the diagnosis of impingement syndrome and that based on the MRI scan, he recommended a steroid injection. He testified that he gave Petitioner an injection that day. He testified that he also recommended that Petitioner not work as of that date. (PX7).

Dr. Schierer testified that Petitioner returned on April 7, 2017, at which time her pain was no better. He testified that Petitioner graded the pain as an 8/10, and that she stated that she could not sleep on the left side. He testified that he recommended surgery, which was that of an acromioplasty of the shoulder. He testified that his note referenced that they were awaiting workman's comp authorization for the surgery, so he suspected that his office staff put in a request for it. He testified that when Petitioner returned on July 14, 2017 she was basically the same, and that she had pain with abduction. He testified that he mentioned that they were waiting for approval with workman's comp to proceed with the acromioplasty. He testified that Petitioner returned on October 31st at which time she still had the pain, that she stated that this was a disputed workman's comp injury, that it had been denied, and that she wanted to schedule her surgery using her private insurance. He testified that surgery was performed on November 9, 2017. (PX7).

Dr. Schierer testified that Petitioner followed-up after surgery and that the last time that he saw her was on February 23, 2018. He testified that at that point Petitioner was finishing up therapy, that she was significantly improved and happy with the progress, and that he recommended that she do exercises on her own and return as needed. He testified that he gave Petitioner a full duty release at that point. He testified that his chart was not well documented as to Petitioner's restrictions as she was not really going to work anymore, but that from the first time he mentioned taking her off work she was excused until after her surgery in February 2018. (PX7).

Dr. Schierer testified that he believed that the treatment that he provided to Petitioner was reasonable and necessary. When asked whether he had an opinion as to whether the treatment he provided to Petitioner was related to an injury that she had that was related to work, Dr. Schierer responded in the negative and testified that he did not see her when she was actually working. He testified that he was basing this on Petitioner's history of her job description and the timing, and that certainly the impingement syndrome was consistent with someone who had injured her shoulder doing heavy, repetitive lifting and abduction. (PX7).

On cross examination, Dr. Schierer agreed that in November 2016 Petitioner was referred to him for trigger finger on the fourth finger of the right hand. He agreed that Petitioner had indicated to him at that time that a couple of weeks prior, her employment relationship with Farmland Foods had ended. He agreed that he assumed that in late October Petitioner no longer worked for Farmland Foods. He agreed that this would have been the visit closest to the time when Petitioner was performing the job duties which she claims to have caused her shoulder problem. He agreed that he rendered no causation opinion regarding the trigger finger. He further agreed that later in the treatment, Petitioner had no additional complaints regarding the trigger finger. (PX7).

On cross examination, Dr. Schierer testified that on November 11, 2016, the closest visit that he had when Petitioner was working for Respondent, he had no record that she complained of her shoulder. He agreed that no work restrictions were issued at that time relative to the shoulder, and that there would be no need to. He testified that he did not know whether Petitioner was having shoulder pain or not, but that he did not document it one way or the other. He agreed that had Petitioner mentioned that she was having shoulder pain, it would have ended up in his note. He agreed that the fact that it was not in there likely meant that Petitioner did not make any mention of it to him at that time. He agreed that there would have been no need for any care relative to the shoulder at that time based upon the lack of complaints. (PX7).

On cross examination, Dr. Schierer testified that it was his understanding that at no time after October 2016 did Petitioner return to work for Respondent. He agreed that there was about a 3½-month

gap before Petitioner came back and saw him in the middle of February 2017. He agreed that at that time Petitioner had not worked for Respondent for about four months. When asked whether this was the first time that she documented shoulder complaints to him, Dr. Schierer responded that Petitioner said she had had it for three years. He testified that he had not reviewed any outside medical records other than his own chart notes. He agreed that he was not aware of any complaints that Petitioner had or treatment that she had had relative to the left shoulder prior to her coming to see him. (PX7).

On cross examination, Dr. Schierer agreed that Petitioner was complaining of 8/10 pain when she saw him in February. He agreed that to his knowledge Petitioner was no longer performing the job duties she claimed to have caused the left shoulder problems when she came in complaining of left shoulder problems to him. When asked whether Petitioner had indicated to him that she had had an injury in 2014, Dr. Schierer responded that she had been injured at work at Farmland but had since been fired. When asked of his understanding of the mechanism of injury, Dr. Schierer responded that as he recalled Petitioner stated that she was working and began to experience pain, and that he did not recall a traumatic incident. He agreed that it was his understanding that Petitioner was alleging some form of repetitive trauma injury. (PX7).

On cross examination, Dr. Schierer agreed that his opinion on causation was based on Petitioner's history of her job description and what she provided to him regarding what she did at Farmland. When asked of his understanding of what Petitioner did at Farmland, Dr. Schierer responded that she cut meat. When asked whether he had any additional information beyond that, Dr. Schierer responded that he did not specifically. He agreed that he testified that impingement syndrome could be caused or aggravated by somebody who did heavy, repetitive lifting or abduction. When asked whether he knew if Petitioner's position had any overhead work involved Dr. Schierer responded that she described it as being that way, but that he did not have a document saying that. (PX7).

On cross examination, Dr. Schierer agreed that if it was shown at the time of trial that the job duties that Petitioner performed did not involve overhead work and whether that would affect his opinions, Dr. Schierer responded that if she was working with her hands above shoulder-level then he would agree with that. When asked whether he knew what weights were involved in Petitioner's position, Dr. Schierer responded that he did not. When asked whether he knew how often Petitioner would be manipulating the meat that she was working on on the line Dr. Schierer responded that he did not, but that they had patients frequently from Farmland and that he just knew that it was hard work. (PX7).

On cross examination, Dr. Schierer agreed that he had testified at another deposition that in the years past he had gone out to Respondent's facility. He testified that it was in 1999. When asked whether he was aware of any ergonomical or technological updates that they had made to the facility, the line, and the work that was being performed, Dr. Schierer responded that he was happy if they had. (PX7).

On cross examination, Dr. Schierer testified that he did not know if by February 2017 Petitioner was working elsewhere. He testified that he did not have any information as to what Petitioner's activities of daily living were and what she was doing in her life at that time. He agreed that no work restrictions were issued when he saw Petitioner in November 2016. When asked to confirm that no work restrictions were issued when he saw her in February 2017, Dr. Schierer responded that Petitioner was not working and that if she had been working in February, he probably would have restricted her overhead work. (PX7).

On cross examination when asked whether, when he saw Petitioner on March 7, 2017, there was any objective difference or change in her condition or physical examination as compared to the February 17, 2017 visit, Dr. Schierer responded that Petitioner was more or less the same. He agreed that Petitioner was taken off work on March 7, 2017. When asked whether there was any objective reason that she needed to be completely off work at that time, Dr. Schierer responded that he did not recall what the rationale was and that Petitioner should have had some type of restricted activity and that to say she was completely off

work at that time was just based on the fact that she was not working. He agreed that at the March 7, 2017 visit Petitioner objectively could perform light duty work and that he would have encouraged her to do so assuming that it was available and she was employed. He testified that this probably would have been up until the time of surgery, and that then Petitioner would have had to be completely off work. (PX7).

On cross examination Dr. Schierer agreed that, as of March 17, 2017, Petitioner no longer had the trigger finger complaints and that no further care or treatment was needed for that condition. He agreed that he last saw Petitioner on February 23, 2018, and that no further care was required relative to the left shoulder at that time. He agreed that no work restrictions were required. When asked whether he indicated in his narrative report that he did not feel as though Petitioner would suffer any permanent impairment relative to the left shoulder, Dr. Schierer responded that it was possible but that he said that she was to return to the office if she had any problems and that she had not. He agreed that as of April 2019 he had not seen Petitioner in almost 14 months. (PX7).

On cross examination, Dr. Schierer agreed that as of the last time that he saw Petitioner in February 2018 her condition as to the left shoulder was in a better position at that point than she was before surgery. When asked whether he knew how long Petitioner worked at Farmland, Dr. Schierer responded that in 2017 she said that she had worked there for 14 years. He testified that he did not know how many hours a day Petitioner would work or what her hours a week were. He testified that he did not know if Petitioner's job duties varied throughout the day or throughout the timeperiod that she actually worked for Farmland. He testified that he had not seen any pictures or videos of Petitioner's work station or specifically the job duties that she was claiming caused the shoulder problems. (PX7).

On redirect when asked whether it was his impression that Petitioner's job involved pushing meat, flipping meat, grabbing meat, and cutting meat and whether that was the impression that he had as to what Petitioner would be doing on the line when she was working at Farmland, Dr. Schierer responded in the affirmative. (PX7).

The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 8.

The transcript of the deposition of Dr. Lawrence Li dated June 24, 2019 was entered into evidence at the time of arbitration as Respondent's Exhibit 1. Dr. Li testified that he is certified by the American Board of Orthopedic Surgery. He testified that he focuses his practice on shoulders, hands, and knees, that he treats upper and lower extremity problems both operatively and non-operatively, and that he treats spinal conditions only non-operatively. (RX1).

Dr. Li testified that he saw Petitioner for an IME on October 11, 2018, and that he obtained a history from her that she worked at Farmland for about 14 years from 2002 to 2016, that from 2012 to 2016 she had to put hams on the squares of a moving line, that the hams would come off a chute, and that she would have to take them and put them in the appropriate place in the moving line. He testified that Petitioner would have to do some sort of processing on the ham before she could get them on the line, that the work was at waist height, that she was right-hand dominant, and that when it was busy she estimated that she processed 15-20 hams a minute. He testified that Petitioner stated that it was repetitive work that caused her to have left shoulder pain, that she stated that sometime around 2013 she slipped and fell and hit her shoulder on the door but returned to work after three weeks, and that it got better but never completely better. He testified that Petitioner stated that that was with her left shoulder. He testified that his review of records indicated that on October 31, 2013, Petitioner did go to Occupational Health for a fall on the right side and that she injured her right shoulder, elbow, wrist, and right knee, and that the exam that day showed no tenderness throughout the left shoulder and full range of motion of the left shoulder. He testified that Petitioner stated that she was much better after surgery, that she had only slight pain and had no general

problems, that she was currently working at a factory that repaired Coke machines, that her job was basically to clean out the casing of the machine, and that she had been working full duty. (RX1).

Dr. Li testified that Petitioner stated that the line was about waist height, that the hams would come down off a chute, that she would have to pick them up to do whatever she needed to do to them and then put them in the right place, and that this would be all below her chest. He testified that when Petitioner presented to him she was doing quite well, and that she had only slight pain and had no real general problems with the left shoulder. He testified that he reviewed the interpretive report for the MRI of March 2017 and that it showed a partial-thickness tear with a small thickness communicating defect, and that Dr. Schierer's operative report from November 2017 indicated that he did not find a tear. (RX1).

Dr. Li testified that on physical examination Petitioner's shoulder exam was basically normal, and that she was just about 11 months following her left shoulder surgery. He testified that the diagnoses that he rendered from reading Dr. Schierer's operative report was that Petitioner had left shoulder impingement syndrome and had had a successful surgery for it. He testified that in his opinion Petitioner did not need any further care and that her prognosis was excellent. He testified that Petitioner did not require any restrictions and that she did not have any at the time that he saw her. When asked whether it was his understanding that Petitioner was claiming a specific accident or repetitive trauma relative to the claim that she had filed against Farmland Foods, Dr. Li responded that she told him that it was repetitive trauma. (RX1).

Dr. Li testified that, based on her medical records and the fact that she did her work at waist-level, it was his opinion that Petitioner's left shoulder condition that she had surgery for was not caused by any repetitive work incident because she was working below chest-level. He testified that Petitioner did not describe any above-the-chest or any overhead lifting. He testified that he asked Petitioner what level that she worked at, and that she told him waist-level. He agreed that it was his understanding that Petitioner was terminated in 2016, and that she initially presented for medical care for her left shoulder in 2017. (RX1).

Dr. Li testified that Petitioner was at maximum medical improvement at the time that he saw her. He testified that regardless of causation, it was his opinion that Petitioner did not suffer any permanent disability relative to the left shoulder. (RX1).

On cross examination, Dr. Li agreed that Petitioner appeared to have worked at Farmland from 2002 through 2016. He agreed that the surgery that Petitioner had was appropriate and necessary, and that the surgery helped her. He testified that he had no records before 2002 so he agreed that there were no medical records showing any shoulder problems for Petitioner before 2002. He agreed that he asked Petitioner generally where she worked, and that she indicated that she worked at or below waist-level. (RX1).

On cross examination, Dr. Li testified that it was significant to him that the work was at waist-level in a repetitive trauma case. He testified that in a repetitive trauma case the force itself was not very great and that for the shoulder, it would have to be shoulder-level or above because the force of each act was so low. He testified that Petitioner was diagnosed with a rotator cuff tear and then subsequently that turned out not to be the case, and that it reverted to shoulder impingement syndrome. When asked of the significance of waist-level as to Petitioner's shoulder injury, Dr. Li responded that the significance was that it was below the shoulder and that as long as it was below the shoulder, the shoulder did not have to be raised in her repetitive movements. He testified that if someone had to repetitively raise their shoulder above shoulder-level that could lead to impingement syndrome, and that it could lead to injury to the rotator cuff on a repetitive basis. He testified that that happened because the rotator cuff was raised and that it hit the undersurface of the acromion at about shoulder-level and slightly higher. He testified that if Petitioner

was to do the same job but that the job was to move the hams on a line and the line was at shoulder-level, then he would agree that it could cause the kind of problem that Petitioner had. (RX1).

On cross examination, Dr. Li testified that he did not recall specifically talking to Petitioner about when the hams would get jammed on the line and what she would have to do under those circumstances. He testified that he did not recall reviewing the Physical Therapy Evaluation from Azer from October 20th or 21st of 2014 that talked about having to pull the hams to get them out when they got jammed. He agreed that he reviewed the records of Dr. Ayers. He testified that he did not recall reviewing or talking to Petitioner about the October 21, 2014 note from Dr. Ayers about her having to hold the hams back when they got jammed up. (RX1).

On cross examination when asked if Petitioner would have to grab and pull the hams back at shoulder-height and whether that type of repetitive activity would change his opinion about causation, Dr. Li responded that if that was the activity that was happening all the time then it would, but that if it happened occasionally then it would not. When asked how often that would have to happen for it to be something that would cause or contribute to the shoulder problem that Petitioner had surgery on, Dr. Li responded that it would have to happen at least every one or two times per minute based on his experience with shoulder injuries. When asked whether he talked to Petitioner about whether she had to bend over while she was working on the line and outstretch her arms, Dr. Li responded that he was not aware that she had to bend over and that he was not pursuing that because bending over typically was more of a back problem and that she did not have any. (RX1).

On cross examination, Dr. Li testified that if one were lifting or raising something up or pulling it towards himself while bent over and his arms were outstretched in front of him then he would agree that it was working at or above-shoulder level if one were actually lifting it up, but that to pull it towards himself he would not agree. When asked whether he had an opinion as to how many hams Petitioner would handle during a shift, Dr. Li responded that she told him that when she was busy she processed 15-20 hams a minute. He testified that Petitioner did not say how heavy the hams were, but that he assumed that they were heavy hams. He testified that he did not know what the combo line was. (RX1).

On cross examination, Dr. Li testified that Petitioner did not talk to him about having to lift the hams above her shoulder. When asked if Petitioner had to lift hams above her shoulders as part of her job and whether that could have caused or aggravated the condition that Dr. Schierer operated on, Dr. Li responded that if her job was to repetitively lift hams that weighed 20-25 pounds over her head every minute then he would say there was causation. He testified that if the hams weighed 4 pounds instead of 15-20 pounds, then it would be less likely but was still possible. (RX1).

On redirect, Dr. Li testified that Petitioner did not give him any history regarding a specific accident in October 2014 when a ham was jammed on the line, but that there was a fall in 2013. He testified that Petitioner did not give a history regarding repetitively having to extend or reach to get the hams and bring them to herself. He testified that that Petitioner gave ho history regarding overhead work or shoulder or above work. (RX1).

On further cross examination, Dr. Li agreed that in his report he did not put anything in there about Petitioner denying lifting hams over her shoulder or that she denied working above shoulder-level. (RX1).

The Payout Documentation was entered into evidence at the time of arbitration as Respondent's Exhibit 2.

CONCLUSIONS OF LAW

With respect to disputed issues (C) and (F), given the commonality of facts and evidence relative to these issues, the Arbitrator addresses those concurrently.

The Arbitrator finds that Petitioner has failed to prove that she sustained accidental injuries that arose out of and in the course of her employment with Respondent on October 21, 2014, and that her current condition of ill-being is causally related to her work activities.

The Arbitrator admittedly questions the credibility of Petitioner in this matter. At the time of arbitration, Petitioner testified initially that she had suffered no other injuries to her left shoulder, other than her claim of her job duties being the cause of her left shoulder condition. Petitioner's own medical records from Cottage Clinic of Monmouth, however, demonstrate that she had claimed a prior fall at work with an injury to her left shoulder, and that her left shoulder had not been the same since. (PX3). Upon being presented with this information on cross examination, Petitioner recanted her prior testimony. The Arbitrator also notes that Petitioner testified that when she initially presented to Dr. Schierer on November 11, 2016, she indicated that her main focus was that of her left shoulder. The medical evidence reveals, however, that Petitioner made no complaints relative to her left shoulder at that time to Dr. Schierer. (PX4; PX7).

Furthermore, the Arbitrator does not find that Petitioner performed any work at- or above-shoulder level. The Arbitrator notes that Dr. Lawrence Li specifically asked Petitioner whether she performed work at- or above-shoulder level, and that she denied that she did so. (RX1). The Arbitrator finds that Petitioner's denial to Dr. Li, when considered in conjunction with the testimony of Respondent's witness, Scott Collins, that she did not perform any overhead work, supports the denial of benefits in this matter.

Having considered and reviewed the entirety of the medical testimony proffered by both Dr. Schierer and Dr. Li in this matter, the Arbitrator finds the opinions of Dr. Li to be more persuasive than those proffered by Dr. Schierer. While Dr. Schierer testified that there was a causal connection between Petitioner's work activities and her condition of ill-being in the left shoulder, the Arbitrator notes that Dr. Schierer appears to have had lesser understanding of the specific physical requirements of Petitioner's job than Dr. Li. For example, on cross examination Dr. Schierer agreed that his opinion on causation was based on Petitioner's history of her job description and what she provided to him regarding what she did at Farmland. When asked of his understanding of what Petitioner did at Farmland, Dr. Schierer responded that she cut meat. When asked whether he had any additional information beyond that, Dr. Schierer responded that he did not specifically. (PX7). The Arbitrator finds to be highly persuasive the fact that Dr. Li asked Petitioner about the motions involved with performing her work, and as a result thereof finds his testimony that Petitioner was not required to work with weight at- or above-shoulder to be very significant. (RX1). As a result thereof, the Arbitrator finds Dr. Li to have had a better understanding of the physical requirements of Petitioner's job, and therefore gives his opinions greater weight than those proffered by Dr. Schierer.

Based upon the foregoing and the record as a whole, the Arbitrator concludes that Petitioner has failed to prove that she sustained accidental injuries that arose out of and in the course of her employment with Respondent on October 21, 2014, and that her current condition of ill-being is causally related to her work activities. All benefits are denied. The remaining issues of medical bills, temporary total disability, and the nature and extent of the injuries are moot, and the Arbitrator makes no conclusions as to those issues.

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

Josh Konneker,

Petitioner,

vs. NO. 17 WC 10300

International Paper Co.,

Respondent.

20IWCC0360

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, penalties and fees, permanent disability, temporary disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 18, 2019 is hereby affirmed and adopted.

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

20IWCC0360

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 26 2020
SJM/sj
o-6/23/2020
44

Stephen J. Mathis

L. Elizabeth Coppoletti

Douglas D. McCarthy

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

20IWCC0360

KONNEKER, JOSH
Employee/Petitioner

Case# **17WC010300**

INTERNATIONL PAPER CO
Employer/Respondent

On 9/18/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.87% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

6296 JEROME LINDSAY & SALMI
DAVID JEROME
333 SALEM PL SUITE 260
FAIRVIEW HTS, IL 62208

6020 GOLDBERG SEGALLA LLC
EMILY BORG
311 S WACKER DR SUITE 2450
CHICAGO, IL 60606

20IWCC0360

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

Josh Konneker
Employee/Petitioner

v.

Intenational Paper Co.
Employer/Respondent

Case # 17 WC 10300

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 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. ☒ 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 February 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 not sustain an accident that arose out of and in the course of employment.

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $n/a; the average weekly wage was $734.00.

On the date of accident, Petitioner was 39 years of age, single with 0 dependent child(ren).

Petitioner has received all reasonable and necessary medical services.

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

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

Respondent is entitled to a credit of $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.

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

September 14, 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 February 21, 2017. According to the Application, Petitioner "Jammed arm/hand" and sustained an injury to his "Left shoulder, left upper extremity, neck" (Arbitrator's Exhibit 2). Respondent disputed liability on the basis of accident and causal relationship. Petitioner also filed a Petition for Section 19(k) and 19(l) penalties as well as Section 16 Attorneys' Fees (Arbitrator's Exhibit 1).

Petitioner worked for Respondent as a corrugator operator and had just been hired on February 13, 2017. Petitioner was a probationary employee on the day he sustained the accident on February 21, 2017.

Petitioner testified that on February 21, 2017, he was walking on a two level corrugator stacker. He stated that a coworker on the top of the machine asked him to come to the top because some cardboard needed to be cleared. Petitioner said he was directed to hurry up, but was then told not to worry about it.

Petitioner stated he was going up the steps to get to the top of the platform and he had his left arm extended outward to reach for the gate when he was directed to stop. When this occurred, the momentum of Petitioner's body caused him to fall forward and his left hand struck the door jamb of the gate. At that time, Petitioner stated he felt a "pop" in his left shoulder. At trial, Respondent tendered into evidence a photograph of the site of the alleged accident (Respondent's Exhibit 5).

Petitioner acknowledged that the "Shop Rules" required him to report the accident to Respondent within 60 minutes of its occurrence and he failed to do so. Petitioner's explanation was that he hoped the pain would subside and, because he was a probationary employee, he was fearful of having his employment terminated by Respondent.

Petitioner reported the accident to Respondent the following day, February 22, 2017, and completed/signed a "First Aid Report." According to the report, Petitioner was going from the bottom part of the stacker to the top to help clear scrap. The report noted "I had hold of the gate with my left hand. An employee already at the top told me to stop and that we would clear what was left after it came out of the stacker. When I went to stop it felt like my shoulder popped out of place" (Respondent's Exhibit 6). At trial, Petitioner testified that when he reported the accident he may have used the word "gate" instead of "gate jam."

Petitioner testified a coworker, Jeff Meng, witnessed him sustain the accident. Afterward, Petitioner stated Meng asked Petitioner if he was okay.

Jeff Meng testified for Respondent at trial. Meng worked with Petitioner on February 21, 2017, on the stacker. Meng stated he did not recall seeing Petitioner sustain an accident on that day and, if he had, he would have directed Petitioner to report it to a supervisor. Meng also denied asking Petitioner if he was okay.

Petitioner sought medical treatment at Midwest Occupational Medicine on February 22, 2017, where he was evaluated by Dr. Bradley Breeden. According to the record of that date, Petitioner was running up some steps on a machine until someone told him to stop. Petitioner then "...put his hand on a door jamb, stopped himself abruptly. The patient indicates he felt a pop in his left shoulder and has had discomfort in his left shoulder since that time." Dr. Breeden diagnosed Petitioner with left shoulder pain, recommended he take over-the-counter medication and authorized him to return to work (Petitioner's Exhibit 1).

Petitioner was subsequently seen at Midwest Occupational Medicine on February 27, March 3, and March 6, 2017. Petitioner continued to have shoulder symptoms as well as numbness in his left hand and fingers. It was recommended Petitioner have two weeks of physical therapy (Petitioner's Exhibit 1).

Walter Rivera testified for Respondent at trial. Rivera was the site manager and he stated he was notified on February 22, 2017, that Petitioner had sustained a work-related accident the day prior. He participated in an investigation of the accident which included an interview with Petitioner in which he, Petitioner's supervisor, Mohammed Chaudri, and another supervisor, Monica Jackson, were present. Rivera testified Petitioner initially stated he was going up the stairs of the stacker, put his left hand out to grab the gate and stopped suddenly. Rivera then informed Petitioner that the gate swung away from the body when it was opened and Petitioner then stated that maybe he grabbed the side. When asked to clarify exactly how the accident happened, Petitioner then stated that maybe he was going down the stairs. Rivera testified the circumstances of the accident, as described by Petitioner, did not make sense.

Mohammed Chaudri, Petitioner's supervisor, was called by Petitioner's counsel to testify. Chaudri's testimony was consistent with that of Rivera. He noted Petitioner changed his description of the accident from going up the stairs to going down the stairs as well as the placement of Petitioner's left hand.

At the direction of Respondent, Petitioner was examined by Dr. Jason Young, an orthopedic surgeon, on March 27, 2017. At that time, Petitioner advised he sustained an accident while being trained on a machine that makes cardboard. Petitioner was working with another employee who hollered at him to come up the stairs and Petitioner did so quickly and proceeded up the stairs to a swinging door. Petitioner then put his hand on the swinging door and was directed by the other employee to stop and, when he did so, he did so suddenly. After that, Petitioner began to experience pain in his left shoulder blade going down his arm/hand and also had numbness in his left hand/fingers. Petitioner did not describe "...a substantial trauma or direct blow to the shoulder" or any "...eccentric force to the left shoulder." Petitioner just put his left hand on the swinging gate to stop his forward momentum (Respondent's Exhibit 2).

Dr. Young opined there was no internal derangement in Petitioner's left shoulder, but he did note Petitioner had some C7 type radicular symptoms. He opined Petitioner had left arm pain. He also opined that running up a flight of stairs and extending an arm to stop the momentum could cause radicular symptoms; however, he suggested Petitioner be evaluated by a cervical spine specialist to address the radicular findings (Respondent's Exhibit 2).

Petitioner sought treatment from Dr. Daniel Bunkhorst, a chiropractor, who initially evaluated him on April 6, 2017. According to Dr. Bunkhorst's record of that date, Petitioner informed him he sustained a work-related accident on February 21, 2017. Petitioner stated he was going up the stairs of a machine he was being trained to operate to clear debris. The trainer informed Petitioner the debris had been cleared at the time Petitioner reached the gate at the top of the stairs. "The patient states he had his left arm extended out in front of him while grabbing the gate and partially resting on the guard rail" and Petitioner fell forward injuring his left shoulder and neck (Petitioner's Exhibit 2).

Dr. Bunkhorst provided chiropractic treatment to Petitioner from April 6, 2017, through June 22, 2017. At the time of his last visit, Dr. Bunkhorst opined Petitioner was at MMI and released him from care. He opined the injuries Petitioner sustained were possibly a result of the accident (Petitioner's Exhibit 2).

Petitioner was also evaluated by Dr. Nathan Mall, an orthopedic surgeon, on April 12, 2017. According to Dr. Mall's record of that date, Petitioner sustained a work-related injury on February 21, 2017, when he was "jogging up" some steps to assist with the operation of a conveyor belt. His trainer then informed him the problem had been corrected. "He states his hand was then resting on the guard rail, and his momentum was going forward, causing him to jam his shoulder" and Petitioner developed left shoulder pain thereafter. Dr. Mall opined Petitioner had rotator cuff tendinitis which had resolved, Petitioner was at MMI and could work without restrictions (Petitioner's Exhibit 3).

At the direction of Respondent, Petitioner was examined by Dr. Kevin Rutz, an orthopedic surgeon, on December 19, 2017. This examination was in regard to Petitioner's alleged cervical spine injury. According to Dr. Rutz' report, Petitioner advised that on February 21, 2017, he was going up a flight of stairs and fell forward on his outstretched left arm and felt a pop in his left shoulder. Dr. Rutz opined Petitioner's cervical spine complaints had resolved at that time and there was no evidence of any cervical pathology (Respondent's Exhibit 3; Deposition Exhibit 2).

Dr. Rutz was deposed on June 29, 2018, and his deposition testimony was received into evidence at trial. Dr. Rutz' testimony was consistent with his medical report and he reaffirmed the opinions contained therein which included his restatement of the history provided to him by Petitioner regarding the accident of February 21, 2017 (Respondent's Exhibit 3; pp 5-6).

Dr. Young was deposed on December 4, 2018, and his deposition testimony was received into evidence at trial. Dr. Young's testimony was consistent with his medical report and he reaffirmed the opinions contained therein including the history Petitioner provided to him regarding the accident of February 21, 2017 (Respondent's Exhibit 4; pp 15-16).

Petitioner's employment was terminated by Respondent on April 10, 2017. Petitioner testified he was terminated because he had contacted an attorney regarding his work injury as well as poor job performance.

When Walter Rivera testified, he stated Petitioner's termination was solely because of poor job performance. He specifically stated Petitioner was not fired because he had contacted an attorney regarding his work injury.

Petitioner subsequently returned to work as a forklift operator for Amazon, but, for some unknown reason, he lost that job shortly thereafter. At the time of trial, Petitioner was unemployed. Petitioner has not sought any medical treatment for over two years for his left shoulder and neck issues, but he continues to complain of left shoulder and neck pain.

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 his employment by Respondent on February 21, 2017.

In support of this conclusion the Arbitrator notes the following:

As noted in the findings of fact, Petitioner provided multiple versions of how the accident of February 21, 2017, purportedly occurred which were inconsistent with one another.

At trial, Petitioner testified he was going up the steps, reached for the gate with his outstretched left arm, was told to stop, and the momentum of his body caused his left hand to strike the doorjamb.

The "First Aid Report" which was completed and signed by Petitioner noted Petitioner struck the gate with his left hand.

Petitioner testified a co-worker, Jeff Meng, witnessed the accident and, afterward, asked him if he was okay. Jeff Meng testified that he did not see Petitioner sustained the accident and did not ask Petitioner about his condition.

Petitioner informed Dr. Breeden he had put his hand on the doorjamb and then stopped abruptly.

Walter Rivera, the site manager, testified Petitioner changed his description of how the accident occurred when he was informed the gate swung outward and the Petitioner subsequently stated that he may have, in fact, been going down, not up the stairs.

When Petitioner was seen by Dr. Young, he gave a history of putting his left hand on a swinging door.

Petitioner informed Dr. Bunkhorst he sustained the injury while grabbing the gate and partially resting his arm on the guard rail.

Petitioner advised Dr. Mall he was resting his left hand on the guard rail and when he sustained the injury he jammed his shoulder because of his forward momentum.

Petitioner informed Dr. Rutz that he fell forward on going up a flight of stairs and fell forward on his outstretched left arm.

The Arbitrator finds that there were not just one or two minor inconsistencies in the histories of the accident provided by Petitioner, but several. Based upon the preceding, the Arbitrator finds Petitioner's credibility to be suspect.

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

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

STEPHEN P. COOK,

Petitioner,

vs. NO: 19 WC 07485

STATE OF ILLINOIS, DEPARTMENT OF NATURAL RESOURCES,

20IWCC0361

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petitions for Cross-Review under §19(b) having been filed by the parties herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, causal connection, prospective medical, temporary total disability, and penalties pursuant to §19(k) and §19(l), and attorney's fees under §16, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

Medical Bills
Section 8(a) of the Illinois Workers' Compensation Act states, in pertinent part,

§8(a): Employer to Pay Necessary Medical Expenses

Section 8. The amount of compensation which shall be paid to the employee for an accidental injury not resulting in death is:

> (a) The employer shall provide and pay the negotiated rate, if applicable, or the lesser of the health care provider's actual charges or according to a fee schedule, subject to Section 8.2, in effect at the time the service was rendered 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, even if a health care provider sells, transfers, or otherwise assigns an account receivable for procedures, treatments, or services covered under this Act. If the employer does not dispute payment of first aid, medical, surgical, and hospital services, the employer shall make such payment to the provider on behalf of the employee... *820 ILCS 305/8(a)* (West 2013)

The Arbitrator notes the gross charges of the medical bills submitted to Springfield Clinic (Petitioner's Exhibit 2) total $33,598.00. Petitioner testified that his benefits, including his temporary total disability benefits (TTD) and medical bills were paid beginning the day of the work accident on January 23, 2019 until June 15, 2019. (T, pp. 17-19) Petitioner's Exhibit 2 is a certified copy of the medical bills from Springfield Clinic in the form of a Statement of Professional Services that confirms the treatment dates, procedures/services, charges and the payments received from the workers' compensation insurance carrier through August 16, 2019, the date the certification was signed and eleven days before the Arbitration hearing. The Statement of Professional Services confirms that five therapy sessions, four in June and one in May, were unpaid as of August 16, 2019. All other service date payments were noted to be made by the workers' compensation insurance carrier and appear to be made pursuant to the workers' compensation fee schedule with adjustments made to the billed amounts leaving a zero balance. The five service dates that do not reflect payments received combine for a total of $2,040.00, the amount listed on page one as "Charges pending with your insurance."

The Commission finds that the Petitioner's testimony is consistent with the Statement of Professional Services from Springfield Clinic evidenced in Petitioner's Exhibit 2. Respondent paid the medical bills at Springfield Clinic, subject to the provisions of the fee schedule provided in Section 8.2 of the Act, except for five dates of therapy which total $2,040.00 for services rendered. Respondent is liable for the five physical therapy visits and shall satisfy these unpaid charges in accordance with Section 8(a) and subject to the provision of Section 8.2 of the Act. Respondent is to receive credit for any and all medical expenses paid.

All else is affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's Decision filed on December 5, 2019, is hereby modified for the reasons stated herein, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $991.08 per week for a period of 31 weeks, that being the period of temporary

total incapacity for work under §8(b), and that as provided in §8(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay for the reasonable related medical services provided by Springfield Clinic pursuant to Petitioner's Exhibit 2 as provided in Section 8(a) and subject to the provision of Section 8.2 of the Act. Respondent shall have credit for all medical bills paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall provide and pay for prospective medical treatment prescribed by Dr. Wolters and/or Dr. Cook.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's request for fees under §16, and penalties under §19(k) and §19(l) are denied.

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

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

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

Pursuant to Section 19(f)(1) of the Act, this decision is not subject to judicial review. *820 ILCS 305/19(f)(1) (West 2013).*

DATED: JUN 2 6 2020
KAD/bsd
O050520
42

Kathryn A. Doerries

Thomas J. Tyrrell

Maria E. Portela

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

COOK, STEPHEN
Employee/Petitioner

Case# **19WC007485**

ILLINOIS DEPT OF NATURAL RESOURCES
Employer/Respondent

20IWCC0361

On 12/5/2019, 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:

0246 HANAGAN & McGOVERN PC
BRIAN T McGOVERN
123 S 10TH ST SUITE 601
MOUNT VERNON, IL 62864

4993 ASSISTANT ATTORNEY GENERAL
CHELSA 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

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 - 5 2019

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

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Steven Cook
Employee/Petitioner

v.

Illinois Department of Natural Resources
Employer/Respondent

Case # **19** WC **007485**

Consolidated cases: _____

20IWCC0361

An *Application for Adjustment 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 **Springfield,** on **August 27, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ 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 **Petition for fees under Section 16, Petition for Penalties under Section 19(k) and 19(l)**

FINDINGS

On the date of accident, **January 23, 2019**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$77,304.00**; the average weekly wage was **$1486.62**.

On the date of accident, Petitioner was **50** years of age, ***single*** with **2** dependent children.

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

Respondent shall be given a credit of for paid TTD.

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

ORDER

Respondent shall pay the medical bills in the amount of $33,598.00 directly to Petitioner as provided in Sections 8(a) and 8.2 of the Act.
The Respondent shall authorize and pay for prospective medical treatment prescribed by Doctors Wolters and/or Cook.
The Respondent shall pay TTD benefits of $991.08 per week for 31 weeks from 1/23/19 to 8/27/19 as provided in Section 8(b) of the Act.

Based on the facts presented, Petitioner has failed to prove that Respondent's actions in denying medical treatment and TTD payments related to Petitioner's injury was unreasonable and/or vexatious. Petitioner's request for fees under Section 16, and penalties under Section 19(k), and 19 (l) 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.

Edward Lee
Signature of Arbitrator

11/25/19
Date

ICArbDec19(b)

DEC 5 - 2019

FINDINGS OF FACT

The Petitioner is an employee of the Respondent in the Division of Oil and Gas. He is a Well Inspector II and has been for over 20 years (T1-2, 37). He inspects oil wells for compliance with regulations. This requires him to walk in agricultural fields and the like (T10). Almost every day, he leaves directly from his house to go to the inspection sites and returns directly to his home at the end of the day (T8-9).

On January 23, 2019, he went directly from his house to perform inspections near Mechanicsburg, Illinois. After completing three inspections, he was walking in a bean field to the next well, when his right leg slipped, and his left leg went down. The field was muddy and the weather was cold and rainy (T9-10).

The Petitioner testified it took him a while to get back to, and into, his truck. He called Jim Stephens, his boss (T10-11). He did complete an accident report that listed the time of injury at 9:30, but he testified 8:30-8:40 a.m. would be more accurate, and he actually called Mr. Stephens at 8:56 a.m., not at 9:56 a.m., as stated in the report (T12, 71). Jim Stephens, the Respondent's witness, confirmed the Petitioner called him around 9:00 a.m. (T78).

He testified Mr. Stephens asked if he needed an ambulance, which he declined, because he injured his left leg so he could drive. He further stated he was cold and wet and would drive home and have a friend take him to the doctor (T12-13). He called Glen Freimuth en route to his house. Glen was in his driveway when he arrived. The Petitioner testified that once he arrived home he e-mailed the inspection reports (OG-22s) to the Respondent. He changed clothes, and Mr. Freimuth drove him to Springfield Clinic located at 800 North First Street in Springfield (T13-14).

He arrived around 10:00 a.m. at Springfield Clinic and first saw Tara Jain for his left knee injury. He gave her a history of walking through a farm field while at work on the way to an oil well and fell, with his knee going straight back on him. She immediately suspected a distal quadriceps tendon rupture (Pet. Ex. 1). She referred him to Dr. Wolters in the same Clinic.

He saw Dr. Wolters at 11:00 a.m. Dr. Wolters' history of the accident is that the Petitioner was walking through a cornfield that was partially frozen and that he slipped on his right leg and tried to catch himself with his left leg. He has no prior left knee issues. Dr. Wolters immediately recommended surgery.

Mr. Cook had surgery on January 25, 2019, which confirmed an acute full thickness quadriceps tendon rupture, which required a reconstruction with four holes drilled in the patella for anchoring.

The Respondent accepted the claim as compensable and paid all medical and TTD through June 15, 2019 (T17-18). The Petitioner is not at MMI, and he has only been released to sedentary duty, which the Respondent has not accommodated (T19, 61-62).

The Petitioner testified the Respondent terminated his benefits, alleging that the Petitioner was not at work when he got hurt (T19). That is, he never went to the well sites but rather was at his house.

The Respondent called James Stephens to testify. He testified he has been employed with the Respondent for 31 years (T77). He was the Petitioner's supervisor on January 23, 2019. He testified that on January 23, 2019 around 9:00 a.m., he received a call from the Petitioner who stated he injured his leg when he slipped and fell at a well site. He testified the Petitioner did not want him to send an ambulance or another inspector (T78-79).

He testified that in late 2017 the Respondent placed a program called Field Force Manager (FFM) on its employees' state-issued cell phones (T79).

He testified the program is set up to run from 7:00 a.m. to 5:00 p.m., Monday through Friday (T80). He further testified that the "GPS is accurate to within 15 feet" (T81).

He further testified the Respondent set FFM to record a data point every three minutes and a stop point. A stop point is a stop that is made after moving 600 feet and then there is no movement for a 10-minute duration (T81).

Stephens testified Respondent's Exhibit 6 was "a recording of stop points for Mr. Cook" on January 23, 2019 and was provided to him by FFM upon his request. He testified FFM returns all stop points, but they retain every three-minute data points for only 60 days (T82). Stephens testified, and Respondent's Exhibit 6 confirms, that it was not requested until June 6, 2019 (T94-95).

He testified Respondent's Exhibit 6 shows that on January 23, 2019 the Petitioner logged on at 7:31 a.m. and logged off at 7:32 a.m., while at his home located at 3871 Bison Trail, Rochester, Illinois (T82).

He further testified that FFM is an application (app) on the phone, and the app requires the person to go in and open the app. Opening the app "starts it automatically." Also, there is a feature on the app that allows you to press a button to shut it down. He initially testified that is what "it appears" happened based upon Respondent's Exhibit 6.

He further testified Exhibit 6 shows the phone was turned back on again at 11:59 a.m. when the phone was located at 800 North First Street in Springfield, Illinois (T83-84).

Although he testified FFM never had any problems, Stephens also testified the "only time this program will not work is if either the GPS on the cell phone has been shut off or the app has been exited." He then testified that if the program was not working it would send an e-mail to both the employee and the administrator (T84-85).

When asked if it was his opinion that the phone was deliberately turned off at 7:32 a.m. and not turned on again until 11:59, he could only answer "the app was disconnected at 7:32 and not turned back on" (T85-86).

On cross-examination, Stephens testified that the State issues well inspectors a pickup truck, a laptop, and a cell phone, but there is no GPS tracking on the truck or laptop (T86-87).

When asked how we know Respondent's Exhibit 6 is the Petitioner's state cell phone, he testified that, although the Petitioner's state cell phone number is nowhere on the exhibit, it says worker Steve, and the Petitioner is the only worker named Steve (T87-89).

He testified Verizon is the State's cell phone service provider and FFM is a different company. He testified he received training from FFM, at both the user level and management level, and trained his replacement (T90-91).

He testified FFM was set up by the Respondent so that it could only collect data between the hours of 7:00 a.m. and 5:00 p.m. regardless of anything else; FFM cannot even be logged into outside those hours. Between the hours of 7:00 a.m. and 5:00 p.m., FFM has to be logged on and off by the user (T91-94).

He admitted that FFM is set up to take a data point every three minutes but that information is only available for 60 days (T94). He further admitted Respondent's Exhibit 6 was not run until June 6, 2019, when he requested it from FFM, because another employee had raised questions about the Petitioner's injury (T94-95).

He testified Respondent's Exhibit 6 shows the Petitioner logged off his state cell phone on January 22, 2019 at 3:32 p.m., while at the address of 1630 Young Road, Mechanicsburg, Illinois. Although he admitted GPS was set up to record to an accuracy of 15 feet, when asked which 15 feet the Petitioner was located on at the 1630 Young Road address, he stated that is the closest address it came up with (T96-97). There are no GPS coordinates on Respondent's Exhibit 6.

He testified that Respondent's Exhibit 6 shows the phone was logged on at 7:31 a.m. on January 23, 2019 while at 3871 Bison Trail, Rochester, Illinois (T98).

He testified the next line down under the Departure Time column shows, that in the 60 seconds between 7:31 a.m. and 7:32 a.m., the phone was moving and was logged off at 7:32 a.m. despite no logoff shown under the Event Name column (T99; Respondent's Exhibit 6).

When asked why Respondent's Exhibit 6 showed the Petitioner's state phone was located at Rochester, Illinois, between 7:31 a.m. and 7:32 a.m., when it began to move, but the next row shows the same phone located in Springfield, Illinois, also at 7:32 a.m., he testified that at 7:32 a.m., the phone stopped reading any GPS data. The next GPS data of any kind was when the phone was located 14.1 miles away, 4 hours and 27 minutes later, which was the last known location (T100-105).

The Petitioner's counsel asked the witness why, under the Event Name column in Respondent's Exhibit 6, it could show that the Petitioner logged in at 7:31 a.m. and then logged in again at 11:59 a.m. without a log off shown in the Event Name column. The witness admitted the exhibit showed no logoff and only then said it is possible to go into settings and shut off the GPS

location service without logging off the app (T105-106). When asked if there is a report that shows that is what happened, he admitted there is none.

He further testified that there is a "consensus" with FFM that the only way GPS data will not be collected is 1) the phone is off; 2) the battery is dead; 3) the app is exited, or 4) the GPS has been disconnected on the settings (T107).

Stephens then admitted the Petitioner did not turn his State cell phone off because the Petitioner called him from his state cell phone to report the injury at 9:00 a.m. (T108, 78). Obviously, the battery was not dead for the same reason.

Stephens admitted that FFM could provide no report to show whether the Petitioner's phone was logged out of or he had turned off his GPS tracking (T108-109).

The witness again repeated that Respondent's Exhibit 6 shows the Petitioner logged off, but when pressed as to why the exhibit does not show a logoff under Event Name, he changed his answer to the Petitioner "shut the GPS service off" (T109). When further pressed as to where in Respondent's Exhibit 6 it shows that revised testimony, he admitted that it does not. He further testified it never would because that is a Verizon function, not a FFM function. He further admitted he had not requested any records from Verizon. He also admitted he had no idea if Verizon would even have that information. However, he knows FFM would not have that information because that is not within FFM's purview - FFM only tells what happens on the app, not what happens on the phone (T110-111).

The witness then testified that if FFM is not in contact with the server for 65 minutes, it sends an e-mail to him, and he had, on a few occasions, called the Petitioner when this had happened (T113-114). He testified that he probably received an e-mail on the morning of January 23, 2019 during the 4.5 hours the phone was allegedly shut off, but that e-mail was not presented as an exhibit at this trial (T114-115).

The Petitioner testified in detail concerning the events, his actions, and his whereabouts the morning of January 23, 2019.

The Petitioner testified there is an app (FFM) on his state cell phone that tracks employees. He testified it sometimes works and sometimes does not (T19, 20). He further testified he has to start the app every morning, and he has received many e-mails and texts telling him he needed to restart the program because it is not working (T19-20). He testified he is required to submit OG-22 field reports for each violation on a well that he inspects (T20). He testified he inspected three wells the morning of January 23, 2019 before getting hurt. He testified he inspected Hampton #1 first, Kilbride #2 second, and Kilbride #1 third (T55-56).

Petitioner's Exhibits 4, 5, and 6 each consist of five pages and are the OG-22s on the three wells the Petitioner inspected the morning of January 23, 2019.

The Petitioner testified that Exhibit 4 is the inspection report for the Hampton #1 well (T21). There are two OG-22s because there are two violations (T22). He testified each well has a

reference number in addition to the common name. He testified each well is further identified by its longitude and latitude location shown in the lower right corner of the top box. He testified the case number is the violation, which is recited in the comments section of the OG-22 reports in Petitioner's Exhibit 4 (T22-23).

He testified that is his electronic signature on the bottom and he input that and the January 23, 2019 date on January 23, 2019 (T23). He testified the OG-22s are on his state laptop and they are empty until he types in the reference number and the OG-22 then automatically populates all of the well information, including the date in the lower left-hand corner of the top section and longitude and latitude (T25).

He testified he did complete the reports on the morning of January 23, 2019 while in his truck near the Hampton #1 well site (T26). He further testified that upon completion of the OG-22 he hits a button and it is now saved (entered) in his drafts e-mail. In order to e-mail the OG-22, he has to go into his draft e-mail account and send it (T26-27).

The Petitioner authenticated pages 3 and 4 of Petitioner's Exhibit 4. He testified each page is associated with its OG-22 counterpart that he completed while sitting in his truck after the inspection (T26). He testified that the bottom of each email is where he, stevecook@illinois.gov, sent Steve Hardin, smhardin@hotmail.com, the owner of Trident Resources and permittee of Hampton #1, the OG-22 reports. Page 3, for instance, shows that at "9:23 AM" he sent that OG-22 report to Mr. Hardin, and page 4 shows that he sent that OG-22 report to Mr. Hardin at "9:23:06 AM." The Petitioner testified Emily White, whom he copied in on these e-mails, is the Springfield District Office secretary of the Division of Oil and Gas (T27-29).

He also explained that the "**Subject**" line on the e-mail from him to Hardin and Emily White also self-populates at the time he completes an OG-22 and goes into his draft e-mails (T29-31). Thus, looking at that same bottom email on page 3, the date and time "01-23-2019 8-09-11 AM" in the "**Subject**" line is when he completed that particular OG-22 and saved it to the email drafts at the well site. He further clarified that the times "8:09:11 AM" and "8:07:23 AM" on pages 3 and 4, respectively, in those emails' subject lines, are an "entry time" of the completed OG-22 reports into his e-mail drafts (T30-31) and the "sent time[s]" of "9:23 AM" and "9:23:06 AM" are when he actually sent the OG-22s from his driveway after the injury and after he drove home (T59).

Mr. Cook further testified that the fifth page of Petitioner's Exhibit 4 is the State's database for the Hampton #1 well (T32). He testified that lines 17 and 18 show he e-mailed these two OG-22 reports on January 23, 2019 and the Respondent entered them on February 7, 2019 (T33).

The Petitioner was shown Petitioner's Exhibit 5. He testified it consisted of five pages just as Petitioner's Exhibit 4. He again testified as to how the information got in Exhibit 5, what that information means, and authenticating of the e-mails (pages 3 and 4), etc., would be the same as they were for Petitioner's Exhibit 4, except for the information of the actual inspection (T34).

More specifically, he testified Petitioner's Exhibit 5 was the OG-22 reports he completed the morning of January 23, 2019 for the Kilbride #2 well, reference number 500770 (T33-34).

Moreover, he testified the entry time of the two reports was "01-23-2019 8-17-29 AM" and "01-23-2019 8-14-37 AM" He emphasized that those times in the subject line are self-populating; he did not input the times - the Respondent's program did (T35). He testified he sent those two OG-22 reports to Steve Hardin and the Respondent at "9:22:09 AM" and "9:22:33 AM" (T35).

Mr. Cook was then shown Petitioner's Exhibit 6. He testified this exhibit was the same as Petitioner's Exhibit 4 and Petitioner's Exhibit 5, except it was the OG-22 reports for the Kilbride #1 well, reference number 500768. The entry time of those two violations were "01-23-2019 8-22-38 AM" and "01-23-2019 8-35-26 AM," and he sent those at "9:21 AM" and "9:21:57 AM" (T36).

The Petitioner testified that it is his habit not to send the e-mails until he is done with the whole lease or all the inspections (T31, 37).

The Petitioner testified that over his 20-plus years as a well inspector he had been to the wells he inspected the morning of January 23, 2019 several times and was familiar with the geographic area they are located (T37-38). He testified he was hurt after he entered the OG-22s but before he sent them (T38). He testified he was hurt walking to the next wells he was going to inspect but never got there so did not inspect them, and therefore, there are no OG-22s on them (T39).

Mr. Cook testified Petitioner's Exhibit 7 is an image from Google Earth, which shows his home address in the lower left-hand corner of the image and the location of the three wells he completed inspections on the morning of January 23, 2019; namely, Kilbride #1, Kilbride #2, and Hampton #1. He testified that, based upon his personal knowledge of these wells, they are accurately located on Petitioner's Exhibit 7 (T40). He further testified, based upon his personal knowledge, that Petitioner's Exhibit 8 accurately reflects the location of those three wells relative to Bullard Road, which is shown on Petitioner's Exhibit 8 (T40-41).

The Petitioner testified Petitioner's Exhibit 9 is a close up image of Petitioner's Exhibit 8 and shows the three inspected wells as pins, as well as where the Petitioner's personal cell phone was located at 8:50 a.m. (T41). He testified that one can now see the actual wells on the earth's surface. He testified that the wells he was walking to in order to inspect were across from Kilbride #1 and can be seen in the upper left-hand corner of Petitioner's Exhibit 9 (T41-42).

The Petitioner further testified that the numbers shown on Petitioner's Exhibit 9 for the three pinned wells are longitude and latitude, and he then testified that the longitude and latitude for each of these is the same as the longitude and latitude for these three wells from Petitioner's Exhibits 4, 5, and 6 - the OG-22 reports (T43-44).

Mr. Cook testified that he had his personal cell phone with him at the location of the inspected wells the morning of January 23, 2019. He testified that Petitioner's Exhibit 10 was AT&T's response to a subpoena requesting the precise location of his personal cell phone between 7:15 a.m. and 10:15 a.m. on January 23, 2019 (T44-45).

The Petitioner testified in detail regarding the 3-page document entitled "Historical Prevision Location Information" (HPLI) from AT&T's Subpoena; specifically, Item 51.

He testified his personal cell number is listed in the IMSI/Phone Number column and the Connection date was January 23, 2019. He then testified the column entitled "Connection Time" for Item 51 reads 14:50:39, which is 8:50:39 a.m. Central Standard Time (CST) (T47-48).

He testified he knew this because GMT time is the same as Universal Time (UTC), and Petitioner's Exhibit 13 is a conversion chart for UTC Time to CST and 1400 on the chart is 0800, which is 8:00 a.m. (T49).

He then testified the next two columns on the HPLI are longitude and latitude and the last column entitled "Location Accuracy" shows the Item 51 GPS location is likely better than 300 meters (T49-50). He then confirmed that the longitude and latitude of his personal cell phone location on Petitioner's Exhibit 9 are the same as that shown on Item 51 of the HSPI in AT&T's Subpoena response (T50). He further testified that only the HSPI had any accuracy readings in the AT&T's Subpoena response (T51-52). The Petitioner did acknowledge other closer location accuracies and testified that 10,000 meters is over 6.2 miles (T52-53).

The Petitioner testified as to a timeline of his activities the morning of January 23, 2019.

On the morning of January 23, 2019 he started work at 7:30 a.m. and he turned on FFM on his state cell phone, turned on on his state laptop, and got everything rolling while at home. He testified he went straight to the wells and it took him 15 minutes, give or take, to get there (T53-54).

He testified that an inspection is either driving or walking to the well, then doing the inspection itself, then back to the truck, then completing the OG-22 and making the entry to his draft e-mails (T54-55).

He testified he finished inspecting the three wells approximately 8:30 a.m., give or take (T55). He testified he inspected Kilbride #1 third (T55). The entry time in the "**Subject**" line on the fourth page of Petitioner's Exhibit 6 is "8:35:26 AM."

He then reiterated his prior testimony that he was walking to the Hampton #2 and Hampton #2A wells in a bean field on a cold, rainy day, when he suffered the injury and made it back to his truck around 9:00 a.m., give or take (T56-57).

He again testified he called Jim Stephens immediately and his wife and neighbors because he was going to go home first to change his clothes and get a ride to the hospital (T57).

He testified that after logging on to his state phone at 7:30 a.m. he never turned it off and never logged off (T57-58).

He did not recall making any calls on his state cell phone between 7:30 a.m. and the time he got home after the injury other than to Jim Stephens to report the injury (T57-59).

He again testified that he did not actually send the OG-22 reports (Petitioner's Exhibits 4, 5, and 6) until he had gotten home and was sitting in his driveway after the injury happened (T59). His neighbor, Glen Friemuth, drove the petitioner to the hospital (T59).

He testified he does not know how FFM tracks his state cell phone and he does not know how to disable GPS on his state phone without logging off (T60).

He reiterated that he had been released by his doctor to sedentary duty and made himself available to work, the Respondent knew he was on sedentary duty, and the Respondent did not offer sedentary work (T61-62).

On cross-examination, the Petitioner admitted he started work at his house at 7:30 a.m. and drove to the first well. He testified he thinks he walked to two wells and drove to one but he did not know for sure. He admitted he went to each well, did the inspection, and then went back to his truck, and wrote the report, then fell going to the next well. He admitted he sent the reports from his house. He did not know if there was any data on the report showing where it was sent from (T63-66).

The Petitioner testified Petitioner's Exhibit 10 did not show phone calls made, just where his personal cell was located (T67, 68-69). He admitted the longitude and latitude on Petitioner's Exhibit 10 simply show where his phone was within whatever accuracy it shows (T68-69). He testified FFM had been on his state phone about a year and one half (T70). He denied filing a grievance related to FFM being put on his state cell phone (T70).

He admitted he filled out an accident report while at the Springfield Clinic when the Director of Oil and Gas, Mike Minkowski, hand delivered it to him (Respondent's Exhibit 4).

The Petitioner admitted he originally put 9:30 a.m. as his time of injury but it was really 8:30 a.m. and reported it at 9:56 a.m. but is really closer to 9:00 a.m. He testified he called his supervisor immediately after getting in his truck at the well sites (T71-72).

He admitted he had a previously scheduled doctor's appointment for the afternoon of January 23, 2019 and was scheduled to be off at noon (T72).

He testified FFM sometimes works and sometimes it does not and he does not know it is not working until he gets a text or e-mail that says to restart FFM and he did not receive one on January 23, 2019 (T72). He admitted that as far as he knew FFM was working on the morning of January 23, 2019. He testified he was about 100 yards from his truck when he was injured and he guessed it took him 20-25 minutes to get back to his truck.

He admitted that he gave his sedentary duty work release to two people at the office: Jackie Parsons and Wendy Williams (T74). He admitted no one from the office called him and said they would not accommodate him. Someone told him there is no sedentary work for oil field inspectors, although he could not remember if it was Jim Stephens for sure (T74).

On redirect, the Petitioner testified that if the Respondent had told him to come to the office, he would have reported to work (T75-76). He admitted that Petitioner's Exhibit 10 may show his phone at Kilbride #1 or one of the other wells but its location accuracy may be 5,000; 10,000; or 25,000 meters away (T76).

ARBITRATOR'S CONCLUSIONS

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

The Respondent contends that the Petitioner was not injured where he said he was injured; thus, it did not arise out of and in the course of his employment. The Respondent's evidence in support of this allegation is Respondent's Exhibit 6 and the testimony of Jim Stephens, field manager at the Respondent's Division of Oil and Gas. Respondent's Exhibit 6 is a report from Field Force Manager (FFM), which is a GPS tracking program placed on the Petitioner's state cell phone.

The Arbitrator has carefully reviewed and considered this evidence. The witness did not testify where the Petitioner was injured. He did testify the Petitioner called him from his state cell phone at approximately 9:00 a.m. the morning of January 23, 2019 and the Petitioner told him he was at an inspection site.

Much of Mr. Stephens' testimony was confusing in that there appears to be a difference in the FFM program between logging in and logging off, which would show under Event Name, and turning the FFM program itself on and off. But he used log in/log off and on/off interchangeably when testifying what he thought the Petitioner had done. But he had to admit, that Respondent's Exhibit 6 shows a log in at 7:31 a.m. but no log off before the next log in at 11:59 a.m. (T106); therefore, the Petitioner did not log off.

When confronted with this fact, Stephens then testified it is possible to go into settings and shut off the GPS service without logging off (T106). However, he did not testify Respondent's Exhibit 6 supported this possibility. Rather, he admitted there is no FFM report that would show that is what happened (T106-107).

He further testified that there is a "consensus" with FFM that the only ways that GPS data is not picked up is if:

1. the phone is turned off;
2. the battery is dead;
3. the app is exited; or,
4. GPS is disconnected in the settings.

(T107).

The Respondent admitted the battery was not dead and the Petitioner's state cell phone was on because the Petitioner called him to report the injury at 9:00 a.m. (T108, 78); squarely in between 7:31 a.m. and 11:59 a.m. Also, exiting the app would show as a log off under Event

Name, which Respondent's Exhibit 6 does not show. So that leaves only option 4. When challenged about option 4, Stephens testified that disconnecting from GPS without logging off would never show up on Respondent's Exhibit 6 because "that has nothing to do with Field Force Manager" (T110). That would have to come from Verizon, and he testified that he did not request records from Verizon; nor did he have any idea if the Department [of Oil and Gas] requested Verizon records. Yet, he then stated he did not know whether Verizon would even have information establishing that the Petitioner shut off the GPS on his state phone through settings (T110-111).

The Arbitrator notes Stephens testified that Respondent's Exhibit 6 shows there was no GPS data for 4 hours and 27 minutes (T100-105). The Arbitrator further notes that Stephens testified that when the server loses contact with the phone for 65 minutes that he, as administrator, would receive an e-mail from FFM. He testified that he "probably" received an e-mail on the morning of January 23, 2019 regarding the Petitioner's state cell phone and it is in his archived e-mails (T114). The Respondent did not offer that e-mail into evidence nor did he testify he either called or forwarded that e-mail to the Petitioner. The Petitioner logged on at 7:31 a.m. and was hurt at approximately 9:00 a.m. - a period of 90 minutes. The Petitioner testified he did not turn his phone off or log off (T57-58, 123). He also testified he does not know how FFM tracks his state cell phone and he does not know how to disabled his state phone without logging off (T60). The Petitioner further testified that he only knows FFM is not working if he gets a phone call, a text, or an e-mail and he did not receive any of these the morning of January 23, 2019 (T72).

The Arbitrator feels the Respondent's evidence, given the seriousness of the allegation, is more speculative than factual and surprisingly superficial.

But, even assuming the Respondent is correct, that the Petitioner logged on at 7:31 a.m. and then logged off at 7:32 a.m. and/or turned his phone or GPS setting off until 11:59 a.m., such that the period of time between 7:32 a.m. and 11:59 a.m. is unaccounted for, that does not at all prove where the phone was during that 4 hours and 27 minutes. The Respondent offered absolutely no testimony where the Petitioner's state phone actually was at the time period in question and Respondent's Exhibit 6 does not show that. There is absolutely no GPS data on Respondent's Exhibit 6 between those times. The Arbitrator gives Exhibit 6 little to no weight in supporting the Respondent's charge.

Whereas the State's evidence lacks corroboration of its allegation that implies deceit by the Petitioner; the Petitioner's timeline evidence is compelling and corroborated; and, most importantly, he has provided actual evidence his personal cell phone was located at the inspection site at the time of his injury.

The timeline accounting for the 4-1/2 hour period begins with the Petitioner logging into FFM at 7:31 a.m. while located at his house (Respondent's Exhibit 6). The Respondent's witness, Jim Stephens, testified that between 7:31 a.m. and 7:32 a.m. the Petitioner's state cell phone "was moving" (T99) and at 7:32 a.m. the phone stopped reading GPS data and did not do so again until 11:59 a.m. Thus, Respondent's Exhibit 6 provides no information regarding the location of the Petitioner's state cell phone between 7:31 a.m. and 11:59 a.m.

The Petitioner testified that on January 23, 2019 he started work at 7:30 a.m. at his house (T63-64). He drove straight from his house to the first well, which took about 15 minutes so he arrived on site at 7:45 a.m., give or take (T54).

The Petitioner testified he inspected Hampton #1 first, Kilbride #2 next, and Kilbride #1 third (T55). He testified he finished those inspections at approximately 8:30 a.m., give or take (T55). The Petitioner testified he "entered" the OG-22s at the well location following each well's inspection and they were saved in his draft e-mails. He then "sent" them later (T31). The last entry time from Petitioner's Exhibits 4, 5, and 6 "8-35-26 AM," which is the Kilbride #1 well (Exhibit 6). The first entry is "8-07-23 AM" (Exhibit 4). The Arbitrator has also eyeballed the various distances in Petitioner's Exhibits 7, 8, and 9 and finds the entry times from Petitioner's Exhibits 4, 5, and 6 and testified to by the Petitioner is entirely credible, given what would have been the Petitioner's driving and walking distances in the exhibits. Moreover, the Arbitrator notes the Petitioner traveled to the well sites from the south and the Petitioner's testimony that he inspected Hampton #1 and then Kilbride #2 and then Kilbride #1 is common sensical and geographically logical, given their relative locations.

The Petitioner testified that after completing the OG-22s for Kilbride #1 he began walking to Hampton #2 and #2A (T56), which are across the road from Kilbride #1 and can be seen in the upper left-hand section of Petitioner's Exhibit 9 (T42). This, too, makes geographic sense.

He testified that after he got hurt it took him 20-25 minutes to get back to the truck (T73) and he immediately reported the injury with his state cell phone to Jim Stephens at 9:00 a.m., give or take (T57).

The Petitioner further testified he drove home and while sitting in his driveway he e-mailed the inspection reports to the well owner and the Respondent. Petitioner's Exhibits 4, 5, and 6 establish all six OG-22s were sent between "9:21 AM" and "9:22:33 AM." Again, the timeline from the well site to arriving back home is supported by Petitioner's Exhibits 4, 5, 6, and 7.

The Petitioner testified after sending the e-mails he changed his clothes and then his friend drove him to the Springfield Clinic (T14, 57).

Petitioner's Exhibit 1 clearly shows he saw Tara Jain on January 23, 2019 at 10:00 a.m. It further shows he saw Dr. Wolters at 11:00 a.m. The Arbitrator notes that Respondent's Exhibit 6 shows the distance between the Petitioner's home and the Springfield Clinic is 14.1 miles. The Arbitrator notes that at 70 miles per hour it takes 12 minutes to travel 14.1 miles. Thus, again, the Petitioner's timeline testimony is strongly supported by verifiable corroborating evidence.

Finally, the Petitioner testified he had his personal cell phone with him at the wells the morning of January 23, 2019 (T44, 45).

The Petitioner subpoenaed his personal cell phone GPS locations between 7:15 a.m. and 10:15 a.m. on January 23, 2019 from his mobile service provider, AT&T (Petitioner's Exhibit 10). Item 51 in the section entitled, "Historical Precision Location Information" (HPLI) gives the exact

longitude and latitude of the Petitioner's personal cell phone at 8:50 a.m. on January 23, 2019. It states its accuracy is likely better than 300 meters. The Arbitrator understands that longitude and latitude is a specific GPS location method, and Petitioner's Exhibits 4, 5, 6, and 10 are the only exhibits in the record with longitude and latitude identification. Respondent's Exhibit 6 has no GPS location coordinates. Importantly, Item 51 of Petitioner's Exhibit 10 undeniably proves that the Petitioner's personal cell phone was at the well location (place of injury), within a radius of just 300 meters.

The Arbitrator has also reviewed and considered the entire HPLI section of Petitioner's Exhibit 10, as well as Respondent's Exhibit 9.

The Arbitrator notes the HPLI section is the only section of the subpoena's response which provides accuracy information. The Arbitrator notes Item 86 is the earliest time - 7:26:40 a.m. (after conversion) and Item 1 is the latest - 9:56:53 a.m. (after conversion). The Arbitrator notes accuracies range from 200, 300, and 400 meters to 5,000, 10,000, and 25,000 meters. The Arbitrator notes that 10,000 meters is 6.2 miles.

The timeline described above establishes a few relevant time periods. E.g., at or around 7:31 a.m., the Petitioner was at 3871 Bison Trail. Between roughly 7:45 a.m. to 9:00 a.m. he was at the well sites. His home address and the well sites can be clearly seen in Petitioner's Exhibit 7. Another relevant period is at 9:21 a.m. when he was back at his home following the injury.

The Respondent offered no testimony whatsoever regarding its Exhibit 9 but the Arbitrator can see that the second and third pages are copies of the HPLI from Petitioner's Exhibit 10. The Arbitrator can also juxtapose the Respondent's map in its Exhibit 9 with Petitioner's Exhibit 7. Moreover, the Arbitrator surmises that the numbered green dots on Respondent's Exhibit 9 are the numbered longitude and latitude locations on the second and third pages of the exhibit. The Arbitrator notes, however, that the longitude and latitude are not displayed on the map's green dots and, given there was no testimony about their accuracy, they are more suspect to input error. Nevertheless, the Arbitrator can draw some general conclusions regarding the location of the green dots.

Green dots 1 and 2 are items 74 and 68 on the HPLI. They are just north of the Petitioner's home at 3871 Bison Trail at 7:36 a.m. At these locations, the HPLI states accuracy is likely better than 400 meters and their locations are further supported by the testimony of witness Stephens that the Petitioner's state cell phone "was moving" between 7:31 a.m. and 7:32 a.m. and the Petitioner's testimony that he left straight from home to go to the wells and would have been heading north.

Green dots 3, 4, and 5 are Items 63, 57, and 52 on Petitioner's HPLI. The Arbitrator takes notice that Item 51 is the location the Petitioner authenticated on Petitioner's Exhibit 9 and its location accuracy was likely better than 300 meters. Though green dot 3 was at 10,000 meters, green dot 4 at 5,000 meters, and green dot 5 was unknown, they are in the general area of the wells where the Petitioner testified he was at the time. Green dots 6 and 7, Items 46 and 39, are at 9:15:48 a.m. and 9:23:37 a.m. The former being when the Petitioner was driving back home following the injury and the latter after he arrived home following his fall. Their accuracy is a poor 10,000

and 25,000 meters. Dots 8 and 10, Items 37 and 23 on the HPLI, are 26 seconds apart and their accuracy is likely better than 200 and 600 meters, respectively. They are at the Petitioner's house as the Petitioner testified and his sent e-mails reflect. The latest reading, green dot 13, Item 4, is taken at 9:48:10 a.m. when the Petitioner was on his way to the Springfield Clinic and that dot's location supports that.

In sum, Respondent's Exhibit 9 actually better supports the Petitioner's case than the Respondent's contention that he never went to the wells the morning of January 23, 2019.

Base on the foregoing, the Arbitrator concludes the Petitioner did sustain an accident that arose out of and in the course of the Petitioner's employment by the Respondent.

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

The Petitioner credibly testified that on the morning of January 23, 2019 he was walking in a muddy field on a cold and rainy day when his right leg slipped and sustained an injury to his left leg. There is no evidence of any prior left knee problems and the medical evidence in the records confirms this. The description of the injury is compatible with a knee injury. The Petitioner immediately reported the injury and promptly sought and obtained medical treatment. He was immediately diagnosed with distal quadriceps tendon rupture, which was operated on just two days later.

Therefore, the Arbitrator concludes the Petitioner's current condition of ill-being in his left knee is causally related to his accident of January 23, 2019.

This is based upon the Petitioner's credible testimony, the medical records, no contrary evidence in the record, and the chain of events. A chain of events, which demonstrates a previous healthy left knee, an accident, and a clear 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?

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

The Petitioner's only medical treatment has been at the Springfield Clinic. The Petitioner submitted Springfield Clinic's bill (Petitioner's Exhibit 2). The Arbitrator notes the gross charges total $33,598.00.

The Petitioner also claims TTD benefits from January 23, 2019 through the date of hearing, August 27, 2019 (31 weeks).

The Petitioner also claims entitlement to prospective medical care.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

SVEN MUNCK,

Petitioner,

vs. NO: 18 WC 28664

TOWNE MACHINE TOOL COMPANY,

20IWCC0362

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, causal connection, permanent disability, §19(k) and §19(l) penalties, attorneys' fees under §16, and evidentiary objections to Respondent's Exhibits 6, 7, 8 and 18, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission affirms and adopts the Arbitrator's Decision, however, the Commission disagrees with the Arbitrator's ruling on one evidentiary objection. The Arbitrator allowed Respondent to enter into evidence the Respondent's Interoffice Memorandum to File (RX6) over Petitioner's objection on the basis of relevance. The Commission finds that the Interoffice Memorandum is not relevant to the facts or to the case before the Commission, and was improperly admitted and, as such, strikes Respondent's Exhibit Six from the record.

The Commission further finds that the admission of RX6 is harmless error, and the Commission agrees with the Arbitrator's Conclusions of Law. Thus, the Commission affirms and adopts the Findings and the Conclusions of Law in the Arbitrator's Decision, specifically, that Petitioner failed to prove that his subsequent accident on March 5, 2018, while at home, was causally connected to his work activities or to the work accident on February 16, 2018. Petitioner further failed to prove his ongoing condition of ill-being was related to the work-accident on February 16, 2018. Therefore, Petitioner is not entitled to TTD or medical benefits since both benefits only started accruing after the non-work related March 5, 2018, accident. The

20IWCC0362

Commission further finds that Petitioner suffered a lumbar strain as a result of the work-related accident on February 16, 2018.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's Decision filed on December 3, 2019, is hereby modified for the reasons stated herein, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner failed to prove that his subsequent accident on March 5, 2018, while at home, was causally connected to his work activities or to the work accident on February 16, 2018. Petitioner suffered from a lumbar strain as a result of the work-related accident on February 16, 2018. Petitioner also failed to prove that his ongoing condition of ill-being was related to the work-accident on February 16, 2018. Therefore, Petitioner is not entitled to TTD or medical benefits since both benefits only started accruing after the non-work related March 5, 2018, accident.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $654.62 per week for a period of five weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the loss of use of 1% of the person as a whole. However, Respondent has already provided Petitioner an advance of permanent partial disability benefits in the amount of $4,909.56, for which Respondent is entitled to a credit. Respondent shall also be given a credit of $19,534.54 for TTD benefits paid. Therefore, Respondent has satisfied its liability for the compensation awarded.

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: JUN 26 2020
KAD/bsd
O050520
42

Kathryn A. Doerries

Thomas J. Tyrrell

Maria E. Portela

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MUNCK, SVEN
Employee/Petitioner

Case# **18WC028664**

TOWNE MACHINE TOOL COMPANY
Employer/Respondent

20IWCC0362

On 12/3/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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:

1551 STOKES LAW OFFICES
JACOB R JACKSON
200 N GILBERT
DANVILLE, IL 61832

1337 KNELL LAW LLC
LLIR IMERI
504 FAYETTE ST
PEORIA, IL 61603

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

Sven Munck
Employee/Petitioner

v.

Towne Machine Tool Company
Employer/Respondent

Case # **18** WC **28664**

Consolidated cases: _____

20IWCC0362

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Hemenway**, Arbitrator of the Commission, in the city of **Springfield**, on **June 20, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **February 16, 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 $**56,733.56**; the average weekly wage was $**1,091.03**.

On the date of accident, Petitioner was **55** years of age, ***married*** with **0** dependent children.

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

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

Respondent shall be given a credit of $**19,534.54** for TTD, $**0** for TPD, $**0** for maintenance, and $**4,909.56** for other benefits, for a total credit of $**24,444.10**.

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

ORDER

The Arbitrator finds that Petitioner only suffered a lumbar strain as a result of the work-related accident on February 16, 2018.

Petitioner failed to prove that his subsequent accident on March 5, 2018, while at home was in any way casually connected to his work activities or to the work accident on February 16, 2018. Petitioner also failed to prove that his ongoing condition of ill-being was in any way related to the work-related accident on February 16, 2018. Therefore, Petitioner is not entitled to any TTD or medical benefits since both benefits only started accruing after non-work related March 5, 2018, accident.

As a result, of the work-related portion of this claim, that being a temporary back strain that resolved without treatment, Respondent is to pay Petitioner 5 weeks of PPD at $654.62 per week , or $3,273.09, since the injury to Petitioner constituted 1% loss of use of the person as a whole. However, Respondent has already provided Petitioner an advance of $4,909.56, for which Respondent is entitled to a credit. Therefore, Respondent owes Petitioner no further benefits as it relates to this injury.

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

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

David A. Kane
Signature of Arbitrator

December 3, 2019
Date

DEC 3 - 2019

Findings of Fact

Testimony of Petitioner

After trial, this matter was reassigned to Arbitrator David A. Kane for Decision. This Arbitrator has reviewed the transcript of proceedings and all evidence submitted at close of proofs.

Petitioner, Sven Munck, is a 56-year-old male who works for Respondent, Towne Machine Tool Company. Respondent operates a machine and welding shop that repairs metal parts and metal machinery. (R. 21). Petitioner was employed as a welder fabricator by Respondent, and his responsibilities included fabricating, ordering materials and consumables for the shop, and making decisions as to how best to repair a piece of equipment. (R. 22).

Petitioner testified that the accident in question occurred on February 16, 2018. Petitioner testified that he was working for Respondent on that day when the heel of his boot got caught on the power cord of a piece of machinery. (R. 23). Petitioner testified that this caused him to both twist his left knee and jerk and pull his back. However, Petitioner did not fall as a result of this accident since he was able to catch himself and recover his balance. (R. 23, R. 38). Petitioner testified that on that day he was given some extra responsibility, so he was running late and was in a bit of a hurry when the accident occurred. (R. 23).

Petitioner testified that he notified his supervisor of the accident right away. (R. 23). Petitioner also testified that, over the next couple weeks, his back and knee progressively got worse. (R. 24). However, Petitioner did not seek any treatment whatsoever for this injury. Petitioner testified that he didn't seek treatment because he didn't think his injury was that bad and in fact thought it was just a small strain. (R. 24, R. 40).

In addition to not seeking any treatment, Petitioner also continued working for Respondent without restrictions, doing his regular job duties, following the February 16, 2018, accident. (R. 24, R. 38). In fact, Petitioner continued to work for Respondent, without restrictions, over the next two and a half weeks without issue. (R. 41).

Then, on March 5, 2018, Petitioner had a new accident while at home. (R. 25). This second accident occurred as Petitioner was traversing a couple of steps that go from a mud room into the main part of Petitioner's home. (Id). Basically, as Petitioner described it, the accident occurred as he went to take a step to go up the stairs and into his home when his left knee went sideways, popped, and completely just gave out on him. (R. 25-26, R. 42). Petitioner testified that when this happened it felt like there was no support from his knee at all, almost like there was nothing holding it together anymore. (R. 43). As a result of his knee giving out, Petitioner went down and twisted his back and his left knee. (R. 25-26). Petitioner testified that this caused him "excruciating pain". (R. 43).

Petitioner testified that the second accident at home on March 5, 2018, caused him to have a lot of issues and pain in his left knee. (R. 45). Far more than did the initial accident on February 16, 2018, while at work. (R. 45-46). Petitioner also testified that the second accident on March 5, 2018, escalated the back pain that he had from the initial injury. (R. 46).

Petitioner testified that he was taken to the emergency room immediacy after this second accident on March 5, 2018, due to the level of pain and nature of his injury. (R. 46). Petitioner testified that was seen at the ER on March 5, 2018, due to complains of both back and left knee pain resulting as a result of the second accident.

Medical Treatment

Petitioner's emergency room records from March 5, 2018, were introduced into evidence as by Petitioner as Petitioners' Exhibit 1. That record lists the chief complaint as a left leg injury. The emergency room history indicates that Petitioner was seen due to having twisted his left knee going up two stairs at home earlier that same day. Petitioner reported to the emergency room physician that his left knee gave out on him, resulting in the development of sharp pain and a tearing sensation in his left knee. Petitioner also had swelling and tenderness in the left knee ever since the injury. (P.X. 1). There was no mention of any back pain or injury in the emergency room records. The diagnosis at the emergency room was of a left knee sprain. Treatment included the application of an Ace wrap onto the left knee. (P.X. 1).

Following the emergency room visit, Petitioner was next seen at Carle Occupational Health on March 6, 2018. (P.X. 2). That records indicates that Petitioner was being seen for a follow-up concerning left knee pain, but the indicating was that the injury occurred twelve days ago and had been getting progressively worse. According to March 6, 2018, record, Petitioner was attributing all of his left knee issues to the initial accident on February rather than the second accident on March 5, 2018. This records also indicates that Petitioner had no complaints of any back pain. And in fact, he told the treatment providers that his back pain from the first accident on February 16, 2018, was doing better and that is was really just his left knee that was problematic. (Id).

The examination of Petitioner's left knee on March 6, 2018, showed there to be swelling which was making flexing the knee difficult. (P.X. 2). In addition, the physician note that Petitioner was very guarded when it came to his left knee, so much so that it made it hard for the physician to asses the petition's left knee. Despite this, the assessment was that of a left knee sprain with possible derangement. The recommendation was for Petitioner to be placed on sedentary duty, use crutches to bear weight, use a knee brace, and use Ibuprofen regularly for pain and swelling. (P.X. 2).

The next time Petitioner sought any additional treatment for his injuries was on March 23, 2018, at Carle Occupational Health. (P.X. 2). It was noted that Petitioner was being seen for both back and knee pain. At this time, Petitioner's swelling in the left knee had gone down some, but his left knee still remained swollen and painful. As a result, Petitioner was still having to use crutches to get around. As for his complaints of back pain, an x-ray of the lumbar spine was ordered. That x-ray showed Petitioner to have had a multilevel lumbar spondylitic changes, with the most pronounced changes being at the L5-S1 level. An x-ray of Petitioner's bilateral eye orbits appears to have also been performed on this day, but that x-ray appears to be unrelated to the claim at hand.

On April 9, 2018, Petitioner underwent left knee MRI at Carle Foundation Hospital. (P.X. 2, R.X. 11). The impression from that MRI was that Petitioner's left knee had marrow space edema in the lateral femoral condyle most likely representing a bone contusion. Otherwise, the MRI was noted to have need essentially normal.

On April 16, 2018, Petitioner underwent a lumbar spine MRI at Carle Foundation Hospital. (P.X. 2, R.X. 12). The reason for this MRI was low back pain with left leg radicular symptoms that had been present for about six months. The impression was that Petitioner had a broad-based lumbar disc bulge with a small protrusion at the L5-S1 level that was mildly narrowing the right lateral recesses. There was also some mild broad-based bulging noted at the L5-5 level.

Following the MRIs, Petitioner was again seen at Carle Occupational Health on April 20, 2018, for complaints of both back and left knee pain. (P.X. 2). At this visit, Petitioner made no mention of having been injured during the second accident at home on March 5, 2018. Rather, Petitioner attributed all of his complains to the first accident on February 16, 2018. As far as his left knee was concerned, Petitioner told his treatment providers that his knee was definitely getting better and only has some swelling when he was on his feet for long periods of time. However, Petitioner also stated that his back was not improving at all. Petitioner's lumbar MRI was reviewed and was interpreted as showing a broad-based bulge with slight right para-central protrusion at L5-S1. As a result, the recommendation was for Petitioner to be referred to a spine surgeon for further evaluation. As for this knee, the recommendation was to hold off on any further treatment since his knee was improving. Petitioner was also given work restrictions on this of no lifting, pushing, or pulling over 10 lbs. and to also avoid any bending or twisting. (P.X. 2).

Petitioner was seen at the Carle Spine Institute via Dr. Tipineni on May 1, 2018, for an evaluation of his ongoing back pain. (P.X. 2. R.X. 13). At this visit, Petitioner told Dr. Tipineni that the date of his injury was February 16, 2018, which would have been the first accident, and Petitioner made no mention to Dr. Tipineni of having had a second accident at home on March 5, 2018. Petitioner also told Dr. Tipineni that the first accident on February 16, 2018, jarred his back and caused some acute left sided back pain. However, Petitioner stated to Dr. Tipineni that his leg symptoms did not start until some two weeks later. After an examination and after reviewing the MRI, Dr. Tipirneni noted that the objective x-rays and MRI showed only multilevel wear and tear arthritis, but nothing that was acute in nature. Dr. Tipirneni also noted that the lumbar MRI in particular showed "nothing from this work-related injury." (P.X. 2). As a result, Dr. Tipineni diagnosed Petitioner as having previous lumbar degenerative disc disease, lumbar radiculopathy, lumbar spondylosis without myelopathy, lumbar stenosis,

and ongoing left knee issues. The recommendation was for physical therapy. Lumbar steroid injections were also discussed, but none were ordered as of this visit.

Petitioner was then seen at Sacred Heart Med. Center emergency room on May 16, 2018, due to complaints of bilateral lower leg swelling that he had indicated had been going on for approx. four weeks. (P.X. 1). This visit does not appear to have been related to his injuries.

On May 18, 2018, Petitioner returned to Carle Occupational Health. (P.X. 2). That notes indicates that Petitioner was still complaining of back and knee pain. That note also indicates that Petitioner saw Dr. Tipirneni, but that Dr. Tipirneni was reluctant to do any epidural injections on him at the time "because he was having a non-work-related medical problem." Instead, the recommendation was for Petitioner to undergo physical therapy for both his knee and his back. Petitioner was also told to remain on work restrictions of no lifting, pushing, or pulling over 10 lbs.

Petitioner was evaluated for physical therapy on May 23, 2018. (P.X. 2). The Arbitrator notes that Petitioner told the therapist that all of his injuries were as a result of the February 16, 2018, accident and didn't even mention having had the second accident on March 5, 2018. The Arbitrator also notes this record indicates that Petitioner had neuropathy in both of his feet which was causing some numbness. The recommendation from the physical therapist was for Petitioner to undergo therapy two times per week for four weeks.

On June 21, 2018, Petitioner returned to Carle Occupation Health for yet another follow-up. (P.X. 2). This record indicates that Petitioner had attended therapy, and that therapy believes he has plateaued. And although Petitioner indicated his knee was getting better, he still complained on ongoing pain. As such, the recommendation was for Petitioner to stop therapy and start going to a chiropractor for his low back complaints. The indication was that Petitioner was close to MMI as it pertains to his low back.

Petitioner started going to Robison Chiropractic beginning on July 2, 2018, and continued until July 18, 2018. (P.X. 3). Of note, Petitioner again attributed all of his ongoing back and knee pain to the accident on February 16, 2018, and again failed to disclose or mention to his treaters the second

accident that occurred at home on March 5, 2018. Petitioner's chiropractic treatment was limited, and all chiropractic treatment stopped as of July 18, 2018, without any noted benefit.

On July 12, 2018, Petitioner again followed up with Carle Occupation Health. (P.X. 2). At this time Petitioner was being seen mainly for back pain as his left knee pain was improving. Of note, this record indicates that the only thing that Petitioner's MRI showed was a degenerative changes and a bone bruise. As such, the indication was that Petitioner's left knee symptoms were probably either as a result of a bone bruise or a small cortical irregularity. As for his back complains, Petitioner was diagnosed with back pain that was mostly musculoskeletal in nature and told to finish chiropractic treatment.

On August 16, 2018, Petitioner was seen by Dr. O'Leary for an independent medical examination. (R.X. 3). Dr. O'Leary, after reviewing the records into an examination of Petitioner, noted that the petitioner had a twisting injury which likely strained his back. Although Dr. O'Leary noted some discrepancies in the chart regarding the accident that occurred at home on March 5, 2018, and the accident on February 16, 2018, Dr. O'Leary stated that if we were to take Petitioner at his word as to which accident caused what issues, it does make sense that he would have temporarily exacerbated his underlying degenerative condition. This opinion, by Dr. O'Leary, was based in part on his understanding that Petitioner was previously asymptomatic as far as his back what's concerned. Of note, Dr. O'Leary did not see any obvious abnormalities on the lumbar MRI and felt that there was no permanent aggravation of Petitioner's low back had occurred as a result of either incident. Nevertheless, Dr. O'Leary felt that Petitioner was not at MMI, but was close. Dr. O'Leary felt that Petitioner was not a surgical candidate, but that it would not be unreasonable to try a L4-5 or L5-S1 epidural steroid injection to "just break his pain cycle." However, Dr. O'Leary did not feel that there were any objective evidence to support a work restriction, so Dr. O'Leary opined that there was no reason why Petitioner could not return back to full duty work.

After the IME, Petitioner returned back to Carle Hospital on September, 4, 2018, and October 19, 2018. (P.X. 2). During these visits, Petitioner's main complaints were as to his ongoing back pain. It appears as though his left knee pain had all but resolved. The doctors at Carle agreed with Dr.

O'Leary's recommendation to try some lumbar injections to break Petitioner's pain cycle. As a result, Petitioner underwent a left L4-5 epidural injection on December 4, 2018, followed by another L4-5 epidural injection on December 20, 2018. (P.X. 2). Petitioner's diagnosis at the time of was lumbar degenerative disc disease, lumbar disc bulge, in lumbar radiculitis.

On January 8, 2019, Petitioner was seen one final time at Carle. (P.X. 2). At this time, Petitioner reported good results from the injections, so Petitioner was discharged from care without any type of work restrictions.

Testimony of Brian Blanton

Brian Blanton testified in this case on behalf of Respondent. Mr. Blanton was Petitioner's supervisor at the time of these accidents. (R. 68). Mr. Blanton testified that Petitioner reported having tripped over a cord on February 16, 2018, while at work. (Id). However, Petitioner only reported having injured his back on February 16, 2018, and never mentioned having injured his left knee. (R. 69). Mr. Blanton also testified that he asked Petitioner if he needed to go get checked out after the accident, but that Petitioner told him he was ok, and was just going to take Tylenol and see how it went. (R. 68-69). Petitioner never asked to go to a doctor. (Id).

Mr. Blanton also testified that Petitioner was able to work after the February 16, 2018, accident, and worked for approx. the next three weeks. (R. 70). Petitioner worked his regular schedule and full duty without restrictions. (Id). Mr. Blanton testified that Petitioner was able to work the three weeks following the accident without any noticeable issues. (R. 70, 71). Moreover, Petitioner never reported not being able to do any part of his job due to any pain from the February 16, 2018, accident. (Id). Mr. Blanton testified that the only time that Petitioner missed any work was after the accident at home on March 5, 2018. (R. 71).

Testimony of Scott Towne

Scott Towne testified that he is the President of Towne Machine. (R. 76). Mr. Towne testified that he had a phone conversation with Petitioner on March 5, 2018. (R. 76-77). Mr. Towne testified that Petitioner told him, during that phone conversation, that he had blown his knee out while traversing some stairs at home. (R. 77). As a result, Petitioner wanted Mr. Towne to call him an ambulance since he did not have anyone at home at

the time to drive him to the emergency room. (R. 78). Mr. Towne testified that Respondent had paid Petitioner's medical bills for this claim and that Respondent had also paid and accepted other prior claims Petitioner had filed against Respondent. (R. 79).

Video Surveillance

Respondent introduced into evidence a video of Respondent's facility where Petitioner worked after the February 16, 2018, accident. (R.X. 18). The video shows Petitioner working for Respondent on three separate days following the February 16, 2018, accident, including on March 5, 2016, which would have been just before the second accident at home later that same day. This video shows Petitioner being able to walk, lift, pull, bend, and do his job duties on all three days without any visible issues of pain or limitation. The video does not show any objective signs of limping or outward expressions of pain as a result of the original work-related accident that occurred on February 16, 2018.

Findings of Law

The Arbitrator hereby incorporates by reference the Findings of Fact noted above, and the Arbitrator's and parties' exhibits are also hereby included as part of this claim. After reviewing all of the evidence presented, and after due deliberation, the Arbitrator finds as to the disputed issues as follows:

1. In support of the Arbitrator's decision as it relates to issue (F), whether Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator finds the following:

In order for a petitioner's injury to be compensable under the Illinois Workers' Compensation Act (Act), a petitioner must prove, by a preponderance of the credible evidence, each element of their claim. Illinois Institute of Technology v. Industrial Commission, 68 Ill.2d 236 (1977). In order to prevail on the element of causation, the petitioner is required to prove that there is some causal relationship between his employment and his injury. Caterpillar Tractor Co. v. Industrial Commission, 129 Ill.2d 52, 63 (1989). However, since a decision of the Commission cannot be based upon speculation or conjecture, the burden is on the petitioner to present actual credible evidence to prove said causal relationship. Deer & Comp. v.

Industrial Commission, 47 Ill.2d 144 (1970). Where a petitioner fails to prove by a preponderance of the credible evidence that there exists a causal connection between their work and the alleged condition of ill-being, compensation is to be denied. Illinois Institute of Technology, 68 Ill.2d 236 (1977).

Although the petitioner's testimony alone could potentially be sufficient to establish causation, the mere existence of said testimony does not necessarily require its acceptance. Smith v. Industrial Commission, 98 Ill.2d 20 (1983). Rather, that testimony must be proven to have been credible. Caterpillar, 83 Ill.2d 213 (1980). To require otherwise would require that an award be entered or affirmed in every case in which a claimant testifies to an unwitnessed injury, no matter how much his testimony might be contradicted by the evidence or how evident it might be that his story is a fabrication. U.S. Steel v. Industrial Commission, 8 Ill.2d 407 (1956). Uncorroborated testimony will support an award for benefits only if all the facts and circumstances support that decision. See Gallentine v. Industrial Commission, 147 Ill.Dec. 353 (2nd Dist. 1990); Seiber v. Industrial Commission, 82 Ill.2d 87 (1980).

In this case, Petitioner testified that he had a work-related accident on February 16, 2018, when he tripped on power cord. Although this was an unwitnessed accident, Respondent accepted this accident as a compensable work-related claim. Some seventeen days later, Petitioner had a second non-work-related accident at home while attempting to go up a set of stairs. Petitioner claims that the second accident at home was as a result of a weakened left knee resulting from the first accident. Respondent, on the other hand, asserts that the second accident at home had nothing to do with the first accident, that all of Petitioner's injuries are as a result of the second accident only, and that even if there was some type of connection between the first accident and Petitioner's condition of ill-being, that chain of causation was broken by the intervening second accident.

In order to properly analyze all of these issues, the Arbitrator must first determine what type of injuries, if any, Petitioner suffered as a result of the first accepted work-related accident on February 16, 2018, versus the type of injuries he suffered as a result of the second accident at home on March 5, 2018.

The Arbitrator notes that Petitioner did not seek any medical treatment whatsoever as a result of the February 16, 2018, accident. Although Petitioner attempted to make it seem as though he did not seek treatment after this accident because Respondent did not specifically direct him to go seek treatment, the evidence clearly demonstrates that Petitioner was free to go seek treatment if he so wished. In fact, Petitioner himself admitted as much. Therefore, the fact that Petitioner did not seek any treatment immediately after the February 16, 2018, work accident indicates to this Arbitrator that any injury that Petitioner may have suffered as a result of said accident must not have been that serious or severe. The fact that Petitioner was able to work without restrictions doing his regular job duties for the next seventeen days after the February 16, 2018, work accident also supports this conclusion.

At trial, Petitioner attempted to make the severity of his February 16, 2018, accident seem far greater than the evidence would seem to suggest. For example, Petitioner testified that after the accident he was moving slower, was in pain, and was "hobbling around like a fool." However, Petitioner admitted that he didn't seek treatment, wasn't really taking any medications for the pain, and Petitioner's supervisor, Mr. Blanton, clearly testified that he didn't notice any difference between Petitioner's pre and post-accident status. This fact was also confirmed by Mr. Towne.

What's more, the video (R.X. 18) of Petitioner working for Respondent in the days after the February 16, 2018, accident, which the Arbitrator had a chance to review after reassignment, clearly shows that Petitioner was able to work and move around without any noticeable hobbling. In fact, it appears from said video that Petitioner was able to work after the February 16, 2018, accident without any visible issues whatsoever. Therefore, the Arbitrator finds Petitioner's testimony as to the severity of his injury as a result of the February 16, 2018, accident not be credible.

Although Petitioner alleges to have suffered both a left knee injury and a back injury as a result of the February 16, 2018, work accident, the evidence does not support this position. What the evidence does support is a finding that Petitioner likely suffered a back strain as a result of the February 16, 2018, work-related accident. The fact that Petitioner complained of having twisted his back on February 16, 2018, was confirmed by Mr. Blanton. And although Petitioner did not seek any treatment for this back strain until after the second accident on March 5,

2018, Dr. O'Leary does indicate that Petitioner having suffered a back strain would made sense based on the February 16, 2018, mechanism of injury. And since the lumbar MRI demonstrated only degenerative changes without any abnormalities, there is no evidence to indicate that the back injury was anything more than a simple strain. Therefore, the Arbitrator finds that Petitioner suffered nothing more than a simple back strain as a result of the February 16, 2018, work-related accident.

As far as Petitioner's assertion that he also suffered a left knee injury on February 16, 2018, the Arbitrator finds that this assertion is not supported by the evidence. First, Mr. Blanton disputed Petitioner's assertion that he also complained of having injured his left knee as a result of said work-related accident. Contrary to Petitioner's testimony, Mr. Blanton clearly testified that Petitioner never mentioned having injured anything but his back as a result of the accident on February 16, 2018. In addition to being contradicted by the other witnesses, Petitioner's testimony, as it relates to the left knee, was also contradicted by the medical records that were submitted by Petitioner. Specifically, the Arbitrator notes that the medical record from Dr. Tipirneni, the orthopedic surgeon who evaluated Petitioner's complains of back pain on May 1, 2018, clearly indicates that Petitioner's leg symptoms did not start until some two weeks after the February 16, 2018, work accident. This would mean that his knee complains would have started right around the time when the second accident occurred at home on March 5, 2018, and not as a result of the first accident on February 16, 2018. Therefore, the Arbitrator finds that Petitioner did not suffer any type of left knee injury as a result of the work accident on February 16, 2018.

It is clear from the evidence submitted that all of Petitioner's left knee issues started after the second accident at home on March 5, 2018. Petitioner admitted that he heard a "pop" and felt excruciating pain that resulted in his left knee giving out on him while he was attempting to ascend the stairs at home on March 5, 2018. Petitioner admitted that this was a significant event that forced him to twist his entire body, including his back, in an effort to prevent himself from falling forward onto his face. This was such a significant injury that Petitioner had to immediately be taken to the emergency room, something that never happened after the first injury on February 16, 2018.

At the emergency room, Petitioner stated that he felt a "tearing sensation" in his left knee and developed "sharp" left lateral knee pain after his knee gave out on him while attempting to go up two stairs at home. Edema and tenderness in the left knee were noted, and Petitioner was given an Ace wrap. The next day, on March 6, 2018, Petitioner was seen at Carle Occupational Health and given crutches and told to keep off his feet and bear weight to tolerance. The Arbitrator notes that these symptoms were completely absent after the February 16, 2018, accident. In fact, Petitioner was able to not only bear weight after the February 16, 2018, accident, but was actually able continue working without restrictions. Therefore, it's clear to the Arbitrator that all of Petitioner's left knee injuries are as a result of the second accident on March 5, 2018, and not as a result of the first accident on February 16, 2018.

In addition to having suffered a left knee injury on March 5, 2018, Petitioner also re-injured his back. Petitioner confirmed as much when he indicated that the March 5, 2018, accident aggravated his prior back injury. And although Petitioner claims his ongoing back issues are all just a continuation of his original injury on February 16, 2018, the Arbitrator finds this not be the case.

Petitioner admitted to having had back issues in the past. Although Petitioner denied having had any back issues since 2001 to his treating doctor and to Dr. O'Leary, he admitted at trial during cross examination that he had had ongoing back issues, including an incident in 2005, 2007, and 2010, and that he was never pain free as far as his back was concerned. Moreover, all of the evidence presented, including Petitioner own testimony, Dr. O'Leary's report, and the medical records, indicate that the second accident on March 5, 2018, was a much more significant injury than was the initial accident on February 16, 2018. Lastly, the Arbitrator notes that Petitioner only started seeking treatment for his back a week after the March 5, 2018, accident but never sought any treatment for his back as a result of the February 16, 2018, accident. Therefore, based on a preponderance of the credible evidence, the Arbitrator finds that Petitioner suffered a new injury to his back as a result of the March 5, 2018, accident.

Having identified what types of injuries Petitioner suffered as a result of each accident, the Arbitrator must now determine if the second accident on March 5, 2018, was somehow related to or connected with the first accident on February 16, 2018, thereby making the second accident that occurred at

Petitioner's home on March 5, 2018, a compensable work accident. Stated differently, the Arbitrator mush determine if the second accident was an independent intervening accident which broke the chain of causation between the work-related back injury and Petitioner's ensuing disabilities.

"Every natural consequence that flows from an injury that arose out of and in the course of one's employment is compensable under the Act absent the occurrence of an independent intervening accident that breaks the chain of causation between the work-related injury and an ensuing disability or injury." National Freight Industries v. Illinois Workers' Compensation Comm'n, 2013 IL App (5th) 120043WC, ¶ 26, 993 N.E.2d 473. "Under an independent intervening cause analysis, compensability for an ultimate injury or disability is based upon a finding that the employee's condition was caused by an event that would not have occurred 'but for' the original injury." Id. "For an employer to be relieved of liability by virtue of an intervening cause, the intervening cause must completely break the causal chain between the original work-related injury and the ensuing condition." Global Products v. Workers' Compensation Comm'n, 392 Ill. App. 3d 408, 411 (2009).

At the onset, the Arbitrator notes that, as outlined above, Petitioner did not suffer a left knee injury as a result of the first accident on February 16, 2018. Rather, Petitioner's left knee injury was solely and exclusively as a result of the second accident on March 5, 2018. Therefore, there is no need to even engage in an intervening accident analysis as far as the left knee claim is concerned since the Arbitrator has already found that Petitioner's left knee issues are not work-related.

But even if one was to assume, *arguendo*, that Petitioner injured his left knee on February 16, 2018, the evidence presented clearly indicates that the March 5, 2019, accident was a much more serious intervening accident which would have broken any chain of causation that may have existed from the first accident on February 16, 2018. Simply put, the evidence demonstrates that Petitioner heard a pop in his knee and felt a tearing sensation at the moment his left knee gave up on him as he was about to ascend a set of stairs at home. Immediately after this occurred, Petitioner was taken to the emergency room, given crutches, and order to be non-weight-bearing. There is no evidence to suggest Petitioner had any of these issues as a result of the first accident on February 16, 2018. To the Arbitrator, the fact that Petitioner heard a pop, felt a tearing sensation, and

had immediate excruciating pain suggests that he had a new singular injury to his knee on March 5, 2018. There is no evidence, other than Petitioner's own testimony, to suggest that the left knee injuries Petitioner suffered on March 5, 2018, had anything to do at all with the original accident on February 16, 2018.

Since Petitioner's left knee injury was exclusively as a result of the non-work-related second accident, and not as a result of the work-related accident that occurred on February 16, 2018, the Arbitrator cannot find that "but for" the first injury, the second accident on March 5, 2018, would not have occurred as Petitioner has asserted. However, even though there is no" but for" connection in this case, the Arbitrator must still look to see if the March 5, 2018, accident broke the chain of causation between as it relates to Petitioner's back strain that he suffered as a result of the work-related accident on February 16, 2018.

A review of the evidence in this case demonstrates that Petitioner's back strain, as a result of the February 16, 2018, work-related accident, had resolved prior to the subsequent non-work-related accident on March 5, 2018. Quite simply, the evidence demonstrate that Petitioner only suffered a very minor back strain that caused a very temporary aggravation of his pre-existing degenerative back condition. In support of this finding, the Arbitrator points to the fact that Petitioner did not seek any treatment for this back strain and was able to continue working full duty without any issues. Moreover, the medical evidence presented, including the opinion of Dr. O'Leary, supports the conclusion that Petitioner suffered nothing more than a temporary aggravation of his underlying condition via a back strain. Since Petitioner was able to continue working without restrictions after having suffered his work-related back strain, and was only off work and only sought treatment after the second accident on March 5, 2018, the Arbitrator finds that Petitioner's second non-work-related accident on March 5, 2018, was a new intervening accident that broke the chain of causation between Petitioner's work-related back strain resulting from the accident on February 16, 2018, and the non-work-related back issues he had after March 5, 2018.

The arbitrator would like to note that although Dr. O'Leary indicated that Petitioner's back condition was causality related to the work injury, Dr. O'Leary provided that opinion without a full understanding of just how severe the March 5, 2018, accident was, and without a full and accurate

understanding of Petitioner's prior, pre-existing back issues. Moreover, Dr. O'Leary did not have the benefit of reviewing the video provided at the time of trial showing Petitioner able to work without issue immediacy after the February 16, 2018, accident. Therefore, Dr. O'Leary did not have a full and clear understanding of Petitioner's history when he rendered his opinion.

The Arbitrator specifically notes that Petitioner told Dr. O'Leary that he hadn't had any back issues or treatment since 2001, and that he was essentially pain free up until the accident on February 16, 2018. However, as was demonstrated on cross examination at trial, this was not true. In fact, Petitioner had received treatment for his back in 2005, 2007, and in 2010. In addition, Petitioner admitted to having had ongoing back pain since his original back surgery, which meant that he was not pain free prior to the accident. Therefore, since Petitioner did not provide a full and accurate history to Dr. O'Leary, the Arbitrator cannot find Dr. O'Leary's opinion providing a causal connection between Petitioner's work-related accident on February 16, 2018, and Petitioner's current back condition of ill-being to be persuasive. Although the Arbitrator finds Dr. O'Leary to be credible, the Arbitrator must discount his opinion as to causation for the reasons listed above.

2. In support of the Arbitrator's decision as it relates to issue (K), what temporary benefits are owed, the Arbitrator finds the following:

As noted above, the Arbitrator finds that Petitioner suffered nothing more than a temporary aggravation of is underlying degenerative lumbar condition when he suffered a strain as a result of his work-related accident on February 16, 2018. Petitioner was able to continue working without restrictions as it relates to that work-related back strain. It was only after the non-work related second accident at home on March 5, 2018, that Petitioner was taken off work. And since the Arbitrator has already found that the second accident was an intervening accident which broke the chain of causation between the work-related back strain and Petitioner's subsequent need for treatment, the Arbitrator also finds that Petitioner is not entitled to any temporary total disability (TTD) benefits since Petitioner's temporary disability arose out of the non-work-related accident on March 5, 2018. Thus, Petitioner's claim for TTD benefits is denied.

3. In support of the Arbitrator's decision as it relates to issue (L), what is the nature and extent of the injury, the Arbitrator finds the following:

Since Petitioner only suffered a temporary aggravation of his underlying degenerative lumbar condition as a result of the work-related accident on February 16, 2018, the Arbitrator finds that the nature and extent of Petitioner's injury was that of a minor back strain. Petitioner did not obtain any treatment for that back strain. And since the second non-work-related accident broke the chain of causation as it relates to his work-related back strain, the Arbitrator finds that Petitioner's back strain resolved as of the date of the second accident on March 5, 2018.

In determining the level of permanent partial disability, the Arbitrator is obligated to consider the five factors outlined in Section 8.1b of the Act. Those factors being: (1) the reported level of impairment as assessed pursuant to subsection (a) (the AMA "Guides to the Evaluation of Permanent Impairment); (2) the occupation of the injured employee; (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.

In this case, no AMA disability report was introduced, so this factor is not applicable. Petitioner's occupation was that of a welder/fabricator which required him to do heavy physical labor, so this factor suggests a higher permanency. Petitioner's was 55-years-old, which would suggest that he would not have to live with this injury for as long as a younger person would. Therefore, this factor suggests a lower permanency. Petitioner did not establish any loss of future earning capacity as a result of the work-related back strain, so this factor suggests a lower permanency. Lastly, the medical records, or lack thereof, indicate that Petitioner received no treatment whatsoever for the work-related portion of his back injury. Therefore, this factor suggests a lower permanency should be awarded.

After taking into consideration all the evidence presented, and after analyzing all five factors under 8.1b, the Arbitrator finds that Petitioner's suffered a minor low back strain that resulted in a 1% loss of use of the person as a whole.

4. In support of the Arbitrator's decision as it relates to issue (M), should penalties or fees be imposed upon Respondent, the Arbitrator finds the following:

Petitioner's Petition for Penalties and Fees is based on his claim that he was temporary totally disabled after March 5, 2018, as a result of a work-related accident. Since the Arbitrator has already found that not to have been the case, Petitioner's Petition for Penalties and Fees is hereby denied.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MICHAL THOMAS,

Petitioner,

vs. NO: 17 WC 32983

JBS USA,

20IWCC0363

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issue of permanent disability, and being advised of the facts and law, 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, with respect to the award of permanent partial disability.

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. *820 ILCS 305/8.1b(b)* (West 2013).

In considering the degree to which Petitioner is permanently partially disabled as a result of the work-related accident, the Commission views the evidence differently with respect to Section 8.1b(b) factors (i) and (v). Thus the Commission weighs the five factors in Section 8.1b(b) of the Act as follows:

(i) Respondent offered an AMA rating of 2% whole person impairment pursuant to Dr. Alpert's report. (RX9) At the time of his examination, Dr. Alpert noted Petitioner had full forward elevation, full abduction, both internal/external rotation, 5/5 rotator cuff strength testing and no pain over the biceps. *Id.* All objective testing, including O'Brien and Spurling's tests, were normal. *Id.* Dr. Alpert opined that Petitioner's ongoing symptoms were consistent with pre-existing non-work-related pain, cervical degenerative disc disease and C5-C6 herniation. *Id.* The Commission assigns significant weight to this factor.

(ii) Petitioner was employed as a picnic boner at the time of the accident, he returned to work in his prior capacity, and continues to hold this position with Respondent as of the date of arbitration. Thus, this factor is assigned greater weight.

(iii) Petitioner was 33 years old at the time of the accident. Given the younger age of Petitioner and the fact that the medical records lack any reference to his having been placed under any permanent restrictions, the Commission places lesser weight on this factor.

(iv) The Petitioner testified that he continues to be employed by Respondent as a picnic boner. There was no evidence of reduced earning capacity contained in the record, thus this factor is assigned lesser weight.

(v) Regarding evidence of disability corroborated by the treating medical records, as a result of the work-related accident of December 31, 2016, Petitioner was diagnosed with a right shoulder superior labral (SLAP) tear and impingement. Petitioner underwent two surgeries. The first surgery consisted of a right shoulder diagnostic arthroscopy with intraarticular debridement, arthroscopic subacromial decompression, and open subpectoral bicep tenodesis. The second surgery consisted of a right shoulder arthroscopic distal clavicle excision and extensive debridement with rotator cuff defragment anterior posterior bursa debridement and revision.

Petitioner testified at Arbitration that he wakes up in pain every day. He also testified that his range of motion is pretty good, however, he has stiffness and soreness. Physical therapy notes on January 19, 2018 show Petitioner had excellent strength and range of motion, but he still had some pain. On February 7, 2018, the therapist reports he is doing well. He rated his pain 2-3/10 with activities of daily living. He admitted he was lifting weights at home "more than in therapy." He was discharged from therapy and deemed ready to begin a work hardening program. On February 14, 2018, Petitioner saw Dr. Gordon for a biomechanical assessment. The notes confirm that Petitioner reported that the second surgery had been helpful and his right shoulder "is doing well." Dr. Gordon noted that Petitioner's surgeon, Dr. Wolters, had seen

Petitioner that same day and the plan was to continue restrictions with lifting less than 30 pounds for the next two weeks and then begin a work conditioning program. Petitioner reported he believed he would be able to begin work conditioning after two weeks, or sooner, however, he also reported an incident on February 9, 2018 in which he fell on an outstretched right hand in back of him on steps secondary to his dog tripping him up. Petitioner complained of cervical region pain. (RX4) Petitioner resumed therapy on February 12, 2018 and reported that on Friday morning he was walking down the stairs and was tripped by his dog and fell backwards, caught himself with his affected arm, hyperextending his elbow and quickly extending his affected shoulder which he believed to be the cause of his soreness. The next day he reported he still had a little stiffness likely from a fall that he had the prior Friday morning. He did respond to more advanced exercises with increased strength. (PX8) After work hardening, Petitioner returned to Dr. Wolters for follow-up of his right shoulder. It was noted that Petitioner stated that his collarbone pain was much better than before the surgery, that he still had pain through the rotator cuff region as well as up into his neck and behind his ear, and that he also got pain that radiated down to his elbow as well as to his wrist and hand and into the fourth and fifth fingers. It was noted that Petitioner had some numbness and tingling in his right hand, and that he stated that the nerve conduction studies were normal in his right arm. It was also noted that Petitioner had completed physical therapy, that he had returned to work full duty, and that he said that if he rested his shoulder he felt better. Dr. Wolters noted that Petitioner was at maximum medical improvement with regard to recovery following his right shoulder surgery, and that he had some residual pain regarding the rotator cuff. It was noted that Petitioner was recommended a consultation with Dr. Pineda regarding his ongoing complaints related to his cervical spine, that he could continue to work full-duty without restrictions with regards to his right shoulder, and that he was to follow-up as needed. (PX6) Based on the treating medical records, this factor is assigned significant weight.

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 foregoing factors, the Commission modifies the permanency award to 12-1/2% loss of use of the person-as-a whole as provided in Section 8(d)2 of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's Decision filed on January 13, 2020, 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 $448.49 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 12.5% loss of use of a person-as-a-whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner compensation that has accrued from May 23, 2018 through August 29, 2019, and shall pay the remainder of the award, if any, in weekly payments.

Figure 10:

20IWCC0363

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $28,200.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUN 2 6 2020
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O060920
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Kathryn A. Doerries

Thomas J. Tyrrell

Maria E. Portela

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

THOMAS, MICHAEL
Employee/Petitioner

Case# **17WC032983**

JBS USA
Employer/Respondent

20IWCC0363

On 1/13/2020, 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:

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

2461 NYHAN BAMBRICK KINZIE & LOWRY
JASON H PAYNE
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

Appendix

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
CORRECTED ARBITRATION DECISION
NATURE AND EXTENT ONLY

Michal Thomas
Employee/Petitioner

v.

JBS USA
Employer/Respondent

Case # **17** WC **32983**

Consolidated cases: **N/A**

20IWCC0363

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 **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Springfield**, on **August 29, 2019**. By stipulation, the parties agree:

On the date of accident, **December 31, 2016**, 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, per the stipulation of the parties, Petitioner's earnings in the year preceding the injury were **$38,868.96**; the average weekly wage was **$747.48**.

At the time of injury, Petitioner was **33** years of age, ***married,*** with **0** dependent children.

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

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

Respondent is entitled to a credit for all medical bills paid under its group medical plan for which credit may be allowed under Section 8(j) of the Act.

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 **$448.49/week** for a period of **75 weeks,** as provided in Section **8(d)2** of the Act, because the injuries sustained caused **15% loss of use of the person-as-a-whole.**

Respondent shall pay Petitioner compensation that has accrued from **May 23, 2018** through **August 29, 2019**, and shall pay the remainder of the award, if any, in weekly payments.

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

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

Melinda M. Pope-Sullivan
Signature of Arbitrator

1/13/2020
Date

JAN 13 2020

ILLINOIS WORKERS' COMPENSATION COMMISSION
CORRECTED ARBITRATION DECISION
NATURE AND EXTENT ONLY

Michal Thomas
Employee/Petitioner

Case # 17 WC 32983

v.

Consolidated cases: N/A

JBS USA
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that on December 31, 2016, his job with Respondent was that of a picnic boner, which involved removing bone from the front leg for which he used a knife. He testified that on that date his line was undermanned and that he was trying to keep up. He testified that while performing his job as a picnic boner, he felt sharp pain in his right shoulder while he was cutting meat.

Petitioner testified that after having been seen at Respondent's nurse's station, he was seen at Orthopedic Center of Illinois and treated with Dr. Maender. He testified that after the surgery performed by Dr. Maender he started to feel better at first, but that the more therapy he did and the more work he did at his job his shoulder started getting worse. He testified that by November 2017, he sought a second opinion.

Petitioner testified that he then went to Springfield Clinic and saw Dr. Wolters, who ordered another MRI. He testified that he underwent a second surgery on his shoulder on December 18, 2017, which was that of a revision surgery. He testified that after surgery, he did post-operative follow-up with Dr. Wolters and underwent physical therapy. He testified that he returned to full duty work and that he was doing the same full duty work as he had done prior to the accident.

Petitioner testified that he wakes up in pain every day, that the pain was tolerable but that the more he used his right arm, the more his pain increased. He testified that it was to the point where he would like to start looking for an easier job in the plant. He testified that his range of motion is pretty good, but that he has a lot of stiffness and soreness. He testified that he has constant pain in the right shoulder on the front. He testified that things that he could no longer do included hunting, pulling his boat, and throwing a ball. He testified that it hurts to brush his teeth because of the motion involved.

On cross examination, Petitioner agreed that he last saw Dr. Wolters on May 23, 2018 and that he had no appointments scheduled to see him. He agreed that he has no restrictions and that he is working the bone picnic job. He agreed that he was doing voluntary overtime. He agreed that his rate of pay was higher now, as there was a plant-wide raise.

The Application for Adjustment of Claim was entered into evidence at the time of arbitration as Petitioner's Exhibit 1.

The medical records of Passavant Area Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 2. The records reflect that Petitioner underwent an MRI of the cervical

spine on September 20, 2017. Petitioner underwent an MRI arthrogram of the right shoulder on February 8, 2017, which was interpreted as revealing a small SLAP tear extending beyond the expected margin of a sublabral sulcus. (PX2).

The medical records of Orthopedic Center of Illinois were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The records reflect that Petitioner was seen by Dr. Maender on November 13, 2017, at which time it was noted that he returned for follow-up of his right shoulder. It was noted that at the last appointment on September 27th Petitioner had been given a subacromial shoulder injection, and that he stated that he did not get any relief from that injection. It was noted that Petitioner continued to have pain, that he felt his pain and range of motion of the shoulder were getting worse, and that he was having issues with performing his job duties of boning picnics. It was noted that Petitioner felt that he had not been able to really do anything the past two weeks due to the pain he was experiencing, that he continued to attend physical therapy, and that he located his pain over his AC joint and a bony prominence in the area. It was also noted that Petitioner's pain was severe enough that he did not think that he could continue to work with it, and that he wanted a second opinion. The assessment was noted to be that of (1) impingement syndrome of right shoulder; (2) superior glenoid labrum lesion of right shoulder; (3) arthrosis of right acromioclavicular joint. It was noted that Petitioner was 5½ months after right shoulder arthroscopy and biceps tenodesis, that he had persistent pain at his AC joint, and that he had attempted to return to work but had severe pain. It was noted that Petitioner's pain was still localized at his AC joint and that local only at the AC joint was recommended. It was noted that after the injection Petitioner was re-examined and that his pain was nearly completely resolved, and that he then had full range of motion and full strength. It was noted that Petitioner was a good candidate for a distal clavicle excision, that he would go with the second opinion, and that then he would let them know how he wished to proceed. (PX3).

The records of Orthopedic Center of Illinois reflect that Petitioner was seen on September 27, 2017 by Dr. Maender, at which time it was noted that he was there to review the MRI of his cervical spine. It was noted that Petitioner had no change in his symptoms, that he had anterior superior shoulder pain, that he had pain that was in the base of his skull radiating down the shoulder, and that he had numbness and tingling intermittently from his elbow to his right ring and small fingers. It was noted that Petitioner took Ibuprofen for the pain, that he continued to have a click with forward flexion and internal and external rotation, and that he had tried a return to work and had tried to do 15 minutes with 45 minutes off. It was noted that Petitioner still had enough pain that he had not been able to progress beyond that, that he stated that he did his strengthening activities on his own but admitted that sometimes he got too busy, and that despite his pain he had been able to ride his motorcycle and rode it to the office that day. The assessment was noted to be that of (1) impingement syndrome of right shoulder; (2) superior glenoid labrum lesion of right shoulder; (3) cervical radiculopathy. It was noted that Petitioner had persistent pain of his right shoulder after arthroscopy, subacromial decompression, and biceps tenodesis, and that he had a click at his anterior shoulder which they had not been able to localize, that this produced pain but was less symptomatic than previous visits, and that it was expected to improve with continued strengthening activities. It was noted that Petitioner still had parascapular weakness on examination and that his cervical spine MRI showed no significant compression to cause the numbness down his arm. It was noted that as to his neck pain, the chronic headaches, and radiating numbness, Petitioner was referred to Dr. Gordon for evaluation. It was noted that further treatment options were discussed and that Dr. Maender thought a repeat arthroscopy would be unpredictable to improve the symptoms Petitioner complained of. It was noted that Petitioner did not feel that he could return to work the way that his shoulder was and that he agreed to proceed with a subacromial injection, which was provided. Petitioner was recommended to return to strengthening activities with therapy and a gradual return to work limiting him to 15 minutes out of each hour and progressing as he was able. Petitioner was also recommended to return in six weeks. (PX3).

The records of Orthopedic Center of Illinois reflect that Petitioner was seen on September 13, 2017 by Dr. Maender, at which time it was noted that he continued to have pain in the right shoulder. It was

noted that Petitioner had not seen any improvement with the Mobic and felt Ibuprofen 800 mg helped better. It was noted that they tried an injection into the right AC joint which did not give Petitioner much relief. It was noted that Petitioner's pain would come across his clavicle, down his arm, and would shoot up into his neck, that he would still get occasional numbness and tingling of his ulnar two digits, and that he had a nerve study performed last March which showed no peripheral compressive neuropathies. It was also noted that Petitioner continued to have a mechanical click in his shoulder with internal external rotation and forward flexion, and that this gave him significant pain. It was noted that Petitioner had persistent right shoulder pain with mechanical click after right shoulder arthroscopy, subacromial decompression, and biceps tenodesis. It was noted that Petitioner had been working with physical therapy and that he had had an injection and anti-inflammatories without relief. It was noted that Petitioner's options were to live with his pain which was not a reasonable option for him, or to proceed with a repeat right shoulder arthroscopy and distal clavicle excision. It was noted that prior that Dr. Maender recommended an MRI of the cervical spine given the pain that Petitioner had coming down the arms. It was noted that Dr. Maender did not think Petitioner's numbness was coming from his shoulde,r and that his nerve study previously showed no peripheral compressive neuropathies. Petitioner was recommended to hold off on therapy until the MRI was performed. (PX3).

The records of Orthopedic Center of Illinois reflect that Petitioner was seen on August 16, 2017 by Dr. Maender, at which time it was noted that he returned for post-operative follow-up. It was noted that Petitioner indicated that overall the shoulder was improving, that he had a new "knot" along the superior shoulder in the area of the AC joint, that it was exquisitely tender, and that he had pain in this area with any kind of forward flexion or abduction motion of the shoulder. It was noted that Petitioner felt like the prominence of this knot was increasing over the last month, and that he indicated that the therapists were concerned about it as well. It was noted that structurally Petitioner's shoulder was in good condition, that he may start work hardening, and that he may progress and have no restrictions as he went to work hardening. It was also noted that Petitioner had new pain of his AC joint, that this was unusual, and that he had also developed a loose body over his superior AC joint. Petitioner was recommended to try an injection into the acromioclavicular joint to see how it resolved his pain. It was noted that if it resolved Petitioner's pain but it returned, he may require distal clavicle excision. At the time of the July 12, 2017 visit with Dr. Maender, it was noted that overall Petitioner stated that he was doing better than he was prior to surgery, that he denied discomfort of the shoulder, and that his range of motion had improved. It was noted that Petitioner had been attending physical therapy and doing home exercises, and that he stated these had been helpful to his recovery. The assessment was noted to be that of (1) impingement syndrome of right shoulder; (2) superior glenoid labrum lesion of right shoulder. It was noted that Petitioner's pain was much better than before surgery, that he was progressing as expected, and that he was to work on progressive strengthening with physical therapy. Petitioner was to return to work with restrictions and was recommended to return in one month. (PX3).

The records of Orthopedic Center of Illinois reflect that Petitioner was seen on June 12, 2017 by Dr. Maender, at which time it was noted that the shoulder was sore as expected after surgery, that he remained in his sling, that his pain had been tolerated, and that he denied fever and chills. The assessment was noted to be that of (1) impingement syndrome of right shoulder; (2) superior glenoid labrum lesion of right shoulder. Petitioner's stitches were removed and he was instructed in scar massage. It was noted that Petitioner could begin to work on range of motion activities and that he was referred to a formal physical therapy program. Petitioner was also recommended to return in four weeks. At the time of the May 10, 2017 visit with Dr. Maender, it was noted that Petitioner stated that the muscles around his shoulder were better and less painful, that he felt his range of motion had improved, and that he felt his shoulder was still weak and that his strength had not improved. It was noted that Petitioner would have stabbing pain with lifting and strengthening activities, and that he had been attending physical therapy at Apex in Beardstown. It was noted that at the last appointment Petitioner had been given a glenohumeral injection that did help at first, but that he felt that his pain had returned. It was noted that Petitioner continued to have numbness of

the right arm that had not changed. The assessment was noted to be that of (1) superior glenoid labrum lesion of right shoulder. It was noted that Petitioner had persistent right shoulder pain with superior labral tear on MRI. It was noted that the injection resolved this pain for a short period of time, but that Petitioner's pain had already returned. It was noted that Petitioner had excellent strength of the rotator cuff and that his history, exam, and MRI were consistent with superior labral tear. It was noted that given Petitioner's good response to the injection, Dr. Maender recommended a right shoulder arthroscopy with evaluation of the superior labrum, possible repair versus biceps tenodesis, and evaluation of the rotator cuff with subacromial decompression. It was noted that Petitioner wished to proceed. (PX3).

The records of Orthopedic Center of Illinois reflect that Petitioner was seen on April 10, 2017 by Dr. Maender, at which time it was noted that at the last appointment they recommended an EMG for his right arm numbness and tingling and that it was performed on April 3, 2017. It was noted that Petitioner reported no changes in his symptoms since his last office visit, and that he still had numbness and tingling down his right arm. It was noted that Petitioner had pain around the right shoulder, especially anteriorly and anterolaterally, and that in regard to his numbness and tingling there were no nerve study findings of compressive peripheral neuropathies. It was noted that Dr. Maender did not see a good explanation for Petitioner's numbness and tingling at that time. It was noted that Petitioner had significant right shoulder pain more than expected with superior labral tear, and that he was recommended a diagnostic injection into the glenohumeral joint which was performed. Petitioner was also recommended physical therapy working on rotator cuff and scapular stabilizing exercises. Petitioner was also recommended to return in one month, and to continue the same work restrictions of no working on the line. At the time of the March 8, 2017 visit, it was noted that Petitioner presented for initial evaluation of his right shoulder. It was noted that Petitioner worked at the JBS meat processing plant, that on December 31, 2016 he was cutting meat at work moving at a quick rate of speed when he began to feel a sharp pain in the right shoulder, and that he did not feel a pop. It was noted that Petitioner did not notice any bruising but that there was some swelling in the days following this injury. It was noted that Petitioner described his pain as anterior and very deep "in the socket," and that he noted popping when reaching up overhead. It was noted that with increased use Petitioner noted pain at the medial aspect of his elbow which radiated down the forearm, and that he had been having some numbness in the ulnar two digits as well which was all new since the injury. It was noted that Petitioner complained of some tightness around the right side of his neck and parascapular muscles as well, and that he had not been on any official restrictions but that management had been moving him to lighter work. It was noted that the only heavy duty work that Petitioner still performed involved reaching into a bin to pull out 20-30 pound shanks, and that as he hooked them and pulled them up and then pushed them up overhead that this was when he noted the popping. It was noted that as the activity continued throughout the day, Petitioner would begin to notice the elbow pain and numbness in the hand. The assessment was noted to be that of (1) superior glenoid labrum lesion of right shoulder; (2) cubital tunnel syndrome on the right. It was noted that Petitioner had significant right shoulder pain after a lifting injury, and that he had crepitation within the shoulder which was very painful for him. It was noted that Petitioner's exam was consistent with impingement and superior labral tear, and that in addition to his shoulder pain he also had numbness of his ulnar two digits which had begun about the same time as this injury. Petitioner was recommended a nerve study for further evaluation of the nerve and that there were two options for the shoulder: one was to proceed with physical therapy and an injection into the shoulder, and the other was to proceed with surgical repair of the shoulder. It was noted that Petitioner would consider his options as they worked on the nerve study, and that he may do strengthening activities in the meantime to balance his rotator cuff and scapular stabilizers and see how that helped. (PX3).

The records of Orthopedic Center of Illinois reflect that Petitioner underwent electrodiagnostic testing on April 3, 2017 by Dr. Watson, which was interpreted as revealing (1) no electrodiagnostic evidence of a right upper extremity cervical radiculopathy; (2) no electrodiagnostic evidence of a right upper extremity brachial plexopathy; (3) no electrodiagnostic evidence of a right upper extremity median or ulnar neuropathy. (PX3).

The Operative Report dated May 30, 2017 was entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The records reflect that Petitioner underwent right shoulder diagnostic arthroscopy with intraarticular debridement, arthroscopic subacromial decompression, and open subpectoral biceps tenodesis by Dr. Maender for a pre- and post-operative diagnosis of right shoulder pain, superior labral tear, and impingement. (PX4).

The medical records of Springfield Clinic were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. The records reflect that Petitioner underwent an MRI of the right shoulder on November 24, 2017, which was interpreted as revealing (1) tendinosis of the rotator cuff, without tear; (2) small amount of fluid within the subacromial – subdeltoid bursa could be physiologic or represent mild bursitis; (3) mild osteoarthritic changes of the acromioclavicular joint with a moderate amount of reactive increased signal within the distal clavicle; (4) post-operative changes of biceps tenodesis. Petitioner underwent x-rays of the right shoulder on November 15, 2017, which were interpreted as revealing post-operative changes of right proximal biceps; right distal clavicle osteoarthritis versus osteolysis. (PX5).

The records of Springfield Clinic reflect that Petitioner was seen by Dr. Wolters on November 15, 2017, at which time it was noted that he stated that he injured his right shoulder at work when he was boning a picnic, that it was the front arm of a hog, that he said that he had no prior pain before the injury, and that he was initially seen by Dr. Gordon. It was noted that Petitioner stated that he was eventually seen by Dr. Maender, that an EMG nerve conduction test was performed which was negative for radiculopathy or nerve compression, and that there was physical therapy that was recommended. It was noted that Petitioner had an MRI which was consistent with a small SLAP tear, that he stated that he eventually had surgery on his right shoulder on May 31, 2017, that he had a biceps tenodesis performed as well as a subacromial decompression with arthroscopy of the right shoulder, and that he said his pain increased after strengthening exercises. It was noted that initially Petitioner's pain was better, that he said his pain after the strengthening exercises was more located over the front of his shoulder, and that he also had an MRI of the cervical spine which was performed which was positive for C5-C6 degenerative disk disease with more left-sided foraminal stenosis and mild right-sided foraminal stenosis. It was noted that Petitioner's pain was worse with use, that the pain was better with ice, that he said he had tried physical therapy including work hardening with continued pain, and that he did have pain while working on the line at work. The assessment was noted to be that of (1) status post right shoulder arthroscopic subacromial decompression and open subpectoral biceps tenodesis; (2) right shoulder acromial clavicular joint osteoarthritis. Petitioner was recommended to undergo an MRI of the right shoulder. It was noted that Petitioner could continue to work full duty without restrictions. (PX5).

Included within the records of Springfield Clinic was a MOHA On-Site Physician Services note dated February 14, 2017, which noted that Petitioner was there for follow-up of a shoulder injury. It was noted that Petitioner had not improved on Prednisone and that he did complete the MRI at Passavant Hospital dated February 8, 2017, which showed a small SLAP tear extending beyond the expected margin of the sublabral sulcus. The assessment was noted to be that of (1) right shoulder pain with a small SLAP tear per the MRI. Petitioner was referred to an upper extremity specialist and it was noted that he chose Dr. Maender. It was also noted that Petitioner was on 50% reduced piece count. Included within the records of Springfield Clinic was a MOHA On-Site Physician Services note dated January 24, 2017, which noted that Petitioner saw Dr. Gordon on January 12th and was placed on 15 days of Prednisone. It was noted that Petitioner stated that it felt like the swelling had diminished, but that the pain had not. It was also noted that Petitioner was usually "not a complainer" based on Dr. Clem's discussion with the supervisor. It was noted that Petitioner was taking Flexeril which helped slightly, and that he was also complaining of trapezial pain. The assessment was noted to be that of right shoulder pain. Petitioner was recommended to undergo an MRI arthrogram to rule out objective findings. Petitioner was also recommended to continue the medication regimen that he had at the present time. It was noted that Petitioner was performing about 50%

reduced piece count at that time and that he was also training someone. Petitioner was recommended to return after the MRI. (PX5).

Included within the records of Springfield Clinic was a MOHA On-Site Physician Services note dated January 12, 2017, which noted that Petitioner had been employed by JBS for approximately eight years, that he was a picnic boner, that he reported that beginning in October or November 2016 he started having pain of his right cervical/trapezial/right shoulder region and then later his left trapezial region, and that he also noted later pain of his right forearm extensor region and numbness, along with numbness and tingling of his right ulnar two digits. The diagnostic impression was noted to be that of (1) cervical pain most consistent with myofascial pain; (2) bilateral trapezial pain, right greater than left; (3) right shoulder glenohumeral region pain most consistent with a subacromial bursitis/rotator cuff tendinitis; (4) right proximal forearm extensor strain phenomena; (5) paresthesias of the ulnar two digits; question ulnar neuropathy at the elbow. Petitioner was recommended to take Prednisone and Flexeril, was placed on work restrictions, was outfitted with a Heelbo pad to utilize nocturnally to limit flexion at the right elbow, and was recommended to follow-up in two weeks. (PX5).

Additional medical records of Springfield Clinic were entered into evidence at the time of arbitration as Petitioner's Exhibit 6. The records reflect that a letter was issued by Dr. Wolters dated May 30, 2018, which noted that Petitioner was recommended to see his primary care physician for the neck issue and be referred for neck issues to a surgeon of his choice in the future. A Health Status Form was issued dated May 23, 2018, which noted that maximum medical improvement had been met and that Petitioner could return to work full duty with no restrictions. At the time of the May 23, 2018 visit with Dr. Wolters, it was noted that Petitioner returned for follow-up of his right shoulder. It was noted that Petitioner stated that his collarbone pain was much better than before the surgery, that he still had pain through the rotator cuff region as well as up into his neck and behind his ear, and that he also got pain that radiated down to his elbow as well as to his wrist and hand and into the fourth and fifth fingers. It was noted that Petitioner had some numbness and tingling in his right hand, and that he stated that his nerve conduction studies were normal in his right arm. It was noted that Petitioner had completed physical therapy, that he had returned to work full duty, and that he said that if he rested his shoulder he felt better. The assessment was noted to be that of (1) status post right shoulder arthroscopic revision subacromial decompression and distal clavicle excision; (2) right-sided neck pain with right-sided hand numbness with associated cervical disc degeneration at C5-C6. It was noted that Petitioner was at maximum medical improvement with regard to recovery following his right shoulder surgery, and that he had some residual pain regarding the rotator cuff. It was noted that Petitioner was recommended a consultation with Dr. Pineda regarding his cervical spine, that he could continue to work full duty without restrictions, and that he was to follow-up as needed. (PX6).

The records of Springfield Clinic reflect that Petitioner was seen on March 21, 2018 by Dr. Wolters, at which time it was noted that he was doing very well after surgery, that when he went to work full duty his pain increased, that he said that they were running short-handed on his line, and that he said that his pain was mostly to the rotator cuff region. It was noted that the arthritic pain at the collarbone was much better, and that Petitioner was doing his home exercise program and taking Ibuprofen for pain. Petitioner was recommended conservative management of his right shoulder with continued home physical therapy exercises. Petitioner was also recommended to try Diclofenac as opposed to Ibuprofen, and was recommended to return in two months and to continue to work full duty. At the time of the February 14, 2018 visit with Dr. Wolters, it was noted that Petitioner stated that overall he felt 100% better than before the surgery, that he said that he was not ready to return to work full duty at that time, and that he was not taking any pain medications on a regular basis. It was noted that Petitioner did fall and injured his right shoulder and elbow at home last weekend, that he said it was slowly improving, and that he denied any numbness or tingling. Petitioner was recommended conservative management of his right shoulder with continued formal physical therapy. Petitioner was also recommended to start work hardening in two weeks,

was allowed to return to work light duty with no lifting more than 30 pounds, and was recommended to return in one month. (PX6).

The records of Springfield Clinic reflect that Petitioner was seen on January 4, 2018, at which time it was noted that he stated that he was doing well and had been very sore, that he had some tenderness about the shoulder and a bruise on his biceps area, and that he was not sleeping well due to the pain. It was noted that Petitioner was just taking Ibuprofen and Naproxen. It was also noted that Petitioner had pain with cross body movements or reaching behind his back, that he was attending physical therapy, and that he would like to return to work and be able to start using his right arm but that he knew that he could not lift anything heavy at that point. It was noted that Petitioner felt like his range of motion was getting better quickly and that he felt like his strength was slowly getting better. The assessment was noted to be that of (1) status post right shoulder arthroscopic distal clavicle excision, extensive debridement with rotator cuff debridement, anterior and posterior bursa debridement, and revision subacromial decompression. Petitioner was recommended to continue conservative management of his right shoulder with continued physical therapy. Petitioner was to return to work with restrictions was to continue using ice as needed for pain. Petitioner was also given a prescription for Ibuprofen and was recommended to return in four weeks. (PX6).

The records of Springfield Clinic reflect that Petitioner was seen on December 18, 2017 for a pre-anesthetic evaluation. At the time of the December 5, 2017 visit with Dr. Wolters, it was noted that Petitioner had had multiple injections in his right shoulder, that he said the only injection that helped him was with some local anesthetic within the right acromioclavicular joint, and that he said that he had been through extensive physical therapy following his right shoulder subacromial decompression and open subpectoral biceps tenodesis. It was noted that Petitioner developed the pain following the surgery in his collarbone, and that it seemed to radiate down his collarbone to the medial aspect of his collarbone. It was also noted that Petitioner had focal tenderness to palpation on the top of his collarbone joint. The assessment was noted to be that of (1) right shoulder acromioclavicular joint osteoarthritis; (2) status post right shoulder arthroscopic subacromial decompression and distal clavicle excision per Dr. Maender. It was noted that a discussion was had regarding a right shoulder arthroscopic distal clavicle excision. (PX6).

Included with the records of Springfield Clinic was a note from MOHA On-Site Physician Services dated February 22, 2018, which noted that Dr. Gordon had opportunity to evaluate Petitioner performing the job of Bone Picnics to assess the biomechanical factors of the job. It was noted that it was Dr. Gordon's opinion that the job of bone picnics would not cause, precipitate, aggravate, or otherwise accelerate disorders about the cervical spine including disc-related pathology or any arthritis or any strain phenomenon, and that there was no contraindication to Petitioner work progressing back to this job from a biomechanical standpoint as it related to his right shoulder. Included with the records of Springfield Clinic was a note from MOHA On-Site Physician Services dated February 14, 2018, which noted that Petitioner was status post second right shoulder surgical intervention. It was noted that Petitioner reported that the surgery had indeed been helpful to him with regard to his right shoulder, and that his right shoulder was doing well. It was noted that Petitioner was last evaluated by Dr. Wolters on February 14, 2018, that the plan was to continue him on restrictions for the next two weeks and then begin a work conditioning program back to his job of bone picnics, and that he reported that he believed he would be able to do so. It was noted that Petitioner actually stated that he thought he would be able to get back sooner but that he had an incident at home on February 9, 2018, in which he fell on an outstretched right hand in back of him on steps secondary to his dog tripping him up. The diagnostic impression was noted to be that of (1) right shoulder pain, notably improved since Petitioner's second surgical intervention and doing very well; (2) complaint of cervical region pain. It was noted that Petitioner was doing well with regard to his right shoulder, and that he was to follow the orders as dictated by Dr. Wolters. (PX6).

Included with the records of Springfield Clinic was a note from Midwest Occupational Health Associates dated December 15, 2017, which noted that Petitioner underwent a history and physical evaluation for an upcoming surgery. Included with the records of Springfield Clinic was a note from

MOHA On-Site Physician Services dated November 2, 2017, which noted that Petitioner was seen for follow-up evaluation. It was noted that Petitioner's current complaints included pain of the occipital region, pain of the right trapezial region, and pain of the right AC joint region. It was noted that Petitioner also had intermittent pain of his right glenohumeral region, and that he denied any radiation of symptoms down his upper extremity at that time. It was noted that Petitioner reported that up until last week his right shoulder range of motion was good and his strength was about 50%, but that he still had the pain and that he reported that while he was performing his job of boning picnics in which he was utilizing a knife in his right hand, he felt increased pain of his right trapezial region, AC joint region, and right shoulder glenohumeral region, and since that time had had notably increased symptoms. It was noted that a discussion was had regarding a diagnostic/therapeutic injection for the C-spine at the C5-C6 level, that Petitioner was to continue with the work status as stipulated by Dr. Maender, that he was to continue with therapy, and that he was to follow-up with Dr. Maender on November 13, 2017. (PX6).

The Operative Report dated December 18, 2017 was entered into evidence at the time of arbitration as Petitioner's Exhibit 7. The Operative Report noted that Petitioner underwent right shoulder arthroscopic distal clavicle excision and extensive debridement with rotator cuff debridement, anterior and posterior bursa debridement, and revision subacromial decompression by Dr. Wolters for a pre-operative diagnosis of right shoulder acromioclavicular joint osteoarthritis; status post right shoulder arthroscopic subacromial decompression and open subpectoral biceps tenodesis and a post-operative diagnosis of right shoulder acromioclavicular joint osteoarthritis; right shoulder recurrent impingement syndrome with rotator cuff tendinopathy and subacromial bursitis; status post right shoulder arthroscopic subacromial decompression and open subpectoral biceps tenodesis. (PX7).

The physical therapy records of Apex Physical Therapy were entered into evidence at the time of arbitration as Petitioner's Exhibit 8. The records reflect that Petitioner underwent physical therapy for the timeframes of March 9, 2017 through August 15, 2017; September 28, 2017 through November 9, 2017; and December 26, 2017 through March 1, 2018. (PX8).

The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 9.

The April 3, 2017 EMG/NCV report of Dr. Watson was entered into evidence at the time of arbitration as Respondent's Exhibit 1. The records were duplicative of those as contained in Petitioner's Exhibit 3. (RX1; PX3).

The Interpretive Report for the November 24, 2017 MRI of the Right Shoulder was entered into evidence at the time of arbitration as Respondent's Exhibit 2. The records were duplicative of those as contained in Petitioner's Exhibit 5. (RX2; PX5).

The February 14, 2018 office note of Dr. Wolters was entered into evidence at the time of arbitration as Respondent's Exhibit 3. The records were duplicative of those as contained in Petitioner's Exhibit 6. (RX3; PX6).

The February 14, 2018 note of Dr. Gordon was entered into evidence at the time of arbitration as Respondent's Exhibit 4. The records were duplicative of those as contained in Petitioner's Exhibit 6. (RX4; PX6).

The February 22, 2018 note of Dr. Gordon was entered into evidence at the time of arbitration as Respondent's Exhibit 5. The records were duplicative of those as contained in Petitioner's Exhibit 6. (RX5; PX6).

The May 23, 2018 note of Dr. Wolters was entered into evidence at the time of arbitration as Respondent's Exhibit 6. The records were duplicative of those as contained in Petitioner's Exhibit 6. (RX6; PX6).

The May 23, 2018 Health Status Form was entered into evidence at the time of arbitration as Respondent's Exhibit 7. The records were duplicative of those as contained in Petitioner's Exhibit 6. (RX7; PX6).

The May 30, 2018 letter of Dr. Wolters was entered into evidence at the time of arbitration as Respondent's Exhibit 8. The records were duplicative of those as contained in Petitioner's Exhibit 6. (RX8; PX6).

The May 30, 2019 IME Report of Dr. Alpert was entered into evidence at the time of arbitration as Respondent's Exhibit 9. The report reflects that Petitioner was seen for an IME/Impairment Rating on May 30, 2019. It was noted that Petitioner was a 35-year-old right-hand dominant male who worked in meat processing where he deboned the front arms of pigs, that he said that on December 31, 2016 he was working a line and it was running fast, that it felt like something ripped in his right shoulder, and that he was initially treated without restrictions. It was noted that the pain continued, that Petitioner kept working, that he eventually had medications, work restrictions and an MRI which showed a SLAP and biceps tear, and that he eventually had surgery in May 2017 for a right shoulder arthroscopy with labral debridement and biceps tenodesis. It was noted that after surgery Petitioner stated that his AC joint was separated, that he had a second surgery on December 18, 2017 for a right shoulder distal clavicle excision by Dr. Wolters, and that after surgery he did "pretty good," felt sore, started lifting objects, and then went back to work. It was noted that Petitioner noted that he was currently working full duty without restrictions, that when he was working he noted extreme pain down his shoulder, neck and into his hand, and that he noted it started from the posterior aspect of his shoulder and into the elbow and hand. It was also noted that Petitioner had neck pain and pain "all over." (RX9).

The report reflects that Petitioner had a right shoulder work-related injury consistent with a superior labral tear, that he underwent a right shoulder arthroscopic labral debridement and biceps tenodesis procedure on May 30, 2017, that after that surgery he had continued complaints of pain over his AC joint where he underwent a right shoulder arthroscopic distal clavicle excision on December 18, 2017, and that he had completely recovered from his shoulder surgery. It was noted that Petitioner was currently having symptoms that were consistent with pre-existing non-work-related neck pain with cervical degenerative disk disease and C5-C6 disc herniation. It was noted that given the fact that Petitioner was at maximum medical improvement as it related to his right shoulder, he needed no further care and treatment. It was also noted that Dr. Alpert was asked to do an impairment rating and that, using the *Sixth Edition AMA Guidelines to the Evaluation of Permanent Impairment*, Petitioner had a 4% upper extremity impairment which converted to a 2% whole person impairment. (RX9).

CONCLUSIONS OF LAW

With respect to disputed issue (L) pertaining to the nature and extent of Petitioner's injury, and consistent with 820 ILCS 305/8.1b, permanent partial disability shall be established using the following criteria: (i) the reported level of impairment pursuant to subsection (a) of Section 8.1b of the Act; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. 820 ILCS 305/8.1b. No single enumerated factor shall be the sole determinant of disability. *Id.*

With respect to Subsection (i) of Section 8.1b(b), the Arbitrator notes that an AMA rating was offered by Respondent, which was that of 2% whole person impairment as per Dr. Alpert. (RX9). The Arbitrator places some weight on this factor when making the permanency determination.

With respect to Subsection (ii) of Section 8.1b(b), the Arbitrator notes that Petitioner was employed as a picnic boner at the time of the accident at issue and that he continues to hold this position with Respondent as of the date of arbitration. 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 33 years old on his date of accident. Given the younger age of Petitioner and the fact that the medical records lack any reference to his having been placed under any permanent restrictions, the Arbitrator places lesser weight on this factor when making the permanency determination.

With respect to Subsection (iv) of Section 8.1b(b), the Arbitrator notes that Petitioner testified that he continues to be employed by Respondent as a picnic boner. As there was no direct evidence of reduced earning capacity contained in the record, the Arbitrator places lesser weight on this factor when making the permanency determination.

With respect to Subsection (v) of Section 8.1b(b), the Arbitrator notes that Petitioner testified that he wakes up in pain every day, that the pain was tolerable but that the more he used his right arm, the more his pain increased. Petitioner testified that his range of motion is pretty good, but that he has a lot of stiffness and soreness. Petitioner testified that he has constant pain in the right shoulder on the front. At the time of the May 23, 2018 visit with Dr. Wolters, it was noted that Petitioner returned for follow-up of his right shoulder. It was noted that Petitioner stated that his collarbone pain was much better than before the surgery, that he still had pain through the rotator cuff region as well as up into his neck and behind his ear, and that he also got pain that radiated down to his elbow as well as to his wrist and hand and into the fourth and fifth fingers. It was noted that Petitioner had some numbness and tingling in his right hand, and that he stated that his nerve conduction studies were normal in his right arm. It was noted that Petitioner had completed physical therapy, that he had returned to work full duty, and that he said that if he rested his shoulder he felt better. It was noted that Petitioner was at maximum medical improvement with regard to recovery following his right shoulder surgery, and that he had some residual pain regarding the rotator cuff. It was noted that Petitioner was recommended a consultation with Dr. Pineda regarding his cervical spine, that he could continue to work full duty without restrictions, and that he was to follow-up as needed. (PX6). The Arbitrator concludes that Petitioner's evidence of disability at the time of arbitration, namely his continued complaints and limitations, were somewhat corroborated by his treating records. The Arbitrator accordingly places some 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 **15% loss of use of the person-as-a-whole** as provided in Section 8(d)2 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ZOFIA PARYS,

Petitioner,

vs. NO: 17 WC 37388

RICH'S FRESH MARKET,

Respondent.

20IWCC0364

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, temporary disability, causal connection, medical expenses, prospective medical, and permanent disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 27, 2018 is hereby affirmed and adopted.

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

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

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.

DATED:
KAD/bsd
O051920
42

Kathryn A. Doerries

Thomas J. Tyrrell

Maria E. Portela

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

PARYS, ZOFIA
Employee/Petitioner

Case# **17WC037388**

RICH'S FRESH MARKET
Employer/Respondent

20IWCC0364

On 12/27/2018, 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 2.48% 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:

4626 MICHALSKI & GUBERNAT PC
MARTIN B MICHALSKI
636 S RIVER RD SUITE 100
DES PLAINES, IL 60016

0766 HENNESSY & ROACH PC
JASON D KOLECKE
140 S DEARBORN ST SUITE 700
CHICAGO, IL 60603

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

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

ZOFIA PARYS
Employee/Petitioner

v.

RICH'S FRESH MARKET
Employer/Respondent

Case # **17** WC **37388**

Consolidated cases: _____

20IWCC0364

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Cellini**, Arbitrator of the Commission, in the city of **Chicago**, on **April 19, 2018 and May 15, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

20IWCC0364

FINDINGS

On the date of accident, **December 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 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 $**24,960.00**; the average weekly wage was $**480.00**.

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

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

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

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

ORDER

The Arbitrator finds that the Petitioner failed to prove she sustained accidental injuries arising out of and in the course of her employment with the Respondent on December 2, 2017.

Based on this determination, 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

December 21, 2018
Date

DEC 27 2018

STATEMENT OF FACTS

The Arbitrator notes that multiple witnesses testified via interpreter, including Petitioner, Janina Kruzolek, Wladyslawa Trznadel, Wanda Ostrowska and Anita Paluch. Additionally, due to time constraints, this matter was heard on a bifurcated basis on both 4/19/18 and 5/15/18.

Petitioner began working for Respondent, a grocer, in May 2015 as buffet worker. She testified her duties included serving customers, weighing meal/grocery products, preparing lunches and performing work as a cashier. Part of the job involved lifting boxes or crates weighing up to 30 pounds (see Px1). She testified she was able to perform the job without any problems.

On the alleged date of accident, 12/2/17, Petitioner testified that her manager, Anita Paulch, asked her to do a different job preparing food packages to be placed in the store. On cross examination, she acknowledged that she had been doing this food preparation job for three weeks leading up to 12/2/17. This involved getting boxes or crates of products from the walk-in storage cooler, weighing them, labeling them, and then putting crates of the packaged food onto a cart and bringing them out into the store. She would bring a cart to the cooler and put the boxes/crates on it to bring to her work station. She testified the boxes / crates were both on the floor and on shelves, some of which she had to reach overhead for. Products in the containers included soups, salads, pancakes, dumplings and pierogis.

Petitioner testified that because other kitchen staff would use the carts, they would often not be available. At other times her cart would be full when she needed more product. At these times, she testified she would have to carry the boxes / crates to her station manually, and this could include carrying two boxes at once. Petitioner testified that when performing this job, she would have to keep up a certain pace, and that there were times she would be reprimanded by manager Paluch if she didn't. The Arbitrator notes that the boxes/crates were what would be typically referred to as milk crates.

Petitioner testified that in addition to the work moving crates and weighing containers of the noted products, pallets would come in with salad products on them weighing 70 to 100 pounds. She and other workers would put these products under the table, weigh the salads and place them into containers and then cart them either directly into the store or into the cooler. Overall, Petitioner testified that on a day like the accident date she may have to work with 60 to 80 crates of product in a shift. The individual containers in the boxes weighed 2 to 3 pounds each, which she knew since she weighed them, and since twenty of the smaller product containers would be packed into the bigger box/crate, the boxes/crates would weigh between 40 and 60 pounds each. She estimated that an empty crate weighed two to three pounds.

Petitioner testified her normal shift ran from 8 a.m. to 4 p.m., though she would sometimes work more hours. She testified that she felt fine the morning of 12/2/17 and had no back pain or other health problems. She had worked her full shift the day before. She testified she would walk to and from work, about a mile each way, and that she walked to work that morning. Around 10:00 a.m. on 12/2/17, Petitioner testified that she had to go to the cooler to get salads, but the cart was being used by someone else, and that she had previously lifted boxes/crates at work that morning without difficulty. She testified she went into the cooler and picked up two boxes/crates and felt sudden back pain. She indicated she dropped the boxes and then slid them on the floor to her work station. She testified he cared about her job and tried to continue working, but at some point, without specifying exactly when, "I screamed that I'm in pain and I cannot continue doing this." She testified her coworkers Janina Krusolek and Wanda Ostrowska came to help her, and she told them she was in severe pain. She testified she asked Krusolek to call the manager for her and told Ostrowska she wanted to leave her station

to go tell the manager. She assumed one of them told the manager because Paluch then came to see her. She testified that Paluch said she could see that something was wrong with her, sat her in a chair and advised Petitioner to call her daughter Natalia. Petitioner testified she called Natalia to come and pick her up because she had lifted boxes and couldn't walk home.

Petitioner testified that her pain worsened while waiting for Natalia, who arrived after about 20-25 minutes, and that Natalia then called Petitioner's family doctor, Dr. Dudas, when she arrived. Petitioner testified she was unable to get up, and that Paluch and Ostrowska helped her up and out of the store, which is depicted in Px1. Petitioner testified the woman seen standing at the counter was Dorota, who had the same job as Petitioner, and the woman shown standing further down was Wladyslawa Trznadel. Petitioner testified she asked Natalia to take her home. At home she asked Natalia for pain meds and to take her to bed, and she testified that Natalia had to help her to the bathroom. This occurred on a Saturday, and Dr. Dudas was not available on Sunday. Petitioner agreed she did not go to the emergency room despite her pain. On Monday morning, Natalia took her to see Dr. Dudas.

The 12/4/17 report notes Petitioner was off work that week due to acute low back pain: "had picked up big boxes of salads Saturday at work, status post 2015 lumbar discectomy." Petitioner complained of 10 out of 10 pain with radiculitis to the left leg with pain and spasms. The diagnosis was lumbar strain. (Px2). 12/4/17 lumbar x-rays reflected stable (versus 12/1/15) mild to moderate spondylitic changes of the mid to lower lumbar spine with greatest involvement at L4/5. Milder disc space narrowing at L3/4 and L5/S1 were similarly unchanged versus 12/1/15. (Px1).

Petitioner testified that Dr. Dudas referred her to Dr. Yang but could not recall if she received a physical note of referral. On 12/6/17, Petitioner saw Dr. Yang, who noted the prior 4/2/15 discectomy at L4/5. Petitioner noted she had been working since he last saw her but had been given heavier duties 3 weeks prior: "She says she is asked to pick up 50-60 heavy cases every day to put on shelves. She developed pain 5 days ago in her low back after lifting a heavy object and there was an instance where she appeared faint and could not move. Over time the pain improved but she still has pain across the low back with extension upwards." She also noted some left outer foot numbness. Neurological exam appeared to be normal. Dr. Yang's impression was stable mild to moderate spondylitic changes of the mid to lower lumbar spine with greatest involvement at L4/5, and diagnosis was herniated disc. In a separate note, Dr. Yang diagnosed lumbar disc displacement without myelopathy and a lumbar strain. Physical therapy was prescribed, and Petitioner was held off work, with Yang noting if she didn't improve with therapy she should obtain a lumbar MRI. (Px3).

The 12/29/17 lumbar MRI radiology report reflected a broad-based 4-5mm L3/4 disc herniation with extruded pulposus with generalized spinal stenosis and bilateral neuroforaminal narrowing; a posterior and right sided 2-3mm L4/5 disc herniation indenting the thecal sac with mild bilateral neuroforaminal stenosis, right greater than left, and discogenic endplate changes with loss of disc height; and, a broad-based 3-4mm posterior L5/S1 herniation indenting the thecal sac with mild bilateral foraminal narrowing. (Px3 & 4).

On 1/5/18, Petitioner saw Dr. Yang and indicated some improvement with therapy. She noted some left knee pain had resolved, and that she felt low back pain with some radiation to the right when she moved. She had no radicular pain. Dr. Yang noted the MRI findings and stated: "I continue to suspect her back pain is likely muscular in origin. I do not recommend spinal fusion for axial back pain typically." He then noted Petitioner had an issue where she felt uncomfortable if her legs were still, and Dr. Yang advised her to check with her primary care doctor or a neurologist about restless leg syndrome. (Px3).

On 1/8/18, Dr. Dudas completed a Secretary of State form for Petitioner to obtain a 6-month disability placard for her vehicle. In this document, the doctor indicated: 1) Petitioner cannot walk without an assistive device or human assistance, 2) Petitioner is severely limited in her ability to walk due to an orthopedic condition, and 3) Petitioner cannot walk 200 feet without stopping to rest. (Px2).

On 1/9/18, Dr. Yang's note states: "(Petitioner's) primary doctor Dr. Dudas expressed concern that patient was in so much pain." Dr. Yang called Petitioner's daughter Natalia and advised he would write a prescription for an epidural injection at L4/5. He noted that if this failed, L3 to L5 fusion could be considered ("L4/5 has severe degenerative changes and L3/4 has the herniated disc."), but the odds of success would be in the 50/50 range – "if a patient has failed all reasonable conservative measures and is willing to take those odds, I believe surgery would be indicated." (Px3).

On 1/9/18, Dr. Dudas noted Petitioner was moving big boxes at work: "repetitive motion for three weeks, a lot of heavy lifting. I told the manager that I had back surgery in 2015, then sudden onset of pain 12/2/17." Petitioner noted constant 7/10 low back pain with left leg radiculitis. Petitioner was crying and indicating "my life is completely different." She was noted to be wearing a back brace from therapy. Petitioner was noted to be taking high blood pressure medication as well, Amlodipine. The report notes "Dr. Yang will not operate", and a second opinion with Dr. Clay was to be obtained. Petitioner was continued off work. (Px2).

Instead of Dr. Clay, Petitioner testified she next sought treatment with orthopedic surgeon Dr. Sokolowski on 1/18/18. She testified her daughter found him on the internet while looking for a Polish-speaking doctor. A pain drawing from that date reflected pain in the center of the low back (8/10) and symptoms in the left ankle (4/10). Petitioner reported she was instructed to pick up containers of soup and salad at work, weigh and label them and then place them back down onto the floor: "As she did so, she developed the acute onset of severe back pain. She screamed for her coworkers and was helped into a chair in the manager's office." Her pain remained severe over several days and she sought treatment. Therapy has provided some relief. Petitioner reported a history of low back pain and a 2015 lumbar surgery, noting her symptoms improved and she had worked for nearly two years with no significant difficulty. She reported her back and leg pain had been severe since the 12/2/17 work injury. She had a history of hypertension. He reviewed the lumbar x-ray report, and his review of the MRI films indicated moderate L3/4 spinal stenosis and a large left L4/5 herniation with relative preservation of disc height. He noted Petitioner's 2015 pre- and post-surgical MRIs showed interval resolution of the L4/5 disc herniation. Exam noted antalgic and slow gait, pain with various aspects and that she was wearing a back brace. The diagnosis was lumbar pain and radiculopathy. Dr. Sokolowski indicated that, given Petitioner had no significant symptoms for two years after surgery and the MRI showed resolution of the disc post-surgery, "the work injury rendered her L4/5 disc changes and foraminal stenosis symptomatic, precipitating the onset of lumbar pain and radiculopathy." He prescribed 4 more weeks of therapy, a Medrol dosepak and off work through 2/20/18. If no improvement, he recommended an epidural at left L4/5. (Px6).

Petitioner was examined by orthopedic surgeon Dr. Lami at the request of Respondent on 1/29/18, and a Polish interpreter was utilized. He testified via deposition on 4/5/18. He testified that Petitioner reported she was moving multiple boxes weighing between 30 and 50 pounds and that this resulted in significant back pain, initially at a 10/10 level and currently 7/10. She also had some pain in the left leg below the knee with numbness, but nothing from her buttock to the knee. She reported a history of hypertension and that she had a prior back injury with 2015 surgery. Dr. Lami reviewed Petitioner's records and noted Dr. Yang 's 12/30/15 report noted the possibility of L3 to L5 fusion. During examination, Petitioner was very anxious, complained of pain throughout and was tearful. Neurologic exam was normal. Dr. Lami diagnosed low back pain without radiculopathy and some pain involving the left ankle, noting her condition both before and after the alleged accident involved degenerative lumbar changes. (Rx11).

Dr. Lami noted Petitioner reported a repetitive lifting of boxes at work as the cause of her pain, not a specific incident. He noted she had some residual numbness in the distal left leg, which Dr. Yang had indicated might be permanent nerve damage, but no active radiculopathy. Dr. Lami testified such residual post-surgery are not uncommon. Because she had mainly central axial back pain and no active radiculopathy, he testified that epidurals were not indicated. Given this and how emotional Petitioner was, surgery was not recommended; "The type of pain she describes is, in my opinion, not amenable to surgical correction." If her job involved lifting up to 20 pounds, Dr. Lami testified he would not restrict her lifting and would limit her walking and standing as tolerated. He did not believe she needed further treatment and, as it related to the 12/2/17 incident, she had reached maximum medical improvement. He testified: "I really didn't find an injury to her back given the amount of pain she reports, her objective findings on exam and her MRI." If she had developed some increased back pain on 12/2/17, three weeks of therapy would have been reasonable. Her December 2017 MRI didn't indicate any acute findings and indicated degenerative changes from L3 to S1 – moderate at L3/4, severe at L4/5 and mild at L5/S1 – including the finding at L3/4. Petitioner had no clinical condition related to an L3/4 herniation, i.e. anterior thigh pain. He did not review Petitioner's 12/21/15 MRI films, but per the report, there was not much difference versus the 2017 films. (Rx11).

On cross-exam, Dr. Lami testified that Petitioner did not report a specific lifting incident verbally to him or in her intake form. He noted she also had reported a repetitive onset to Dr. Yang on 12/6/17 and Dr. Dudas on 1/9/18. He agreed Dr. Dudas' records note a sudden onset of pain, but the same report notes repetitive lifting for three weeks, not a specific lifting incident. His indication that Petitioner first saw Dr. Dudas on 12/3/17 came directly from Petitioner. He testified that the prior 12/21/14 report noting Petitioner hyperventilating and having anxiety to be relevant because "that's how she is behaving in my office, all anxious, all crying." However, he agreed it said nothing about back pain. The 2/20/15 record indicating a diagnosis of RSD on the left ankle was also relevant to him. Her 3/10/15 complaints of hip / pelvis pain were also relevant because these would be considered part of a back evaluation. (Rx11).

Dr. Lami agreed Dr. Yang's 4/15/15 post-surgical report noted Petitioner felt much better with no leg pain and just some numbness on the left dorsal foot. He agreed numbness can take longer to resolve after discectomy and ultimately may not resolve at all. He agreed that he saw no further prior treatment records following Petitioner's 8/19/15 visit with Dr. Yang where she noted two weeks of back pain, and if it continued she should have an MRI, but noted someone must have then ordered the MRI sometime after that date, which from Lami's perspective indicated she was not doing well many months after the surgery. On 12/30/15, Dr. Yang noted Petitioner's complaints included difficulty sitting due to back pain and putting on socks, with pain that was different than pre-surgery. Petitioner's stated history was that she was mostly recovered after the 2015 surgery. Dr. Yang also had offered a possible L3/4 & L4/5 fusion in December 2015, which is a sign Petitioner was not doing well. Dr. Lami agreed he was not aware of any treatment between 12/30/15 and 12/4/17 and he had no information indicating she wasn't able to work in that time period. However, he testified: "once a doctor offers fusion surgery, the next day your symptoms don't go away." Dr. Lami also testified it wasn't unusual for a patient not to return to a surgeon offering surgery if the patient did not plan on having the surgery. The fact that she was able to work doesn't mean she didn't have ongoing symptoms. Dr. Lami testified that even if Petitioner did have an acute lifting incident on 12/2/17 it would have involved an acute back sprain, at most, so it wouldn't change his opinions. He testified that looking at the totality of the case and her MRI after 12/2/17 and her subjective complaints, demeanor and behavior, it was out of proportion to her condition. Dr. Lami agreed that a lifting incident can aggravate a preexisting back condition, but that a sprain and an aggravation of a preexisting condition are not the same thing. (Rx11).

On redirect, Dr. Lami agreed that the 12/4/17 x-rays showed lumbar arthritis with no significant change from 2015 films. Based on no indication on 8/19/15 that Dr. Yang prescribed lumbar MRI, and Petitioner then undergoing an MRI on 12/21/15, Dr. Lami agreed the Petitioner had to have seen Dr. Yang after 8/19/15 despite there being no report. Dr. Yang discussed the same fusion surgery on 1/9/18 as he had before the alleged accident on 12/30/15. The discussion of it on 12/30/15 suggested that her condition had progressed and worsened post-surgery, and Dr. Lami indicated he wouldn't be surprised if Petitioner thereafter had ongoing symptoms into December 2017. Dr. Lami testified that none of the various scenarios for Petitioner's 12/2/17 mechanism of injury changed his opinions. The exam findings and recommendations would not change, including that she was not a surgical candidate. He opined Petitioner would not get better with surgery given the level of pain she described. He opined that she needed to lose weight, exercise and strengthen her back. Again, Petitioner does not have radiculopathy, and an epidural is not indicated for just axial back pain, per the orthopedic surgical academy. (Rx11).

On 2/20/18, Petitioner returned to Dr. Sokolowski and reported slow but steady improvement in therapy and significant improvement in leg pain with some ongoing numbness. Dr. Sokolowski continued the Petitioner off work through 4/18/18 and advised her to continue therapy, to be followed by a work conditioning program to prepare to transition Petitioner back to work. On 3/13/18, Dr. Sokolowski noted Petitioner called for an urgent appointment, stating she had completed therapy and her back pain increased and leg pain returned. He advised her to hold off on work conditioning and prescribed a left L4/5 epidural. On 4/11/18, Petitioner's pain continued, so the epidural was prescribed, she was continued off work and an FCE was ordered pending authorization of the injection. (Px6). On 5/10/18, Petitioner was reporting back and leg pain at a 7/10 level, noting her pain was unbearable with prolonged standing or walking. Petitioner was frustrated and tearful. She had an antalgic gait and positive left straight leg raise. The epidural had not been authorized. Dr. Sokolowski held Petitioner off work through 6/19/18, and again advised an epidural, noting Petitioner might need a round of three injections. He also prescribed Tramadol. (Px7). Petitioner testified that on 5/10/18 Dr. Sokolowski kept her off work and referred her to a pain specialist, Dr. Kurzydlowski, who is accepted by her health insurance.

Petitioner testified that prior to 12/2/17, she last saw Dr. Yang in December 2015, and that she had sought no back treatment between December 2015 and December 2017. She did see Dr. Dudas for other reasons in that time, but not for back pain or problems, and she worked full duty. Petitioner testified she has not had the epidural prescribed by Dr. Sokolowski because Respondent wouldn't authorize it, and she otherwise could not afford it.

Medical records of the Petitioner were submitted into evidence which predate the alleged 12/2/17 accident. On 12/21/14, a medical report notes the Petitioner had three episodes of "near-syncope" with hyperventilation, which was most likely anxiety-related. On 3/10/15, Petitioner complained of left ankle pain from an injury three weeks prior. She was tearful and complaining of a pain level at 10/10. Her diagnosis was RSD. A 3/19/15 EMG noted a two-month history of left foot and ankle pain after twisting the ankle falling on ice. She landed on her left buttock and leg, noting pain across her back and an inability to lie down. Following testing, she was diagnosed with acute bilateral L4/5 and L5/S1radiculopathy, most prominent at the latter level, which was noted to be chronic. There was no evidence of a peripheral neuropathy. (Px2).

Petitioner underwent a lumbar MRI on 3/24/15, which reflected large sequestered L4/5 disc fragment causing severe compression of the thecal sac and probable compression of the left L5 nerve root. A mild disc-osteophyte complex was also noted at L3/4 producing mild canal and mild bilateral neuroforaminal stenosis. (Px2). On 3/25/15, Petitioner saw Dr. Yang with complaints of intractable pain in the left leg to the ankle and foot, with no midline back pain or right leg pain, but noting it started in the low back, and that the back pain was also "intractable." She indicated she was in extreme pain and could barely move. Hypertension issues were also

noted, and that Petitioner took Amlodipine which was increased to Lotrel. (Px2). Noting the MRI findings and concern for foot drop, Dr. Yang recommended a discectomy. Petitioner underwent surgery with Dr. Yang on 4/2/15 involving a left L4/5 microdiscectomy, and a very large extruded L4/5 disc fragment was noted. (Px3).

On 4/15/15, Dr. Yang did note a history of high blood pressure. Petitioner reported almost complete recovery of left foot motor function and that her left leg pain had resolved, with Yang noting numbness could take much longer to resolve and could be permanent depending on how much the nerve was damaged. On 8/19/15, Petitioner noted increased back pain two weeks prior and felt like "she is tied to a board and she cannot twist, like a stiffness. She also started to feel pain extending down her left leg which occurs when she flexes to put on socks; but it normalizes when she straightens it out. There is sometimes episodic numbness which recovers after 5 minutes." Dr. Yang believed her pain was more musculoskeletal in nature and recommended therapy and an MRI, and he prescribed valium. On 12/30/15, Dr. Yang noted Petitioner reported difficulty sitting and putting on her socks/shoes due to back pain, but no problems walking. She reported her pain was different from prior to surgery, and that she felt worse after physical therapy. Neurologic exam was normal. Dr. Yang noted a 12/21/15 lumbar MRI (compared to 3/24/15 films) indicated the previously seen L4/5 disc had been removed with a remaining very small right protrusion with minimal encroachment on the thecal sac. There also was a new disc protrusion at L3/4 with diffuse bulging resulting in moderate thecal sac encroachment and on the inferior margins of the bilateral neuroforamina, right slightly greater than left. A new left sided pelvic cyst was also noted. Dr. Yang reported that the MRI showed degenerative disc disease at L4/5 greater than at L3/4, and that he discussed a possible fusion with Petitioner, but indicated to her there was only a 60-70% chance of significant relief. He believed that her back tightness and the fact she felt better walking indicated her muscles were more likely the cause of her pain. She was not interested in spinal fusion at that time, and he recommended she continue to do therapy/exercises. (Px3). On 9/4/17, Petitioner was noted to have elevated blood pressure and that she was under a lot of stress. (Px2).

When Petitioner was cross-examined, she testified "I'm not sure. I don't know" when asked if her current pain was in the same area as her prior March 2015 low back injury. She testified that her pain resolved following her 4/2/15 surgery with Dr. Yang and she was able to perform her normal activities. She was asked if she told Dr. Yang in post-surgical follow ups that her pain was worse than before the surgery, and Petitioner testified: "I told him that my leg is not in the same health condition as before. And the doctor said it's going to take some time. And everything is fine now." When asked about what she reported in a 12/30/15 post-op visit with Dr. Yang, Petitioner testified she didn't remember what she reported or what was discussed.

Petitioner verified that her pain began on 12/2/17 with the specific incident of lifting the two crates in the cooler. She testified that no one was in the cooler at the time, but that she told both Paluch and Janina that she had back pain. She denied suffering from hypertension, indicating this was only during menopause and that she was taking medication at that time. Asked when this was, Petitioner testified she didn't know but that it would be in her medical records. She denied that she currently takes blood pressure medication and couldn't recall if she indicated to Dr. Dudas in the last year that she had high blood pressure. Referencing the photo in Px1, the Petitioner testified that the cooler would have been in the area where the camera that took the photo was located.

Petitioner testified that she didn't complete an accident report because she was never told she needed to do so for a work accident. Testifying that Wanda and Paluch helped her to the car after the alleged accident, she said she told both of them that she hurt herself but did not say exactly how. "Nobody was asking me how. . . Nobody was asking so I didn't tell anybody." Paluch never asked her how she hurt her back. She testified she didn't go to the ER on 12/2/17 or 12/3/17 despite severe pain because she thought it would go away and she would go back to work on Monday, but the pain instead increased. She was not scheduled to work on Sunday but was on Monday, 12/4/17. That day, her daughter Natalia went to Respondent's store to tell them Petitioner wasn't

coming in, "and she asked for a number for insurance, the work insurance." Petitioner did not call the Respondent herself and did not know who Natalia spoke to at the store or what she actually told that person, noting Natalia would know who to tell since she previously worked there.

The job video contained in Rx7 reflects both the buffet line and soup labeling jobs, and the Arbitrator has reviewed same and notes it is significantly consistent with the testimony in this case. The buffet involves servers who package and label the food containers. The Arbitrator notes that Anita Paluch is depicted doing the soup job, from getting the crates from the cooler to bringing them to the workstation and labeling them. She stacked three crates on the cart, all on the top shelf, stacking two of them on each other. (Rx7).

Surveillance video was also reviewed by the Arbitrator. On 2/23/18, Petitioner was filmed leaving her house in the morning and arriving at a hair salon at approximately 11:28 am. She exited the salon around 12:30 pm and went to Quest Physical Therapy. Arriving at approximately 12:41 pm, she parked in front and walked inside without any apparent difficulty. She left at about 1:51 pm and drove to a TJ Maxx store. The Petitioner was not filmed inside the store, but she testified that she shopped while she was there. She was in the store from about 2:27 pm until 3:20 pm. She was seen leaning into the back seat while on her right leg with no apparent distress. Overall, the Petitioner was seen walking several times with no obvious problems or defects. No further film of Petitioner was obtained that day, and she was not seen during attempted surveillance on 2/26/18. (Rx8 & 9)

Petitioner was asked if Dr. Yang advised her on 1/5/18 that surgery was not likely to help her, and she testified she didn't recall and didn't understand English. While she agreed her daughter Natalia was with her, she could not remember if Natalia translated. She also testified that she changed to a different doctor than Yang because she didn't understand English. She then testified that she wanted a second opinion as to the injection because: "I always do it when it involves more serious things." She agreed Dr. Yang performed her prior surgery and that she had good results. She testified she had a second opinion prior to the 2015 surgery with a doctor from "Lake Shore." When Petitioner then returned to Dr. Dudas on 1/9/18, she didn't recall getting a referral slip and didn't know if he referred her to Dr. Clay, but she never saw Dr. Clay.

Petitioner again testified that she screamed in pain when she got hurt, but that she didn't know if anyone heard her and no one came to help her. She slid the cases on the floor to her work area. She had increasing pain, felt faint and yelled that she couldn't work anymore. Petitioner testified Janina heard her scream and came over to her, and she told Janina she had severe back pain and asked her to tell the manager.

Petitioner testified that when she saw Dr. Sokolowski again on 2/20/18 she had been bedridden with flu for a week and a half, and she thought her back felt better until she got out of bed and started walking and the pain returned. She said she told both Sokolowski and physical therapy that she had been bedridden. Petitioner testified that physical therapy didn't make her feel better or worse. Petitioner sought immediate treatment with Dr. Sokolowski on 3/13/18 because she had severe pain and "didn't know what to do anymore."

Petitioner testified that while she can sit, stand and walk, she has pain, and that she cannot do prolonged walking because it puts pressure on her leg. The Petitioner testified she didn't know the maximum periods of time she could sit, stand or walk. Getting up and lifting from the floor causes pain. Petitioner was examined by Dr. Lami at Respondent's request pursuant to Section 12. She testified she was honest with him, "but he stressed me out a lot because he wasn't very pleasant."

Petitioner agreed she drives a silver Subaru Forester, noting she does so if her daughter is not home. Asked why she could need to drive if she was off work, Petitioner testified she has to drive to therapy and medical visits. Petitioner acknowledged that on 2/23/18 she went to get her hair done at Visage Hair Salon. She couldn't recall

how long she was there, but that "they have a special chair." She wasn't sure how often she got her hair done, indicating "maybe once in a half year." Petitioner couldn't recall if she went to physical therapy after Visage. She said she may have just "stopped by" at T.J. Maxx, and couldn't say how long she was there. She agreed that while she was there, she was either walking or standing.

Petitioner saw Dr. Dudas a second time on 1/18/18. She agreed he provided her with a handicapped driving sign, but she testified she couldn't recall if she asked for it or if he just offered it to her. She testified she was not aware that the application for it states that she couldn't walk without a wheelchair or walker. She agreed she doesn't have a wheelchair or crutches and that she is able to walk unassisted. Petitioner testified she does wear a back brace and that it was provided to her at therapy. She testified she wears it almost all the time but didn't bring it to the hearing: "I'm very stressed out, and I didn't take it with me." While the application also stated Petitioner could not walk 200 feet, Petitioner testified that she could walk that far. Petitioner does use the disability placard for the car.

On redirect exam, despite being unable to answer on cross exam how long she had been at the Visage Salon on 2/23/18, Petitioner testified that it takes about a half hour to get her hair done. She testified she doesn't have to wait to get her hair done because she always has pre-set appointments. She testified there is a special, softer chair there for people with problems like hers. She agreed she still had pain while seated there, but she has to get her hair done. Petitioner agreed she is able to drive, but again testified she has to because her daughter used to drive her but is now in school.

On cross she appeared to indicate that while she knew how long it took to get her hair cut, she didn't know how long she was at the salon. She was asked why she would have picked a time when she was in severe pain to get her hair done, and Petitioner testified "I don't know. Maybe I had a reason to go." She then testified it was on her way, so she just stopped by. Confronted by her prior testimony that she had pre-set appointments, Petitioner testified: "Obviously I made an appointment when I was going there. I could call from the car."

Petitioner's daughter, Natalia Parys, testified that she had previously worked for Respondent during the summer in 2015, and often worked the same shifts as the Petitioner. She worked in the café area but testified she was familiar with both the buffet and the salad/soup labeling and weighing jobs. Natalia testified the Petitioner called her on 12/2/17 to pick her up from work because she was in severe pain. When she arrived, Anita greeted her and when they went to the back the Petitioner looked pale and like she was in a lot of pain. Petitioner was pointing to her back saying it hurt a lot. When asked if the Petitioner indicated at that time that her pain began with lifting crates or boxes, Natalia testified that she could not recall. Petitioner asked Natalia to call Dr. Dudas, but there was no answer at his office. She testified the Petitioner was unable to get up on her own, indicating her back felt like something was holding or stopping her from standing. Natalia testified the Petitioner had seemed fine that morning before she went to work. Petitioner indicated she wanted to go home and see if she felt better, and since Natalia was unable to get hold of her father or sister, she agreed to take her home. She had to help Petitioner to use the bathroom that day. On Sunday, she testified that they felt more comfortable waiting for the family doctor on Monday than going to the ER. Natalia testified she went to the Respondent's store on 12/4/17 to get the workers' compensation insurance information "and to tell them about what happened." She said she spoke to the owner, Lucas Bojak, and told him that her mom hurt her back. She testified she believed she told him how it occurred. He didn't ask her to complete and accident report but gave her a number to call "which I believe was the workers comp number." Natalia testified that she witnessed the Petitioner telling Anita she hurt her back but didn't recall if Petitioner said how she was hurt. She agreed that the Petitioner has had high blood pressure at times and takes medication for it.

Respondent also called a number of witnesses. Ms. Kruzolek, a kitchen manager and chef for Respondent, testified she met the Petitioner when she started working there two years prior. Her job interacted with buffet workers since they packaged food that was cooked. Ms. Kruzolek testified that on 12/2/17 she first saw the Petitioner before work, between 7:30 to 8:00 a.m., and that she did not look good – pale with dry lips, looking weak and faint and moving slow. Petitioner told her she was feeling really bad with high blood pressure and didn't sleep at all the night before. She asked Petitioner why she came into work, and Petitioner said she hoped she would feel better. She was checking on Petitioner from time to time because she had previously had to leave work in an ambulance due to high blood pressure. At some point, she had a second conversation with Petitioner, who again advised she did not want to go home. Ms. Kruzolek testified she asked Petitioner's manager Paluch to go and look at the Petitioner because she wasn't in good condition. She testified that she had seen Petitioner have similar symptoms previously when she was taken to the hospital, which is why she was keeping an eye on her. Ms. Kruzolek verified that she was later asked by a manager, Art Hajus, to prepare a written witness statement, and that the statement was consistent with her testimony regarding what she observed on 12/2/17. Her statement also noted that Petitioner said her high blood pressure was a family problem and that Petitioner had been sent home early many times for the same reason. Ms. Paluch assisted her in translating the statement she wrote in Polish into English. Petitioner didn't say anything to Kruzolek about injuring her back that day. She had previously mentioned injuring her back in an accident at work a long time before, and Ms. Kruzolek didn't think she had a back problem prior to 12/2/17.

Ms. Kruzolek's written statement noted Petitioner didn't look good when she came into work on 12/2/17, and when she asked about it Petitioner said she felt bad and hadn't slept all night because of blood pressure. Kruzolek stated that she checked on her from time to time to make sure she was okay, and that she then reported it to supervisor Paluch. She noted Petitioner often complained of high blood pressure and indicated it was a family sickness. She had been sent home for it before, including once having an ambulance called. The witness statement stated, "There was no accident." She noted that "we" were surprised that Petitioner came to work in the condition she was in. She noted Petitioner was a friend, and that she had told Kruzolek about a prior spine surgery after an accident at a prior employer. (Rx4).

On cross exam, Ms. Kruzolek testified that she wrote her witness statement at the request of Paluch or another manager and gave it back handwritten in Polish. Someone else translated it into English. She could not recall the date she prepared it, agreeing it could have been in February 2018. Ms. Kruzolek was not with the Petitioner in the cooler at any time on 12/2/17 and acknowledged Petitioner could have injured herself there outside of her knowledge. She agreed that while she was paying attention to the Petitioner the morning of 12/2/17 due to her prior high blood pressure issues, the Petitioner did not ask her for help.

Respondent's Customer service manager, Eliza Zacharow, testified she saw the Petitioner on 12/2/17 in the morning around 8 a.m. and that the Petitioner looked really bad. Petitioner stated she felt bad and couldn't sleep due to high blood pressure. Petitioner had previously complained to her about hypertension and problems due to menopause. She didn't see Petitioner again that day and so could not say if Petitioner had been injured later in the day. She testified that typically customer service is notified of a work accident, but agreed it was possible she had an accident and customer service wasn't notified. Ms. Zacharow testified she prepared her witness statement (Rx5) in English, and verified it was accurate. The statement (Rx5) was consistent with her testimony, noting that Petitioner complained of headache that day due to hypertension. On cross exam, she indicated she was the one who translated the other witness statements into English.

Wladyslawa Trznadel testified she is a three-year employee of the Respondent, since the store opened, and worked as a vegetable peeler in the same room as Petitioner so they would interact daily. She met the Petitioner at work. On 12/2/17, Ms. Trznadel saw Petitioner in the morning around 8 when they started work and testified

she did not look good, looked pale. She told the Petitioner this, and Petitioner said she didn't feel well. She didn't say why. At some point the manager sat Petitioner down in a chair and called for her daughter. She did not recall what time this was but testified that she was able to see Petitioner working that day because she was working in front of her. She testified that Petitioner had previously had an ambulance called because she was feeling bad. She indicated she was the person depicted in Px1 at the top of the photo with part of her head cut off. She indicated she would not be able to see the walk-in cooler from where she was at in the photo, but that the cooler was only about 20 meters away, while Petitioner was about 10 to 15 feet away from her. She was sitting, and Petitioner was standing. She did not hear the Petitioner scream in pain and did not witness Petitioner involved in a work accident on 12/2/17. She testified the Petitioner never said she hurt her back that day or that her back hurt her. Ms. Trznadel testified that the statement she gave was also in Polish and translated to English (Rx2) and was accurate. The statement indicated Petitioner came to work with a headache on 12/2/17 and didn't look good but said "all is going to be okay." She felt worse "minute to minute" and Paluch asked her to go home. Petitioner said she would be alright but then ten minutes later called her daughter to pick her up. She stated: "I have seen Mrs. Parys with the same problems many times and it wasn't an unusual thing for her to live [sic] home early because of her high blood pressure that she complained to me many times as we have worked together at Rich's Fresh Market kitchens." (Rx2).

On cross-examination, Ms. Trznadel testified that she saw Petitioner working on 12/2/17 and that every now and then Petitioner would go to the cooler that day and bring back full crates/boxes using a cart. She couldn't say how many of these crates/boxes the Petitioner moved that day but testified she did not see Petitioner that day sliding any boxes/crates across the floor. She could not see the cooler from her work station and agreed she never saw Petitioner while she was in the cooler, so she couldn't say if the Petitioner hurt herself in the cooler. On redirect exam, she testified she did not see the Petitioner appear to be in pain at any time when she saw her coming back from the cooler. Regarding her witness statement (Rx2), she testified she didn't indicate anything in her Polish statement beyond that the Petitioner did not look good in the morning. She appeared to deny saying that the Petitioner felt worse from minute to minute, stating: "Yes. Maybe the manager added." Ms. Trznadel testified that after she sat Petitioner down, Paluch was the one who called Petitioner's daughter to pick her up. She testified that the person in Px1 named Dorota still worked for Respondent but was in Poland at the time of the hearing.

Wanda Ostrowska works for the Respondent as a cook, testifying she met the Petitioner at work in 2016. On 12/2/17 she saw the Petitioner when they said hello in the morning and at various other times that morning in the kitchen area. She agreed that around 10 a.m. she saw the Petitioner sitting in a chair with her daughter and Ms. Paluch present. She testified that the Petitioner didn't look good and complained of a headache and feeling faint, and Ostrowska held her hand. Paluch wanted to call an ambulance but Petitioner didn't want her to. Ms. Otrowska testified that she had no conversation with Petitioner where she indicated back pain or anything about her back. Petitioner did not discuss her back at any time when Ostrowska was present, including when she helped to walk her to her daughter's car. There was no conversation regarding back pain, just that she had a headache and faint. She didn't hear Petitioner discuss back pain with Paluch while she was present. She did testify that Petitioner often would feel bad in the past. Ms. Ostrowska testified that her witness statement (Rx3) was translated accurately from Polish to English. On cross exam, her indication that Petitioner had high blood pressure on 12/2/17 was based on Petitioner complaining of headache, her prior indications of a family history of hypertension and Ostrowska's own experience with it. The Petitioner did not tell her the problem was high blood pressure. She testified she heard nothing about a work accident on 12/2/17, but agreed she just saw Petitioner when she'd pass in the kitchen and didn't speak to her again after they said hello in the morning until Petitioner was sitting in the chair. As to her indication in her statement that there was no accident, all she could testify to is that she didn't see an accident occur.

Ms. Ostrowska's statement indicated she "heard" Petitioner wasn't feeling good. When she walked into the kitchen she saw Petitioner seated and waiting for her daughter, after which she and Paluch helped her to her car. In the chair she looked pale and complained of high blood pressure and headache. "All this time Mrs. Parys complain about high blood pressure and she left home about 10 a.m. Mrs. Parys headaches happened often and she was let go early that day as well." Her statement, like that of Ms. Trznadel, noted the co-workers were discussing Petitioner's condition and that she should not have come into work that day. She noted there was no accident, but that Petitioner had previously mentioned a prior accident and spine problems. (Rx3).

Buffet manager Anita Paluch's statement indicates the Petitioner was sent home around 10 a.m. on 12/2/17 after she complained about high blood pressure. She noted this was not the first time this had happened, and that Petitioner often spoke about hypertension issues and that she had apparently inherited the problem from her mother. She stated: "I do not presume to give a medical opinion, just merely stating the fact I was aware of Mrs. Parys said that the high blood pressure is a level 2 and one of the worst ones. Because of that reason, she also had fainted and had frequent tantrums." Petitioner had talked about a prior back injury while working at Butera Finer Foods but had never complained of back pain "let alone an acute one" while working for Respondent. She noted Petitioner had recently transferred from the buffet to soup packing area because she said the area was more climate controlled and there was less interaction with customers. A separate witness statement for the insurance company stated: "There was no accident. Mrs. Parys did not even tell me that she felt bad that day." She was informed by another worker, and when she went to see Petitioner she was labeling soups - "she looked tired." Ms. Paluch stated that Petitioner was weak even though she had taken her blood pressure medication. She noted Petitioner did not report any injuries beyond her hypertension, and that the problem had happened many times before, and Petitioner was either sent home or an ambulance was called. She noted: "we all talked about her problems that she should not come to work in that condition." (Rx1).

Ms. Paluch testified she'd worked for Respondent since the store opened three years prior and had known Petitioner since then. She supervised buffet workers who deal with both hot meal buffet and cold soups and taking cold products to the store. She works from 7 a.m. to 5 or 6 p.m. The Petitioner started with Respondent in the buffet area. For soups, she would have to label and price them, which would be done in the kitchen, and then put them out in the store. While Petitioner mainly worked at the buffet, she always worked with the soups from time to time as well. Paluch testified that the Petitioner had been working the soup job for three or four weeks prior to 12/2/17 at Petitioner's own request, as she said it was too hot in the buffet area with her high blood pressure and was cooler working in the kitchen. Ms. Paluch testified that the Petitioner specifically told her she had hypertension and that they called an ambulance at Petitioner's request twice before 12/2/17. Noting she has performed soup labeling herself many times, Ms. Paluch testified that kitchen personnel put the soups in the cooler, then the soup person puts them on a cart, labels and prices them and then multiple people distribute them around the store. She testified that the cart shown in Px1 is one of three carts used to move the soups from the cooler in the crates, and that there would be no reason for the Petitioner to be carrying crates to her workstation from the cooler since the carts are readily available. Each crate contains fifteen 16-ounce soup containers, which each weigh a pound, so each full crate weighs 15 pounds plus the weight of the empty crate. She testified there would be no reason to put more than 15 containers in a crate. While she testified that carts should hold two crates on top and two on the bottom, she agreed at times more would be stacked on top. She testified that there are no pace requirements for labeling soups, so there would be no reason for Petitioner to take more than one crate and no need to lift 30 or more pounds: "I don't have anything in that weight." She denied that workers would have to lift pallets of delivered product weighing 80 to 100 pounds.

Ms. Paluch testified that the Petitioner started work at 8 a.m. on 12/2/17, and that it was around 9 a.m. when Ms. Kruszolek told her that Petitioner "feels bad again", i.e. was having high blood pressure issues. When she got to Petitioner's workstation she was standing and labeling soups. She testified that Petitioner stated that she

had high blood pressure again and hadn't slept the whole night, so she told her to sit in the chair. Ms. Paluch denied that the Petitioner ever reported back pain or that she hurt herself lifting crates. She did not report any work injury. Ms. Paluch testified that if a work injury occurs, she was to report it to her supervisor, Lucas Bujak, and complete an accident report. However, she also acknowledged no one had ever reported a work injury to her before. Had Petitioner done so on 12/2/17, she testified she would have completed an accident report and called an ambulance.

Ms. Paluch testified she asked the Petitioner to call her daughter to pick her up and that it took Natalia 20 to 30 minutes to arrive. She and three other people were in the kitchen with Petitioner – Kruzolek, Trznadel and Ostrowska. Petitioner did not report an accident to her at any time and she did not hear Petitioner tell any of the others about a work accident or back problem. Petitioner left work that day and was sent home due to high blood pressure. Petitioner had told her previously that she often had high blood pressure and that she inherited it from her mother and, as noted, an ambulance had to be called for Petitioner twice previously, so this was not the first time this had happened. She testified that the Petitioner had the same facial expressions on 12/2/17 as she had at those times. Ms. Paluch could not recall when she first learned that the Petitioner was claiming she hurt her back on 12/2/17. She acknowledged she had discussed the events of 12/2/17 with the other ladies who testified at hearing and none of them ever indicated Petitioner said she had low back pain. Ms. Paluch testified she also completed a witness statement and indicated that Rx1 was an accurate representation of the statement. As to the statement that Petitioner had frequent "tantrums", she agreed her meaning was difficult to translate and what she meant was "she was more nervous." She also testified, however, that Petitioner "had problems with her co-workers, more conflicts." Ms. Paluch acknowledged she was not generally in physical sight of Petitioner, but that neither she nor anyone else saw Petitioner sustain a work accident. She also testified: "Because there was no accident because she was going, leaving the place on her own power without pain."

On cross-examination, Ms. Paluch agreed that the Petitioner had to be assisted out of the store. She testified that Petitioner was not liked because of tantrums and other employees have complained about her, but that Paluch herself did not have a conflict with Petitioner. She agreed she was not with the Petitioner the whole time on 12/2/17 prior to coming to see her, but essentially denied Petitioner had a work accident based on the fact she reported to Paluch that she was having high blood pressure, and because she was able to walk out of the store under her own power, though she agreed Petitioner was assisted out of the store. Ms. Paluch denied that she assumed Petitioner was having blood pressure issues on 12/2/17 based on her facial expression being the same as the other two times that an ambulance was called, it was based on the Petitioner saying she was having a high blood pressure problem. As to the portion of Ms. Paluch's statement indicating Petitioner had a prior accident at Butera Finer Foods, all she knew was that Petitioner told her she had an accident there and had back surgery. Ms. Paluch testified that it was not possible that Petitioner lifted two crates at a time "because you lift one by one." She also stated that there is a written job description indicating that you cannot pick up two at a time, but she did not have a copy of this with her at hearing. As there are three carts at the store, Paluch testified it was not possible that all three carts were being used at one time and none were available to Petitioner. The milk crates in the cooler are stacked five-high, so there are times you would have to reach up higher or bend down towards the floor to pick up a crate. Ms. Paluch was with the Petitioner the whole time from when she was told Petitioner wasn't feeling well and went to see her and the time Petitioner left the store, and they did have conversation in that time. Paluch was again asked if it was possible that Petitioner could have picked up multiple crates without a cart, and Paluch again denied this, saying Petitioner would not have done this "Because she's reasonable, wise person."

A vocational consultant for Oncor Unlimited, Eric Flanagan testified on behalf of the Respondent and indicated he was retained to prepare a video job analysis. He prepared analyses of both a counter attendant at the cafeteria, and then an addendum was prepared for "some of the duties that were being done in a transitional capacity by

the injured worker", noting his use of the term "transitional" duty simply meant tasks or jobs different from the ones a worker was hired to do. This addressed the soup labeling job and all of the tasks involved from getting the soup from the cooler to putting them back in the crates to get them into the store. He weighed a crate with 15 soups packed into and it weighed approximately 18 pounds total. Mr. Flanagan worked with Ms. Paluch to prepare the report and video. He watched a worker move five crates, one at a time, from cooler to cart, taking them from various heights, as well as the labeling process, but not the weighing process.

Mr. Flanagan's job analysis for the counter/cafeteria, i.e. buffet, job indicated it was in the light physical demand category. The addendum for the soup job was consistent with his testimony. (Rx6).

On cross, Mr. Flanagan testified that, based on his discussion with the supervisor and the worker performing the tasks, he extrapolated the time he spent filming the job to determine that lifting of crates for a soup worker would occur 30 to 50 times per shift in an eight-hour day. He acknowledged that any discussions he had with Respondent workers involved Ms. Paluch interpreting. Paluch was in some of the video and photos, but she was not the one being filmed doing the work. Mr. Flanagan was not made aware of any other products being moved besides soup, and that he did not weigh any other products at the store. He could not say what jobs Petitioner did or didn't do, just that he was asked to do an analysis for the soup job. Mr. Flanagan did testify that the soup worker had an option to put one layer of crates on the top of the cart or could stack them two-high. Nothing was discussed as to whether the workers would lift more than one crate at a time – "that wasn't something that came up" – however, he testified that doing so would be unwise and that it wouldn't make sense to lift two when you can lift one at a time. All he observed was a worker lifting one crate at a time, but he was not aware if Respondent had an unwritten policy about this. With regard to the cooler photograph on page 6 of his report, Mr. Flanagan testified he did not believe workers were taking down crates from the above shoulder position, but rather "something is happening in the interim to help those crates get from that unreachable height down."

Private investigator Matt Morgan of PhotoFax testified with regard to surveillance he performed on Petitioner on 2/23/18 and 2/26/18. His report is Rx8. He identified the Petitioner as the person he investigated and took video of. On 2/23/18, he observed Petitioner back her car out of the garage (11:19 a.m.), travel to a hair salon (11:28 a.m.). Petitioner walked unassisted from her car to the salon, approximately 83 feet, and exhibited no limp. After about an hour, she walked back to her car the same way and went to Quest Physical Therapy. She walked inside, again unassisted and with no limp. She then went to a TJ Maxx store and walked approximately 310 feet from her car to the store. After about an hour, she came out with some clothes items, went to the passenger side and opened both doors, bending and reaching into the back standing only on her right leg (see Rx10). She then returned back home. Flanagan testified that the Petitioner did not appear to be having any physical difficulties, though he agreed he is not a medical professional. He also agreed that he couldn't see Petitioner's face during some of the physical activities he observed, and thus couldn't see if she was grimacing or expressing discomfort. He could not say what her activities were inside of the salon, the therapy facility or the TJ Maxx. He did not observe any further physical activity that day, or any physical activity on 2/26/18.

In rebuttal, Petitioner denied telling Ms. Paluch on 12/2/17 that she was having problems with high blood pressure and testified that she made it clear to her that she was hurt lifting crates. She agreed she had been working as a soup labeler for about three weeks prior to the alleged accident but denied that she asked Paluch to move to that job. She testified that Ms. Paluch told her to do that job or go home, and that when Petitioner said she would report it to the office, Ms. Paluch laughed at her and asked who would listen to her. She testified that she liked working at the buffet and having contact with people and didn't like the soup job.

Petitioner agreed she told Ms. Paluch she had a prior back condition. She denied having any disciplinary problems at work and said that she had become somewhat of a substitute manager for Paluch. She denied being

disliked by her co-workers. Petitioner testified that she believed the full soup crates weighed over 18-pounds but did not indicate the basis for this belief. Petitioner questioned whether there were 30 to 50 crates lifted per day, as indicated by Mr. Flanagan, and testified that she had to deal with crates of other types of food that involved heavier weights than soup. Again, she would weigh many of these items, and the non-soup crates weighed over 18 pounds. As to her current pain, Petitioner testified she has good and bad days, and that there was a period of time after 12/2/17 where she felt better and could walk more easily. She recalled going to TJ Maxx, as noted in the surveillance, and said she purchased a pair of pants there, which is what was in her hands.

On cross-exam, Petitioner was confronted with prior testimony where she said that she didn't specify how she hurt her back because no one from Respondent asked her what happened to her back that day, and she testified that she had back pain that day and that Paluch helped her walk. She also testified that Paluch was present when she told her daughter on the phone and overheard it. She agreed she was aware she was supposed to complete an accident report, but indicated Ms. Paluch also knew this. She was never told she would have to prepare this report herself and "I didn't even think about it at the time because I was in pain and she (Paluch) was right by me." She testified that she didn't think she needed to bring any witnesses to the hearing to support her truthful testimony, and that the witnesses who testified "want to work still." Petitioner testified that other foods contained in 16-ounce containers can weigh more than a pound, such as cole slaw. Petitioner testified that she would sometimes stack crates two-high, and when an order was late the manager would sometimes direct that they be stacked three-high.

Petitioner agreed she testified at the April 2018 hearing that her pain level was 7/10 and that she had to take painkillers "constantly" or she otherwise is in pain. She agreed she was helped to her chair and to the bathroom by her son at the April hearing date "because at night it hurts more." She didn't recall exactly but testified she thinks her pain level at the time surveillance was performed was 4/10. Petitioner was asked if she told Dr. Sokolowski on 2/20/18 that she had a 7/10 pain level, and she testified she didn't remember because she was on painkillers but would agree with his report. Asked then about her testimony of only 4/10 pain three days later during surveillance, Petitioner testified that her pain scale changes often "because there is some pressure." She sometimes must drive while on painkillers because she has no one to drive her. She testified that she takes the painkillers when she is in pain, and she has pain often, but that there are days she doesn't take them if she is feeling better.

CONCLUSIONS OF LAW

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

The Arbitrator finds that the Petitioner has failed to prove that she sustained accidental injuries arising out of and in the course of her employment on 12/2/17.

The Arbitrator notes that this determination was difficult in this case, as there was evidence which supported an accident, including her initial medical records which reflected that she developed back pain while moving heavy crates at work. The Arbitrator also notes that the language barriers in this case with Petitioner and multiple witnesses, despite a yeoman's job by the interpreter, also contributed to some of the inconsistencies in this case. There were multiple inconsistencies with multiple witnesses, but the Petitioner's testimony, in the Arbitrator's view, was the most inconsistent. Ultimately, the burden of proof rests with the Petitioner, and the Arbitrator finds that the preponderance of the evidence does not support an accident occurred on 12/2/17.

As noted, the Arbitrator found quite a few instances of inconsistencies in the Petitioner's testimony. She testified that she did not have high blood pressure and did not take medication for it. The records contain many references to hypertension, both before and after 12/2/17, as well as the prescription of medication. The co-worker witnesses who testified noted multiple instances of the Petitioner reporting problems with high blood pressure and that she had a family history of the problem. Blood pressure medication was prescribed to Petitioner in fall and winter 2017, prior to the alleged accident date.

The Petitioner testified that she didn't want to treat with Dr. Yang because she didn't speak English. This does not make sense given that she had surgery with pre- and post-surgical treatment with the same doctor in 2015.

The Petitioner testified that she wouldn't have to wait to get her hair done because she normally had a set appointment, then testified that she had called the salon on 2/23/18 to get an appointment that same day. She agreed that she obtained a disability placard via Dr. Dudas despite indicating she was able to do the things the application said she couldn't do.

Every witness in this case that saw Petitioner in the morning on 12/2/17, other than the Petitioner and her daughter, testified that the Petitioner looked ill in the morning when she arrived at work, ill enough that it was quite obvious to the co-workers. She also reported to several co-workers that she had not slept the prior night due to the blood pressure problem. Overall, the witnesses also consistently noted the Petitioner complained that the problem was hypertension and that she hadn't slept the prior night as a result. There was a consistent indication that the Petitioner had been in a similar condition multiple times in the past, even to the point that she needed an ambulance once or twice. All or the vast majority of them also testified that the Petitioner herself, when asked what was wrong with her, indicated the problem was hypertension, and no other witnesses beyond Natalia Parys testified that the Petitioner indicated anything about a back problem or hurting her back. Most of the co-worker witnesses indicated the Petitioner should not have come into work that day given how bad she was feeling.

The mechanism of accident itself is in question in this case in terms of whether the Petitioner was alleging a specific or repetitive trauma. Her testimony alleged that she was in the store cooler/freezer and lifted two crates at a time when she felt sudden back pain. The initial report of Dr. Dudas notes Petitioner had picked up big boxes of salads Saturday at work. Dr. Yang notes she said she had to pick up 50-60 heavy cases every day to put on shelves. She developed pain 5 days ago in her low back after lifting a heavy object and there was an instance where she appeared faint and could not move.

Petitioner testified she pushed the crates across the floor to her work station. First of all, the Petitioner did not describe how she did this. It doesn't make sense to the Arbitrator that the Petitioner would have either pushed heavy cases across the floor with her legs/feet with back pain, or how she otherwise would have bent over to do so for the same reason. Secondly, none of the Petitioner's coworkers indicated they saw the Petitioner pushing crates across the floor.

Petitioner testified no cart was available and she had to carry cases to her work station. This was disputed by Ms. Paluch, who indicated carts were generally available, and the testimony of Ms. Trznadel, who indicated she saw Petitioner using a cart to get products from the cooler. Given the condition all of the witnesses indicated the Petitioner was in that morning, it also makes no sense that, even if the Petitioner was carrying a crate, that she would have tried to lift two of them at a time.

Petitioner testified that she screamed in pain. It was not completely clear to the Arbitrator whether this occurred in the cooler or back at her workstation, but the Petitioner testified it occurred after she tried to continue to work. In any case, no one testified that they heard the Petitioner scream. The Petitioner herself initially testified that her scream was responded to, then later on cross-exam testified that no one responded to her scream. The Arbitrator believes that with multiple people in the kitchen, someone would have responded to the Petitioner screaming in pain had it occurred.

The Arbitrator acknowledges that there is no evidence indicating that the Petitioner underwent back treatment between December 2015 and December 2017. However, Dr. Lami's made two good points: For the Petitioner to have undergone an MRI in December 2015, the Petitioner would have to have seen the doctor between 8/19/15 and the 12/21/15 MRI for it to have been prescribed; and, it is unlikely that the Petitioner's symptoms suddenly ended after 12/30/15 after they had worsened to the point that she was discussing a fusion surgery with Dr. Yang.

The Petitioner testified essentially, from what the Arbitrator could gather from the testimony in this case, that she did not report a back injury to Ms. Paluch or any of her coworkers. She testified at one point that Paluch had to have overheard her telling her daughter on the phone that she heard her back. The Arbitrator must question why the Petitioner would somehow believe that this would constitute notice of an injury over specifically telling her supervisor when she was asked what's wrong. Natalia testified she went to the Respondent's store on 12/4/17 to get the workers' compensation insurance information "and to tell them about what happened." Why would she need to tell the Respondent what happened if the Petitioner already had? She said she spoke to the owner, Lucas Bojak, and told him that her mom hurt her back. She testified she "believed" she told him how it occurred. He didn't ask her to complete and accident report but gave her a number to call "which I believe was the workers comp number." Natalia testified that she witnessed the Petitioner telling Anita she hurt her back but didn't recall if Petitioner said how she was hurt. Thus, in three separate instances Natalia indicated only a belief that the Respondent was notified as to how the Petitioner was hurt. The idea that the Petitioner would rely on the Respondent having been notified of a work injury on 12/2/17 via overhearing the Petitioner speaking to her daughter on the phone, again, makes no sense to the Arbitrator when the Petitioner was in the presence of the supervisor and a reasonable person would have told the supervisor what happened. This is particularly the case given the Petitioner's stated level of pain. The fact that Ms. Paluch did not prepare an accident report, and Petitioner apparently did not request one, is an additional piece of evidence weighing against the Petitioner having suffered a specific trauma.

The surveillance video of 2/23/18 shows no significant activity being performed by Petitioner. At the same time, it is relevant to the Arbitrator that the Petitioner appears to be in no significant distress at all while her complaints to physicians paint a different picture of very severe back pain. On 2/20/18, just three days prior, Petitioner testified that when she saw Dr. Sokolowski she had been bedridden with flu for a week and a half, and while she thought her back felt better, she got out of bed and started walking and the pain returned. Additionally, the juxtaposition of the Petitioner's appearance at hearing in terms of being in debilitating pain to where she needed help ambulating just does not comport with what was seen in the video. The Arbitrator notes that there are several entries in the medical records where the Petitioner was noted to have issues with anxiety, or was tearful and crying, or was complaining of debilitating 10/10 pain.

Taking all of this evidence and information together, while this was a close case on the issue of accident, the Arbitrator finds that the Petitioner has failed to prove an accidental injury on 12/2/17 by the preponderance of the available evidence.

WITH RESPECT TO ISSUE (F), IS THE PETITIONER'S PRESENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

Based on the Arbitrator's finding that the Petitioner failed to prove a compensable work-related accident on 12/2/17, this issue is moot.

WITH RESPECT TO ISSUE (J), WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY AND HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, THE ARBITRATOR FINDS AS FOLLOWS:

Based on the Arbitrator's finding that the Petitioner failed to prove a compensable work-related accident on 12/2/17, this issue is moot.

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

Based on the Arbitrator's finding that the Petitioner failed to prove a compensable work-related accident on 12/2/17, this issue is moot.

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:

Based on the Arbitrator's finding that the Petitioner failed to prove a compensable work-related accident on 12/2/17, this issue is moot.

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 Choose reason	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify Choose direction	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

BRIANNA BOSTON,

Petitioner,

vs. NO: 19 WC 27162

RIVER BIRCH SENIOR LIVING LLC.,

Respondent.

20IWCC0365

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, temporary disability, causal connection, medical expenses 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.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 11, 2019, is hereby affirmed and adopted.

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

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

The 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

Blacklisted

20IWCC0365

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 26 2020
KAD/bsd
O060920
42

Kathryn A. Doerries

Thomas J. Tyrrell

Maria E. Portela

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

BOSTON, BRIANNA
Employee/Petitioner

Case# **19WC027162**

RIVER BIRCH SENIOR LIVING LLC
Employer/Respondent

20IWCC0365

On 12/11/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.52% 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:

2217 SHAY & ASSOCIATES
TIMOTHY M SHAY
1030 DURKIN DR
SPRINGFIELD, IL 62704

5647 ACCIDENT FUND HOLDINGS
PERRY GENTILE
PO BOX 40785
LANSING, MI 48901-7985

20IWCC0365

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)

BRIANNA BOSTON,
Employee/Petitioner

v.

RIVER BIRCH SENIOR LIVING, LLC.,
Employer/Respondent

Case # **19** WC **27162**

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 **Maureen Pulia**, Arbitrator of the Commission, in the city of **Urbana**, on **11/13/19**. 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 _____

FINDINGS

On the date of accident, **7/29/19**, 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 not*** sustain an accident that arose out of and in the course of employment.

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

In the year preceding the injury, Petitioner earned $**15,320.78**; the average weekly wage was $**437.34**.

On the date of accident, Petitioner was **23** years of age, ***single*** with **0** dependent children.

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

Respondent shall be given a credit of $**00.00** for TTD, $**00.00** for TPD, $**00.00** for maintenance, and $**00.00** for other benefits, for a total credit of $**00.00**.

Respondent is entitled to a credit of $**00.00** under Section 8(j) of the Act.

ORDER

The arbitrator finds the petitioner has failed to prove by a preponderance of the credible evidence that she sustained an accidental injury that arose out of and in the course of her employment by respondent on 7/29/19. Petitioner's claim for compensation is denied.

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

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

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

Signature of Arbitrator

12/2/19
Date

ICArbDec19(b)

DEC 11 2019

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 23 year old CNA supervisor, alleges she sustained an accidental injury that arose out of and in the course of her employment by respondent on 7/29/19. Petitioner has been a CNA for 3-4 years. Petitioner started working for respondent in November of 2018. Respondent's facility consisted of 3 assisted living houses with 14 rooms each, 7 on each floor. The Nurses Office was in house #1; the Main Office was in house #2; and, the Director's Office was in house #3. Petitioner's shift was 7 am to 3 pm. Petitioner lived in an Apartment complex on S College St. Petitioner's apartment building bordered College St. The arbitrator is excluding the apartment address and unit number for privacy reasons. Petitioner's apartment building is marked on the Apartment Complex map offered into evidence by respondent. (RX1)

As a supervisor, petitioner was the extra "eyes and ears" for the Manager, Michelle Fierge, and would do filing of the ADL sheets. As a supervisor, petitioner was also required to be "on call" 1-2 weeks a month. Her time "on call" was determined by Fierge. What this consisted of was carrying a cell phone issued by respondent, 24/7, and taking all calls related to staffing. She would handle all changes in the schedule and call others to cover if someone could not make their shift, or were going to be late. If petitioner could not find coverage she would have to cover the shift. To perform this duty, in addition to the respondent issued cell phone, petitioner would have a list of phone numbers for all employees so that she could call them. Petitioner was paid $77 a week when she was "on call".

On 7/29/19 petitioner worked the 7 am to 3 pm shift in house #2. Petitioner was "on call" this day. Her supervisor duties were in addition to her regular duties of taking care of the residents. This included assisting with bathing and feeding, cleaning up and doing laundry. While working petitioner got a call from Danielle on her "on call" cell phone. Danielle told petitioner that she was going to be late for her shift that started at 3 pm. As a result, when petitioner finished her shift at 3 pm in house #2, she went over to house #3 to work until Danielle arrived.

Laquita Stennis, a caregiver for respondent, had worked the 7 am to 3pm shift at house #3. As petitioner was entering house #3 on 7/29/19, she stated that she saw Stennis leaving the building after work while she was walking from house #2 to house #3 after 3 pm, but they had no interaction at that time. She testified that Stennis did not wait for her to arrive and walk the floor with her and give her a report like she was supposed to. While in house #3 covering for Danielle, petitioner was approached by Destiny, another employee. Destiny reported that the sheets in one of the resident's room were soiled. Petitioner called Fierge on her "on call" cell phone and reported the situation between 3:20-3:30 pm. Fierge told petitioner to call the two people who covered the upstairs and downstairs on the 7am to 3 pm

shift that day, and find out who was assigned to that resident. Petitioner contacted Stennis and the other worker using her "on call" cell phone. Stennis responded with a text that she was in charge of that resident. Petitioner then contacted Fierge on her "on call" cell phone and told her that Stennis was in charge of that resident.

Petitioner left work shortly after 4 pm. Before heading home, petitioner stopped at her bank to get a check for her rent. Petitioner was driving her uncle's car because her car was broken. While at the bank or before she went home, petitioner received a text from Stennis on her personal phone at 4:13 pm that stated "I will smack both of y'all lame ass". Petitioner responded with "Girl bye". Stennis then texted back "Right bitch y'all lame ass hell I'm on y'all ass". Petitioner testified that she did not respond to this last text from Stennis. Petitioner testified that she then took a screen shot of this conversation and sent it to Fierge. She thought Fierge would resolve the issue by disciplining Stennis in a manner so that she would not lash out at her. Petitioner did not hear anything back from Fierge before she called her on the way to the emergency room later that evening.

Although petitioner did not text Stennis back after her last text message, she did state that Stennis called her on her personal phone and she answered the call. Petitioner testified that Stennis asked her where she was, but she did not tell her. She further stated that Stennis then told her that she was at her house. After she talked to Stennis, petitioner proceeded to her home knowing that Stennis was there. Petitioner testified that when she got to her parking lot, Stennis was parked in front of her building in the spot she usually parked in. She testified that there are no assigned parking spots in her parking lot. Petitioner made no attempt to drive away when she saw Stennis at her apartment in her parking spot. Petitioner parked elsewhere and got out of her car. She testified that after she exited her car, and attempted to access her stairs, Stennis approached her swinging her arm and pointing her finger at her yelling about petitioner reporting her to Fierge regarding the resident. Petitioner testified that she tried to calm Stennis down. She then testified that Stennis got within 2-3 steps away from her and she felt threatened. Petitioner tried to push Stennis away from her because she was scared and felt Stennis would hit her. Petitioner testified that Stennis came at her again and they began to fight, with each striking the other. Petitioner stated that the fight lasted about 1-2 minutes. Petitioner stated that she was just defending herself. She reported that her face and neck were scratched, and her right hand and left knee came in contact with the cement. As they were fighting, a car pulled into the parking lot right where they were fighting. As a result, the fight broke up, they each got in their respective cars, and left the parking lot. Petitioner testified that she went to her uncle's house because she did not feel safe at home. This was the uncle from whom she borrowed the car, and he lived about 3-4 miles away.

Petitioner testified that she stayed at her uncle's house from about 5-7 pm. She testified that Stennis continued to call her on her personal phone during this period, but she did not answer her phone. She testified that she finally blocked Stennis' number. Petitioner knew Stennis was angry. During this period petitioner did not call or contact Fierge, or any other respondent representative. She also testified that she did not call the police to report the incident with Stennis in her parking lot.

At about 7 pm, petitioner's boyfriend, Jermaine Oats, came and picked her up from her uncle's house. She testified that she and Oats lived together. Oats took petitioner home. When they got to the apartment complex they parked in the spot in front of the stairway. They did not go into their apartment right away. She testified that they sat in the car and were smoking for about a half hour because they are not allowed to smoke in their apartment. Petitioner testified that while she and Oats were sitting in the car, Stennis pulled up in a van on College St, next to her building. Petitioner did not call the police or anyone else when she saw Stennis pull up. She testified that she also did not try to pull out because Stennis' van was blocking the driveway. Instead she testified that they both exited their cars at the same time. She testified that Stennis had brought her sister and roommate with her. She testified that Stennis, her sister, and roommate had a knife, mace and a bag full of rice with a can in it. Petitioner testified that they sprayed her with mace and chased her around her building. One person had the knife in their hand, and another had the bag with rice and can in their hand. She did remember what they were saying as they were chasing her.

Petitioner testified that as she was being chased Stennis was waving the knife at her. She stated that she was running backwards and fell backwards, landing on her left arm. She stated that while she was on the ground Stennis came towards her as if she was going to stab her. Petitioner testified that she kicked up at her. She testified that her boyfriend then came around the building and Stennis left and went back to where petitioner's car was parked. Petitioner testified that she got up and followed Stennis back around to the front of the building where Stennis was hitting her car with the bag that had the rice and can in it. She testified that the bag burst open as Stennis was hitting the car. Petitioner testified that Stennis saw her, gave her sister the knife, and then came back after her. She stated that she again defended herself and tried to subdue Stennis. She also stated that Stennis' sister grabbed her hair and she fell. She testified that they were all holding each other, and then Stennis' roommate's foot came at her. At this point, she stated that Oats came to help her and pulled the person who was grabbing her hair off her. Petitioner testified that in all the fighting she again fell on her left arm and injured her left wrist/arm. She testified that while she was on the ground she kept kicking to keep them away from her. She testified that Oats was able to break up the fight, and Stennis, her sister, and her roommate left. Petitioner

testified that her face hurt real bad, and she could not feel her left wrist. She also stated that her right ring finger hurt. Petitioner took pictures of her face that showed the scratches and bruises on her face.

Petitioner testified that Oats took her to the emergency room at St. John's. On her way, petitioner called Fierge and told her that Stennis, her sister, and her roommate jumped her. This was first time petitioner had spoken or communicated with Fierge since she sent Fierge the screenshots she received from Stennis at about 4:13 pm. Fierge told her that she had received the screenshot and she told Stennis to stop threatening people. Petitioner at no time on 7/29/19 contacted the police. She testified that Fierge told her she would meet her at the emergency room to pick up the "on call" phone.

Petitioner arrived at the emergency room around 10:30 pm on 7/29/19. Petitioner stated the Fierge sat with her in the waiting room for a bit, and then for about 10 minutes after they took her back to be examined. Her chief complaints were wrist injury and facial injury. Petitioner gave a history of being punched in multiple body parts with complaints of left sided facial pain and swelling, as well as left wrist pain and left knee abrasion. She reported that she used marijuana after the event to help the pain without improvement. Petitioner had tenderness and limited range of motion in her left wrist due to pain. Petitioner had abrasions over her left knee, and swelling and tenderness over her left cheek. X-rays taken of her left knee showed no acute bony abnormality. X-rays of her left wrist showed a minimally displaced scaphoid wrist fracture. A CT of her facial bones showed no acute maxillofacial bone fractures. A CT of her cervical spine showed no acute fracture or malalignment. A CT of her head showed no acute intracranial abnormalities. Her final clinical impression was closed displaced fracture of the scaphoid of the left wrist, unspecified portion of scaphoid, initial encounter; minor head injury; facial contusion; abrasion; and dehydration.

Petitioner testified that on 7/30/19 she reported the incidents to the police. Stennis did not show up for work on 7/30/19, and did not call off. As a result, Stennis was terminated.

On 8/7/19 petitioner presented to Dr. Maender at Orthopedic Center of Illinois. Her chief complaint was left wrist pain. Petitioner stated that she was right hand dominant. She reported left wrist pain after being assaulted in her home by a co-worker on 7/29/19. Petitioner presented in a left wrist brace. She also reported right ring DIP joint pain since the altercation. Petitioner stated that she smokes a half pack of cigarettes a day. Dr. Maender took x-rays of petitioner's left wrist and right ring finger. He diagnosed left scaphoid mid wrist fracture, and right ring finger bony mallet injury, approximately 50% of the articular surface. Treatment options were discussed and surgery of the left wrist and right ring finger were decided upon. He told petitioner the importance of smoking cessation since smoking will delay her bone healing.

On 8/13/19 petitioner was given an off work authorization from Dr. Maender's office from 7/29/19 through 8/28/19.

On 8/15/19 petitioner underwent an open reduction internal fixation of the left scaphoid and closed reduction percutaneous pinning of her right ring finger DIP joint. Her post-operative diagnosis was left scaphoid mid wrist fracture and a right ring finger bony mallet intraacrticular P3 displaced fracture. These procedures were performed by Dr. Maender. Petitioner followed-up post-operatively with Dr. Maender.

Petitioner testified that a few days after her surgery she talked with the Office Manager, Emily, about returning to work. Petitioner testified that respondent never offered her any light duty work after she was given light duty restrictions on 8/26/19 with no lifting over 2 pounds.

On 9/18/19 petitioner's Application for Adjustment of Claim was filed on her behalf. She alleged injuries to her left wrist and right ring finger after being attacked by her co-worker. Petitioner signed the Application for Adjustment of Claim on 8/29/19.

On 10/16/19 petitioner presented to her primary care physician, Dr. Nicole Florence, for the first time since a visit in May of 2019. Petitioner was being seen for follow-up of her anxiety. In May of 2019 petitioner had a PHQ-9 score of 13. She reported symptoms of anxiety, depression, anger, irritability, feelings of being overwhelmed, and difficulty concentrating. Petitioner was prescribed Celexa at that visit, and hydroxyzine to use as needed. Petitioner reported that she never started the Celexa. Petitioner gave a history of being jumped at home after work one evening by a co-worker and her sibling due to her reporting her co-worker for "neglect" to a resident on the job. Petitioner stated that she had obtained an order of protection against the offenders, and is looking to pursue other charges. Petitioner reported that she recently moved in with her mom, after previously living with her boyfriend. Petitioner reported that living with her mother is a stressor now due to her having restrictions such as a curfew. She stated that she is a night owl. She also reported that she left her cat at her boyfriend's. She reported that she self-medicates with occasional use of marijuana, which has a calming effect. She stated that she uses a half tablet of hydroxyzine on occasion, and that it has a sedating effect. She stated that she was not working, but was going to start employment training classes with a company called T Rock, where she will be selling phones at Walmart through a contracted 3rd party company. She also stated that she was hoping to start school in February. Petitioner's past medical history was positive for cannabis dependency. Following an examination, Dr. Florence assessed petitioner with anxiety associated with depression. Dr. Florence noted that petitioner would be beginning Citalopram.

On 11/11/19 petitioner received an off work status from Dr. Maender releasing petitioner to work with no lifting greater than 2 pounds.

Petitioner stated that currently her left eye is still swollen and painful if bumped or pressed on. She also reported discoloration in the area. With respect to her left wrist, she testified that she currently wears a brace that was given to her by her physical therapist. She testified that she started physical therapy on 10/7/19. She testified that her physical therapy is currently for motion, not strengthening. With respect to her right ring finger, petitioner complained that it is stiff. Petitioner testified that she was being treated for depression/anxiety before the 7/29/19 incident, and was taking Celexa and Hydroxyzine. She testified that her depression/anxiety got worse after the incidents on 7/29/19. She testified that she cannot currently work as a CNA. She also stated that she has no outlet or job; has lost her home; and, lives back with her mother. Petitioner takes Citalopral for her anxiety and depression. She stated that she takes it every night, and it helps. She testified that respondent has never taken her back to light duty work.

Petitioner testified that she and Stennis did not socialize outside of work. She stated that they would only communicate about work. She testified that Stennis knew where she lived because she once had to pick up something she had left at work and petitioner had brought it home.

Petitioner testified that when she was not "on call" other staff would contact her on her personal phone regarding staffing issues and she would directed them to the "on call" person. She testified that she had received other text messages from Stennis on her personal phone before 4:13 pm on 7/29/19. The most recent text message, that was on the screenshot petitioner took of the message on 7/29/19, was a text message from Stennis to her the Saturday before 7/29/19, when petitioner was not "on call". The first message in the screenshot from Stennis was "Wtf call her I'm ready to go her 10 mins up". Petitioner responded "Her number on the phone list". Stennis responded "Her ugly ass talking about she on her way". To which petitioner responded "ok". Stennis responded with "Yo". With respect to these messages, petitioner testified that she has communicated with Stennis in the past on her personal phone regarding work.

Petitioner testified that after she left work on 7/29/19, and while running errands, she did not talk to anyone regarding Stennis, despite the calls and messages she was receiving from Stennis.

Petitioner testified that she would get work related texts on her personal phone and tried to stop it. She also testified that she had never been in a fight before the incidents of 7/29/19 with Stennis.

Kevin Jarvis, Director of Operations for respondent, was called as a witness on behalf of respondent. Jarvis worked for respondent form January of 2015 to November 2018. He then returned on 6/17/19. He testified that petitioner's duties were to work in the house assisting the care of the residents as needed. As a supervisor, he stated that petitioner was the lead person other CNA's could go to. He also testified that petitioner would train new employees and drive senior residents to doctor appointments and bring back notes of the visit for the resident's file. Jarvis testified that he was familiar with petitioner and Stennis. He testified that Stennis clocked out at 3:37 pm on 7/29/19.

Jarvis testified that he was not at work on 7/29/19 but was aware of the discipline of Stennis that day. He testified that the normal protocol when residents are not cooperative is for the caregiver, which Stennis was, to get a colleague and see if the two of them can convince the resident to do what they need. If not, the caretaker is to get the nurse to help. He testified that Fierge reminded Stennis of this protocol on the phone and Stennis agreed.

Jarvis testified that petitioner began missing time on 7/30/19. He testified that 8/13/19 was the first date he got notice that petitioner was off work from 7/30/19 through 8/28/19. He stated that petitioner was offered light duty by Fierge. He testified that petitioner did not contact respondent after 8/13/19.

Jarvis testified that the "on call" person carries a work cell phone issued by respondent so they can handle staffing issues. He further testified that the "on call" person has a staff phone list that they use to make calls to get the shifts covered. He stated that if the "on call" person can't find coverage, the "on call" person must take the shift. He confirmed that petitioner was the "on call" person 1-2 weeks a month. He testified that petitioner did file for unemployment.

On cross examination Jarvis testified that he did not see the light duty slip from 8/29/19. He was unaware that petitioner had a 2 pound lifting restriction. He stated that he did not see the document. He testified that after a certain period of "no call – no show" petitioner was terminated on 8/29/19. He testified that they attempted to contact petitioner and got no response.

Jarvis testified that Stennis was only a caregiver. He testified that he was unaware of any criminal cases where Stennis plead guilty to a criminal felony charge, and a battery charge. He testified that they had fingerprinted Stennis as part of the background process. He testified that Stennis' prints were run as part of the background process and her background came back clean with no convictions. He testified that they never checked the court's public website as part of their background check.

C. DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENT?

Petitioner alleges she sustained an accidental injury that arose out of and in the course of her employment by respondent that arose out of and in the course of her employment by respondent on 7/29/19. Respondent disputes this claim. It is unrebutted that there were three altercations between petitioner and Stennis in the parking lot of petitioner's apartment after work on 7/29/19. There were no altercations between petitioner and Stennis at the respondent's workplace. Petitioner claims she was assaulted by Stennis after she told Fierge, the Manager, that there were soiled sheets in a resident's room that Stennis was responsible for, earlier that day.

In order for an injury to be compensable under the Act only of the claimant proves by a preponderance of the evidence that the injury both occurred in the course of and arose out of the employment. *Sisbro, Inc. v. Industrial Commission*, 207 Ill.2d 193, 203, 278 Ill. Dec. 70,797 N.E.2d 665 (2003). An injury arises out of the employment if it results from a risk that originates in, or is incidental to, the employment. (Id. at 203) When a fight at work arises out of a purely personal dispute, the resulting injuries do not arise out of the employment. *Franklin v. Industrial Commission, 211 Ill. 2d 272, 279-280, 811 N.E.2d 684, 689 (2004);* see also *Fischer v. Industrial Commission, 408 Ill. 115, 119, 96 N.E.2d 478, 481 (1951).* On the other hand, fights arising out of disputes concerning the employer's work are risks incidental to the employment, and the resulting injuries are compensable. (Id.) However, injuries to the aggressor in such a fight are not compensable. (Id.)

In Franklin, the Supreme Court discussed the "aggressor defense" initially announced in *Triangle Auto Painting & Trimming Co. v. Industrial Commission.* The Court held that the aggressor defense essentially provides that the aggression negates all causal connection between the work and the injury, so that the work is neither the proximate nor a contributing cause of the injury. *Triangle Auto Painting & Trimming Co. v. Industrial Commission,* 346 Ill.609, 178 N.E. 886 (1931). Instead, the cause of the injury is the aggressor's own rashness. (Id).

A significant factual difference between this case and other assault cases is the fact that the altercation between petitioner and Stennis did not occur on the respondent's premises. The question then becomes whether or not the assault arose out of and in the course of petitioner's employment by respondent. Petitioner claims it arose out of and in the course of her employment by respondent even though it did not occur on the respondent's premises, because she was "on call" when the altercation took place. In support of this claim the petitioner relies on *City of Springfield v Industrial Commission,* 31 Ill. 2d, 562, 565, 202 N.E.2d 504, 506 (1964). In this case a police officer sustained injuries in a traffic

incident while returning to the station house after lunch. The court found the injuries compensable because the officer was both "on call" and had his radio turned on to the extent that he would have responded in the normal course to any request for assistance or emergency he encountered. The arbitrator finds these facts clearly distinguishable in that a police officer with his radio turned on has to respond in the normal course to any request for assistance or emergency he encountered on the way back to the station after lunch. Additionally, the case at bar does not involve a motor vehicle accident wherein the petitioner was returning to work to cover a shift that she could not get covered while she was "on call", but involves multiple altercations in the petitioner's parking lot. The arbitrator finds the facts in this case distinguishable from petitioner's case.

Petitioner argues that simply because she was "on call" at the time of the altercations, and she had reported Stennis to Fierge prior to the altercations, that her injuries arose out of and in the course of her employment by respondent. The arbitrator finds the facts of this case are not that cut and dry. There are many additional facts that need to be taken into consideration.

On 7/29/19 petitioner worked for respondent and was "on call". After her shift ended at 3:00 pm she went to another building to cover for an employee who was going to be late. While there it was brought to her attention that the sheets in one of the resident's room were soiled. Petitioner used her "on call" phone to report the situation to Fierge. Fierge asked her to contact the two people covering that home that day and find out who was responsible for that resident. Petitioner contacted both workers on her "on call" phone. Stennis responded to the "on call" phone that it was her. Petitioner reported this to Fierge on her "on call" phone. Petitioner left work shortly after 3:30 pm.

Petitioner never heard from Stennis again on the "on call" phone. Instead Stennis began conversing with petitioner on her personal phone. After petitioner left work she went to the bank. Before petitioner headed home she got a text from Stennis on her personal phone at 4:13 pm that stated "I will smack both of y'all lame ass". Petitioner responded with "Girl bye". Stennis then texted back "Right bitch y'all lame ass hell I'm on y'all ass". Petitioner testified that she did not respond to this last text from Stennis. Petitioner testified that she then took a screen shot of this conversation and sent it to Fierge.

Although petitioner did not text Stennis back after her last text message, she stated that Stennis called her on her personal phone. Petitioner answered the call. Petitioner testified that Stennis asked her where she was, but she did not tell her. She further stated that Stennis then told her that she was at her house. Despite being told by Stennis that she was at her home, petitioner did not call Fierge, any respondent representative, or the police and inform them that Stennis was waiting for her at her home. Instead petitioner proceeded home knowing that Stennis was there waiting for her. Once there, petitioner

saw that Stennis was in the spot where she usually parks. Instead of leaving or calling the police, petitioner parked elsewhere and got out of her car. She testified that after she exited her car, and attempted to access her stairs, Stennis approached her swinging her arm and pointing her finger at her yelling about petitioner reporting her to Fierge regarding the resident. Petitioner testified that she tried to calm Stennis down, but Stennis got within 2-3 steps of her. She testified that she felt threatened so she pushed Stennis away and they then began fighting with each other, both striking each other. They fought for about 1-2 minutes until another car pulled in the parking lot and they both went back to their cars and left the lot. Petitioner testified that her face and neck were scratched, and her right hand and left knee had contact with the cement. Again, petitioner made no attempt to contact respondent and let them know Stennis had confronted her in her parking lot because she had reported her to Fierge. Petitioner also made no attempt to contact the police and report this alleged assault by Stennis.

Instead, petitioner went to her uncle's house because she stated that she did not feel safe. She also was returning his car. She remained there from about 5-7 pm. While there, petitioner stated that Stennis continued to call her on her personal phone. Petitioner did not answer Stennis' calls, and finally blocked her number. Although petitioner did not feel safe, and knew that Stennis was angry, she again made no attempt to contact Fierge or any other respondent representative. She also made no attempt to contact the police.

At 7:00 pm petitioner's boyfriend came and picked her up to take her home. They both lived together. When they got back to their apartment building they parked right in front of the stairway up to their apartment. Instead of going in they decided to stay in the car for about a half hour smoking. While in the car, they saw Stennis' van pull up. Instead of remaining in the car and calling the police, getting out of the car and going up to her apartment, calling Fierge or any other respondent representative, or pulling out and leaving the parking lot, which she said she could not do because Stennis' van was blocking the entrance/exit, petitioner got out of her car at the same time Stennis, her sister, and friend got out of their van, and another altercation began. Petitioner stated that Stennis and the two other girls had a knife, mace, and a bag full of rice and a can. Petitioner stated that they began chasing her. She could not recall what they were saying when they were chasing her. She stated that while running backwards she fell on her left arm. While on the ground she kicked up towards Stennis because she felt Stennis was going to stab her. Petitioner's boyfriend then came around the building and Stennis left and went back where petitioner's car was parked.

The arbitrator finds this 2nd altercation was concluded at this point, but instead of calling the police or going for help in a direction opposite the direction Stennis was going, the petitioner followed Stennis

back to where her car was parked. When she saw them striking her car with the bag that had the rice and can in it, she stated that they again spotted her and came after her again. She stated that she again tried to subdue Stennis, but Stennis' sister grabbed her hair and she fell. By then all four of them were fighting and the roommate was trying to kick her. As this occurred, petitioner's boyfriend came and pulled Stennis' sister off petitioner. Petitioner testified that she injured her left wrist when they were all fighting again and she fell on her left arm. She testified that her boyfriend was able to break up the fight and Stennis, her sister, and her roommate left.

Again, petitioner made no attempt to call the police, Fierge, or any respondent representative. In fact, petitioner did not even seek any medical treatment for hours. Petitioner did not arrive at the emergency room until 10:30 pm. It was only on her way to the emergency room that petitioner contacted Fierge and told her Stennis, her sister, and her roommate jumped her. This was the first time petitioner used her "on call" phone to call Fierge or any respondent representative since she contacted Fierge about Stennis' text message at 4:13 pm. Petitioner made no mention of anything that occurred before the final altercation in the parking lot after petitioner returned from her uncle's after 7 pm. Petitioner also made no mention in her testimony that she reported anything to Fierge as to why Stennis, her sister, and her roommate attacked her.

Based on the above, as well as the credible record, the arbitrator finds the petitioner has failed to prove by a preponderance of the credible evidence that she sustained an accidental injury that arose out of and in the course of her employment by respondent on 7/29/19. The arbitrator finds that after petitioner was told by Stennis that she was in her parking lot waiting for her, petitioner knew Stennis was angry, and that her being in her parking lot waiting for her was not going to end well. The arbitrator finds the petitioner had the opportunity at that point to relay this information to Fierge or another respondent representative, or call the police and have them waiting for her at her home. Instead, petitioner drove to her parking lot and saw Stennis parked near the steps to her apartment. Nonetheless, she still got out of her car and got into an altercation with Stennis. Instead of attempting to retreat when Stennis confronted her while she was trying to get to her stairs, petitioner pushed Stennis and a fight ensued. The arbitrator finds the petitioner had many opportunities prior to this altercation to report Stennis' threats to respondent and/or the police and did not. The arbitrator also finds it significant that petitioner was the first one to make physical contact, when petitioner was in her facing yelling at her. The only reason that fight broke up was because someone else pulled into the parking lot and they both went back to their respective cars. At this point petitioner only had scratches on her face and neck, and possible contusions on her right hand and left knee from making contact with the cement.

After this altercation, the arbitrator finds it significant that the petitioner did not reach out to Fierge, any respondent representative, or the police to report this alleged assault, especially given the fact that she testified that she was afraid. The arbitrator finds that had petitioner contacted any of these individuals, especially the police, the future altercations where petitioner ultimately broke her wrist, would not have occurred. The arbitrator finds the petitioner had every opportunity at this point to prevent any further altercations with Stennis, be they work related or not, but took no such steps to make this happen.

Instead, petitioner went to her uncle's home and continued to receive calls on her personal phone from Stennis, but did not answer them because she knew Stennis was angry. She finally blocked Stennis on her personal phone. The arbitrator finds it significant that at no time after Stennis told petitioner she was in charge of the resident with the soiled sheets was there any communication between petitioner and Stennis on petitioner's "on call" phone that was issued by respondent. All communication thereafter was on petitioner's personal phone.

While at her uncle's house, despite the numerous calls from Stennis, and the fact that petitioner knew Stennis was angry, petitioner never contacted Fierge, any respondent representative, or the police. Instead, when her boyfriend arrived she went home with him, spent a while smoking in the car, and then saw Stennis pull up to the apartment complex. The arbitrator finds the petitioner again had the option of staying in her car and calling the police, but instead decided to get out of her car at the same time Stennis got out of her car, and get into another altercation with Stennis, as well as her sister and roommate, who all had weapons. Petitioner testified that she did not recall what they were saying as they sprayed her with mace and chased her around the building. Again, a 2nd altercation occurred and petitioner fell backwards on her left arm. She felt that while she was on the ground Stennis was going to stab her. As she was kicking up at her, her boyfriend came around the corner and Stennis backed off and ran back into the front of the building. For a third time, the petitioner did not retreat and try to get help. Instead she went right back after Stennis who was now damaging her car. When Stennis saw her, all three of them again chased petitioner and Stennis' sister pulled her hair and all three began fighting. Petitioner again fell back on her left arm and injured her left wrist. Her boyfriend then came and broke it up and Stennis, her sister, and her roommate left. Again, the petitioner did not report the incident to Fierge, any respondent representative, or the police.

It was not until petitioner was on her way to the emergency room hours later that she called Fierge and told her Stennis, her sister and roommate had jumped her. Petitioner made no attempt to report any of these instances to the police until the next day.

The arbitrator finds the petitioner has failed to prove by a preponderance of the credible evidence that her injuries arose out of and in the course of her employment by respondent based on the fact that none of the communications that led to the multiple altercations took place on the "on call" phone; the fact that all communications between petitioner and Stennis after the initial text from Stennis at 4:13 pm took place on petitioner's personal phone; the fact that after all the texts and calls to her personal phone from which petitioner determined Stennis was angry with her, petitioner never saw fit to notify Fierge, any respondent representative, or the police about the threats; that after each of the 3 separate altercations petitioner never saw fit to notify Fierge, any respondent representative, or the police about the attacks; the fact that petitioner had the opportunity to remove herself from each and every altercation, but chose not to; the fact that petitioner was the first one to strike Stennis when Stennis was in her face yelling at her; and the fact that petitioner does not even recall what Stennis was yelling at her about when she returned to her parking lot after she returned from her uncle's and they all got out of their cars at the same time and got into it again.

The arbitrator finds any duties petitioner was performing that were incidental to her employment while "on call" ended when petitioner's communications went from the "on call" phone to her personal phone, and petitioner made no attempt to remove herself from any of the altercations by contacting a respondent representative or the police, even when she specifically knew Stennis was angry and waiting for her in her parking lot. The arbitrator finds that had petitioner contacted respondent or the police when Stennis told her shortly after 4:13 pm that she was waiting for her in her parking lot, that all future altercations with Stennis could have been prevented. The arbitrator finds it was petitioner's personal choice, and not duties incidental to her employment, after Stennis told her she was waiting in her parking lot for her, that led to the multiple altercations with Stennis on the evening of 7/29/19. The arbitrator finds that even if the initial calls on her personal phone from Stennis shortly after 4:00 pm were incidental to her employment duties because she reported Stennis to Fierge, all actions petitioner chose to take after knowing Stennis was angry and was waiting at her parking lot, became personal actions that were not incidental to her employment, given that she did not report the fact that Stennis was angry and waiting for her in her parking lot to Fierge, or any other respondent representative at that time. The arbitrator further finds the petitioner had an obligation, once she knew that Stennis was angry and waiting for her in her parking lot to report the same to Fierge, another respondent representative, or the police. The arbitrator finds doing so would have prevented all physical altercations between petitioner and Stennis on 7/29/19 and prevented her from being injured. Petitioner's repeated failure to contact Fierge, a respondent representative, or the police after the initial threat, and after each altercation that evening, rebuts any claim petitioner has that the multiple altercations between her and Stennis were incidental to

her employment. Therefore, the arbitrator finds any injuries petitioner sustained as a result of these altercations with Stennis on 7/29/19 did not arise out of and in the course of her employment by respondent.

F. IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?
J. WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY? HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES?
L. WHAT TEMPORARY BENEFITS ARE IN DISPUTE?

Having found the petitioner has failed to prove by a preponderance of the credible evidence that she sustained an accidental injury that arose out of and in the course of her employment by respondent on 7/29/19, the arbitrator finds these remaining issues moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF ADAMS)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ROBERT BENGE,

Petitioner,

vs.

NO: 03 WC 15596
15 WC 10222
15 WC 10223

KNAPHEIDE MANUFACTURING CO.,

Respondent.

20IWCC0366

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 sole issue of the Arbitrator's denial of Petitioner's Motion for Reassignment pursuant to Section 9030.10(d) and being advised of the facts and law, denies Petitioner's Motion for the reasons set forth below.

Procedural History

On March 6, 2019, the Commission entered an Order allowing Petitioner to proceed with its review concerning the propriety of the Arbitrator's denial of Petitioner's Motion for Reassignment pursuant to Commission Rule 9030.10(d). *50 Ill. Adm. Code 9030.10(d)*. Further, the Commission allowed a hearing for Respondent to present a showing of good cause as to why the Motion should not be granted. A Copy of the Commission's Order date March 6, 2019 is attached hereto as Exhibit A. Pursuant to the Order and the dictates of Rule 9030.10(d), the parties appeared on April 8, 2019 before Commissioner McCarthy in Springfield, Illinois for hearing.

Findings of Fact

Petitioner has filed three Applications for Adjustment of Claim concerning three separate dates of accidents against the same Respondent- 03 WC 15596 (DOA- 10/04/2002-alleging injury to left hand, arm and body); 15 WC 10222 (DOA- 01/30/2014- alleging injury to back and body); and 15 WC 10223 (DOA- 1/31/2014-alleging injury to back and body). Matter 03 WC 15596 previously pended before Arbitrator Nowak in Quincy, Illinois, and Respondent is

represented by Rouse and Cary, Tracy D. Plymell, Esq. Matters 15 WC 10222 and 15 WC 10223 were previously consolidated on February 2, 2016 and previously pended before Arbitrator Hemenway in Quincy, Illinois. Respondent is represented by Rusin & Maciorowski, Ltd., Terry Schoeder, Esq.

Respondent's attorney, Mr. Schoeder, posits the Motion should not be granted as the 2015 cases, which have been disputed from the onset, allege injury to Petitioner's lower back whereas the 2003 case alleges injury to Petitioner's left upper extremity. Moreover, Petitioner continues to treat for the 2003 injury whereas Respondent has received no current medical documentation regarding Petitioner's treatment for the 2015 claims.

Respondent's attorney, Ms. Plymell, concurred with Mr. Schroeder's arguments and reiterated the 2003 case involved an injury to Petitioner's left upper extremity specifically carpal/cubital tunnel syndrome for which Petitioner continues to seek treatment.

Petitioner's attorney argues Section 16 of the Act states the purpose of the Act "is to avoid piecemeal litigation and to reduce expenses to the petitioner and also to avoid inconsistent decisions..." T. 12. Moreover, the authorizations executed by Petitioner for medicals were previously provided to both Respondent's attorneys, and it is his belief there is some overlap in treatment between the two injuries.

Conclusions of Law

Rule 9030.10 governs arbitration assignments. Upon filing of a claim, an arbitrator is randomly assigned by the Commission. Rule 9030.10(d) speaks to two specific situations where cases may be reassigned: 1) petitioner files multiple Applications for Adjustment of Claim against the same respondent; or 2) petitioner files multiple Applications for Adjustment of Claim against different respondents but arising out of injury to the same body part. In either scenario, any party is allowed to file a motion for reassignment of the arbitrator (a/k/a a motion for consolidation) as the Rule contemplates all cases filed in such circumstances should appear before the same arbitrator. Further, the Rule states "shall" which means granting of such motion by the arbitrator is mandatory. See *McMahan v. Industrial Commission*, 183 Ill. 2d 499, 702 N.E.2d 545 (1998).

Effective November 9, 2016, the Rules were amended specifically Rule 9030.10(d) added the following language: "However, the Commission may make an exception based on a showing of good cause by the objecting party." *50 Ill. Adm. Code 9030.10(d)*. This change vested jurisdiction with the Commission to determine if a motion for reassignment can be denied with the showing of good cause.

In the present matter, the Commission finds Respondent has made a showing of good cause. The 2003 matter relates to injuries sustained by Petitioner to his left upper extremity for which he is still treating as agreed by all attorneys. The Application for Adjustment of Claim filed on March 27, 2003 supports such finding. The 2015 matters relate to a low back condition as evidenced by the Applications for Adjustment of Claim filed on March 26, 2015, almost 12 years later. Moreover, Petitioner's attorney's belief there exists an overlap in treatment does not defeat Respondent's showing of good cause where Respondent is prepared to proceed to hearing

20IWCC0366

on the 2015 matters whereas Respondent in the 2003 matter concedes Petitioner continues to obtain treatment. Further, Section 16 of the Act states, in part, "The process and procedures before the Commission shall be as simple and summary as reasonably may be." *820 ILCS 305/16* (West 2013). Requiring the parties to conduct two separate hearings as it relates to separate injuries sustained more than a decade apart involving distinct injuries comports with the requirement of Section 16 of the Act as well as the Act's underlying purpose.

Therefore, the Commission remands matter 03 WC 15596 to a randomly assigned Arbitrator sitting in Zone 2 and consolidated matters 15 WC 10222 and 15 WC 10223 to a randomly assigned Arbitrator sitting in Zone 2 for separate hearings on the merits of the claims.

IT IS THEREFORE ORDERED BY THE COMMISSION the Arbitrator's denial of Petitioner's Motion for Reassignment (consolidation) is affirmed as the Commission finds Respondent made a showing of good cause.

IT IS FURTHER ORDERED BY THE COMMISSION matter 03 WC 15596 is remanded to a randomly assigned Arbitrator in Zone 2 for a hearing on the merits.

IT IS FURTHER ORDERED BY THE COMMISSION consolidated matters 15 WC 10222 and 15 WC 10223 are remanded to a randomly assigned Arbitrator in Zone 2 for a hearing on the merits.

No bond is set as this decision is interlocutory.

DATED: JUN 2 6 2020

L. Elizabeth Coppoletti

L. Elizabeth Coppoletti

Stephen J. Mathis

Stephen Mathis

D. Douglas McCarthy

D. Douglas McCarthy

LEC

D: 7/13/2019

43

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

TERESA BARBOSA,

Petitioner,

vs. NO: 15 WC 16773

CITY OF CHICAGO, 10TH WARD,

20IWCC0367

Respondent.

DECISION AND OPINION ON REMAND

This matter comes before the Commission on an order from the Circuit Court of Cook County wherein the court reversed the decision of the Commission dated February 10, 2017 and remanded the matter.

Procedural History

On April 27, 2016, the matter proceeded to trial before Arbitrator Thompson-Smith. Issues in dispute included accident, causation, medical expenses, prospective medical, temporary disability, and penalties and fees.

On June 9, 2016, the Arbitrator filed her decision wherein she found Petitioner failed to prove she sustained an accidental injury arising out of and in the course of her employment on March 28, 2015:

> The burden is on the Petitioner seeking an award to prove by a preponderance of credible evidence all the elements of his claim, including the requirement that the injury complained of arose out of and in the course of his or her employment. *Martin v. Industrial Commission*, 91 Ill.2d 288, 63 Ill.Dec 1, 437 N.E.2d 650 (1982). The mere existence of testimony does not require its acceptance. *Smith v. Industrial Commission*, 98 Ill.2d 20, 455 N.E.2d 86 (1983). To argue to the contrary would require that an award be entered or affirmed whenever a claimant testified to an injury

> no matter how much his testimony might be contradicted by the evidence, or how evident it might be that his story is a fabricated afterthought. *U.S. Steel v. Industrial Commission*, 8 Ill.2d 407, 134 N.E. 2d 307 (1956) ...
> The Illinois Supreme Court has held that a claimant's testimony standing alone may be accepted for the purposes of determining whether an accident occurred. However, that testimony must be proved credible. *Caterpillar Tractor v. Industrial* Commission, 83 Ill.2d 213, 413 N.E.2d 740 (1980). In addition, a claimant's testimony must be considered with all the facts and circumstances that might not justify an award. *Neal v. Industrial* Commission, 141 Ill. App. 3d 289, 490 N.E.2d 124 (1986). Uncorroborated testimony will support an award for benefits only if consideration of all facts and circumstances support the decision. (Citations omitted). It is the function of the Commission to judge the credibility of the witnesses and to resolve conflicts in the medical evidence, and assign weight to the witness' testimony. *O'Dette v. Industrial* Commission, 79 Ill.2d 249, 253, 403 N.E.2d 221, 223 (1980); *Hosteny v. Workers' Compensation Commission*, 397 Ill.App.3d 665, 674 (2009).
> The Arbitrator finds and concludes that the petitioner has not proven, by a preponderance of the evidence, that an accident occurred that arose out of and in the course of her employment by Respondent therefore, no benefits are awarded, pursuant to the Act. Arb. Dec., p. 6-7.

Petitioner filed a Petition for Review, re-raising all issues before the Commission.

On February 10, 2017, a prior iteration of Commission Panel B issued its decision on review, unanimously affirming and adopting the Arbitrator's decision.

Petitioner appealed to the Circuit Court of Cook County. On November 16, 2017, the Circuit Court reversed the Commission's decision:

> The Arbitrator's decision, which the Commission affirmed and adopted, did not properly address the issues of this case. In the Conclusions of Law section of the decision, the Arbitrator merely specified the rules regarding a claimant's burden of proof and how the Commission judges the credibility of witnesses. Significantly, the decision never provided the rules associated with determining whether an accident arose out of and in the course of employment and never applied the facts of the case to those rules. Moreover, the decision did not explicitly state that Plaintiff was not credible. The decision just provided, in a conclusory fashion, that "the petitioner has not proven, by a preponderance of the evidence, that an accident occurred that arose out of and in the course of her employment." The Court can infer that the Arbitrator and Commission did not find Plaintiff to be credible, but regardless, the Court disagrees with such finding. During the hearing, Plaintiff credibly testified that she was injured while distributing the notices for the City. Mr. Pope also testified that distributing the notices was part of Plaintiff's job duties, and that he was told about Plaintiff's injury within two days after the accident. Additionally, the medical records corroborate Plaintiff's testimony, as they indicate she sought medical treatment the day after the accident and continued to seek follow up medical treatment until January 26, 2016. There is sufficient testimony in the record to support Plaintiff's testimony on events.

> Accordingly, and for the reasons that follow, the Court reverses the Commission's decision. Circuit Court Opinion and Order, p. 3.

On December 5, 2018, an Agreed Order was entered by the Circuit Court of Cook County; this amended the November 16, 2017 Order to state the matter was remanded to the Commission. The physical file was returned to the Commission in 2019.

Findings of Fact

The Commission affirms and adopts the Statement of Facts as set forth by the arbitrator in her decision of June 9, 2016 and incorporates such facts herein, with the following modifications:

° Page 4, Paragraph 1 – The first sentence is corrected to reflect "March 29, 2015"

° Page 5, Paragraphs 6 and 7 – The Commission strikes the existing paragraphs and substitutes the following:

> On November 24, 2015, Petitioner followed up with Dr. Kaz and reported ongoing pain unimproved with physical therapy. Dr. Kaz reiterated he did not see any operative indications and opined Petitioner's pain appeared to be out of proportion to the imaging studies, but ordered an ultrasound to better evaluate the FHL, the posterior tibial tendon, and the lateral ankle ligament complex. Petitioner was also to continue physical therapy and return in four to six weeks. Dr. Kaz indicated he saw no reason Petitioner could not work if she wanted to work and directed her to wear the brace she found most comfortable. PX3.
>
> The ultrasound ordered by Dr. Kaz was completed on December 3, 2015, with the physician comparing the imaging to the September 22, 2015 MRI. The report reflects, "As suggested on the MRI examination of last September, the deltoid and anterior tibiofibular ligaments appear to be torn. These are poorly defined sonographically. There is question of a tiny avulsed bony fragment inferior to the medial malleolus." PX4, PX7. There is no indication Dr. Kaz reviewed the results of the ultrasound. PX3.

° Page 6, Paragraph 3 – The Commission corrects this to reflect John Pope was Petitioner's witness and testified as part of Petitioner's case in chief.

Conclusions of Law

With all due respect to the circuit court, it is the Commission's belief that the prior Commission panel's adverse credibility assessment is supported by the evidence. The Commission performed the function to which it is tasked and weighed the competing evidence. See *Esquinca v. Illinois Workers' Compensation Commission*, 2016 IL App (1st) 150706WC, ¶ 48 ("In resolving questions of fact, it is within the province of the Commission to assess the credibility of witnesses, resolve conflicts in the evidence, assign weight to be accorded the evidence, and draw reasonable inferences from the evidence."). In finding Petitioner failed to prove she sustained a compensable

accident, the Commission did not accept Petitioner's testimony regarding the events of March 28, 2015. This finding, which admittedly was not precisely articulated, formed the basis of the Commission's February 10, 2017 denial of Petitioner's claim.

Nonetheless, the Commission is cognizant of the Court's opinion in *Noonan v. Illinois Workers' Compensation Commission*, 2016 IL App (1st) 152300WC, which holds the Commission is bound to follow the mandate of the circuit court: "Its frustration notwithstanding, the Commission could not simply ignore the circuit court's order. No matter how defective the circuit court's reasoning may have been, the Commission was charged with following the court's order, reversing the Commission and ordering it to award benefits." *Noonan* at ¶ 11. Based upon the circuit court's re-weighing of the evidence and thereby its directive, the Commission finds Petitioner sustained an accidental injury arising out of and in the course of her employment on March 28, 2015. We address the claimed benefits in turn below.

I. Temporary Disability

Petitioner alleged entitlement to two periods of Temporary Total Disability benefits: March 28, 2015 through May 7, 2015; and May 19, 2015 through April 27, 2016, the date of the arbitration hearing. ArbX1.

March 28, 2015 through May 7, 2015

Petitioner testified she was off work from the date of injury through May 7, 2015. T. 70. In the initial Review before the Commission, Respondent contended that, assuming *arguendo* Petitioner sustained a compensable accident, Petitioner is entitled to TTD benefits only from March 29, 2015 through April 27, 2015 as the records from Franciscan Hammond Clinic do not include any work restrictions after that date.

The Commission observes that as of April 27, 2015, Dr. Diel noted Petitioner was in a CAM walker boot and reported persistent pain; Dr. Diel concluded Petitioner's ongoing complaints merited diagnostic workup with an MRI. PX2. The recommended MRI was completed two days later and confirmed the presence of an avulsion fracture and further revealed a complete tear of the anterior talofibular ligament as well as disruption of the calcaneofibular and deltoid ligaments. PX2. The notes from the May 4, 2015 follow-up reveal Dr. Diel reviewed the MRI and discussed casting the ankle; Petitioner opted to continue immobilizing with the CAM boot and utilizing a knee walker. PX2. On May 8, 2015, Petitioner returned to work in a sedentary capacity performing office work and answering phones: "I couldn't go on surveys, I couldn't walk. I had to put my foot on a drawer or garbage can." T. 71. Mr. Pope confirmed Petitioner's foot was in a brace and she had to prop it up when she returned to work from May 8 through May 18. T. 79-80. Although Dr. Diel did not expressly authorize Petitioner off work, the Commission finds the doctor's order that Petitioner continue to immobilize her ankle and utilize a knee walker to ambulate prevented Petitioner from returning to her usual work activity of walking the 10th Ward to disseminate information.

Section 8(b) provides, "In cases where the temporary total incapacity for work continues for a period of 14 days or more from the day of the accident compensation shall commence on the

day after the accident." *820 ILCS 305/8(b)*. Given the Circuit Court Order's finding Petitioner sustained an accidental injury arising out of and in the course of her employment on March 28, 2015, the Commission finds Petitioner entitled was temporarily and totally disabled from March 29, 2015 through May 7, 2015.

May 19, 2015 through April 27, 2016

Petitioner testified her second off work period began on May 19, 2015, when Alderman Pope's office permanently closed. In arguing TTD is not owed for this period, Respondent highlighted the gap in treatment from May to September, as well as Dr. Kaz's opinion Petitioner was not a surgical candidate and could return to work.

On May 15, 2015, Petitioner was re-evaluated by Dr. Diel. The record reflects Petitioner complained of persistent pain at 6/10 and examination revealed ongoing tenderness to palpation of the anterior talofibular ligament. PX2. Dr. Diel again discussed bracing versus casting and ultimately placed Petitioner in a Swede-o-brace; the doctor directed Petitioner to follow up in two weeks, and if she was unable to tolerate the Swede-o-brace, she would be transitioned to a cast. PX2. Petitioner testified she worked in a sedentary capacity through May 18, 2015. T. 71. As of that date, Alderman Pope's term expired, and his entire staff was terminated. T. 78. Petitioner further testified her health benefits ended as of May 18, 2015. T. 71.

Petitioner next sought medical care on September 11, 2015, when she was evaluated by Dr. Scott Rubenstein of Illinois Bone and Joint Institute. Petitioner described a work injury sustained when she was doing some survey for community information and while walking from house to house, she tripped on a curb twisting her right ankle. She reported she was treated with bracing and time but had persistent pain and discomfort that had not gone away. Dr. Rubenstein noted Petitioner presented with an "antalgic limp using a DonJoy ankle lace-up brace, which is appropriate for her problem. Without the brace, she can barely walk at all as I watched her hobble over to our x-ray department." PX3. After an examination and review of the April MRI, Dr. Rubenstein concluded Petitioner's findings were "consistent with a chronic unhealed ankle sprain, which appears to be directly related to the injury she sustained while at work back in March." Dr. Rubenstein's further concluded Petitioner would likely need surgery:

> At this point, I think it is unlikely that this is going to heal on its own, and probably it is going to require reconstruction of her ankle ligaments. The stress x-ray showed some hint of opening of the ankle mortise and further evaluation with an MRI to check the competency of the ligaments is in order. I suspect though that she is going to require surgical intervention to rebuild her ankle ligaments either by direct repair or if there is insufficient tissue allograft tendon reconstruction. PX3.

Noting Petitioner was barely able to walk and severely limited in her activities, Dr. Rubenstein authorized Petitioner off work. PX3.

The repeat MRI was completed on September 22, 2015. The radiologist's findings included, 1) full-thickness tears of the deltoid ligament with residual scarring. Evidence of remote avulsion injury at the medial malleolus at the insertion of the deltoid ligament; 2) remote tear of

the anterior talofibular ligament and prior strain of the syndesmotic ligaments; 3) mild bone marrow edema anteriorly with the tibial plafond may be due to residual bone contusion, although there is minimal defect within the underlying articular cartilage and this may be due to small osteochondral defect; and 4) chronic plantar fasciitis. PX4.

On October 12, 2015, Petitioner was evaluated by Dr. Rubenstein's colleague, Dr. Ari Kaz. Dr. Kaz recorded Petitioner sustained a right ankle injury in March, and her initial treatment was at the emergency room where "[w]orkup was negative for fracture." PX3. The doctor further noted subsequent treatment with a CAM boot, non-weightbearing status for two months, then transition to a lace-up brace. Petitioner complained of persistent pain and significant pain with ambulation. Dr. Kaz's examination findings included antalgic gait on the right, reduced range of motion, mild tenderness over the anterior talofibular ligament, moderate pain over the posterior distal tibial tendon posterior to the medial malleolus, and moderate pain over the FHL tendon; the doctor also reviewed the September MRI and April 27, 2015 x-rays. Diagnosing a recalcitrant right ankle sprain and right posterior tibial tendon and FHL tendon tendinitis, Dr. Kaz indicated he did not see any indications for surgical intervention and recommended physical therapy. Dr. Kaz opined Petitioner's reported pain was out of proportion to the exam findings, but nonetheless imposed restrictions of seated work only. PX3.

Petitioner returned to Dr. Kaz on November 24, 2015 and reported her pain had not improved with physical therapy. Dr. Kaz again indicated Petitioner's pain seemed out of proportion to his exam and review of the imaging, however he ordered further diagnostic workup with an ultrasound "to better evaluate the FHL, the posterior tibial tendon, and the lateral ankle ligament complex." PX3. The doctor directed Petitioner to continue physical therapy and return in four to six weeks; in the interim, Dr. Kaz noted he saw no reason Petitioner could not work if she wanted to work and directed her to wear the brace she found most comfortable. PX3.

On December 3, 2015, Dr. Nicholas Skezas performed the ultrasound ordered by Dr. Kaz. With the September 22, 2015 MRI for comparison, Dr. Skezas' impression was, "As suggested on the MRI examination of last September, the deltoid and anterior tibiofibular ligaments appear to be torn. These are poorly defined sonographically. There is question of a tiny avulsed bony fragment inferior to the medial malleolus." PX4, PX7. Petitioner was thereafter referred by Dr. Rubenstein for an evaluation by an orthopedic foot specialist. PX3. This occurred in the form of the January 26, 2016 consultation with Dr. Burgess. After an examination and review of the repeat MRI, Dr. Burgess concluded the majority of Petitioner's symptoms were related to the distal fibular avulsion fracture and lateral ankle ligaments and recommended surgical repair with extensive arthroscopic debridement, modified Brostrom right lateral ligament reconstruction with excision of chronic fracture fragment and possible syndesmotic ligament repair. PX6.

To be entitled to Temporary Total Disability benefits, it is the claimant's burden to prove not only that she did not work but also that she was unable to work. *Shafer v. Illinois Workers' Compensation Commission,* 2011 IL App (4th) 100505WC, ¶45, 976 N.E.2d 1. "The fundamental purpose of the Act is to provide injured workers with financial protection until they can return to the work force." *Interstate Scaffolding, Inc. v. Illinois Workers' Compensation Commission*, 236 Ill. 2d 132, 146, 923 N.E.2d 266 (2010). "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." *Id.*

The Commission finds the gap in treatment from May 15 to September 11, 2015 is not dispositive. The April 29, 2015 MRI not only confirmed an avulsion fracture but also evidenced tears of multiple ligaments. PX2. The record reflects that as of May 15, 2015, Petitioner was significantly restricted due to her right ankle condition: her ankle was immobilized and she was utilizing a knee walker to ambulate; however, Alderman Pope was able to provide an accommodated position. As of May 18, 2015, that sedentary work was no longer available, and Petitioner remained off work thereafter. Though Petitioner did not seek further treatment until September, the Commission finds this was a function of her loss of health insurance following the termination of her employment. The Commission notes the September 11, 2015 evaluation with Dr. Rubenstein demonstrates Petitioner had remained severely restricted in her mobility. We further find it significant that the September 22, 2015 MRI again revealed internal derangement with interim scarring but no evidence of an intervening injury.

The Commission has considered Dr. Kaz's opinions and we find them to be unpersuasive. The Commission observes Dr. Kaz's opinion that Petitioner is not a surgical candidate is contradicted by the conclusions of both Dr. Rubenstein and Dr. Burgess. Additionally, Dr. Kaz's opinion was predicated on his readings of the MRI images, and we note Dr. Kaz's readings were inconsistent with the interpretations of the radiologists, Dr. Simpson and Dr. Liou, as well as Dr. Diel and Dr. Rubenstein, and were further contradicted by the December 3, 2015 ultrasound which confirmed the ligament disruptions and tears.

Given the Circuit Court Order's finding Petitioner sustained an accidental injury arising out of and in the course of her employment on March 28, 2015, the Commission finds Petitioner was temporarily and totally disabled from May 19, 2015 through April 27, 2016.

II. Medical Expenses

Given the Circuit Court Order's finding Petitioner sustained an accidental injury arising out of and in the course of her employment on March 28, 2015, the Commission finds the medical expenses associated with Petitioner's right ankle treatment, as detailed in Petitioner's Exhibit 8, were reasonable, necessary, and causally related to the March 28, 2015 injury.

III. Prospective Medical

Given the Circuit Court Order's finding Petitioner sustained an accidental injury arising out of and in the course of her employment on March 28, 2015, the Commission orders Respondent to provide and pay for the surgical intervention recommended by Dr. Burgess.

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IV. Penalties and Fees

Petitioner filed a petition requesting penalties and fees. As we believe Respondent established its denial of this claim was reasonable under the circumstances, the Commission denies Petitioner's petition. The Commission observes the incident at issue occurred on a Saturday. While Petitioner testified her job required her to be on-call 24 hours a day to inform constituents of urgent information, the flyers Petitioner was distributing were for dog curbing and a youth summer job program. The Commission finds it was reasonable for Respondent to doubt the information on those flyers qualified as urgent such that distribution on a Saturday was necessary. This is particularly so in light of Petitioner's Facebook post from March 28, 2015, which appears to reference the run-off election 11 days away. The Commission finds Respondent reasonably concluded Petitioner was assisting Ald. Pope's reelection efforts when she fell.

IT IS THEREFORE ORDERED BY THE COMMISSION that, pursuant to the order of the Circuit Court of Cook County, Petitioner sustained an accidental injury arising out of and in the course of her employment with Respondent on March 28, 2015.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $353.09 per week for a period of 55 2/7 weeks, representing March 29, 2015 through May 7, 2015 and May 19, 2015 through April 29, 2016, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay the reasonable, necessary and causally related medical expenses contained in Petitioner's Exhibit 8 pursuant to §8(a) and subject to §8.2 of the Act. Respondent is entitled to a credit under §8(j) of the Act for any related medical expenses that have been paid 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 this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

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

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

Under Section 19(f)(2), no "county, city, town, township, incorporated village, school district, body politic, or municipal corporation" shall be required to file a bond. As such, Respondent is exempt from the bonding requirement. The party commencing the proceedings for

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

DATED: JUN 2 6 2020

L. Elizabeth Coppoletti

LEC/mck

D: 6/17/2020

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Stephen Mathis

D. Douglas McCarthy

STATE OF ILLINOIS)
) SS.
COUNTY OF)
SANGAMON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JAMES NEUNABER,

Petitioner,

vs. NO: 07 WC 38476

MONTEREY COAL COMPANY,

20IWCC0368

Respondent.

DECISION AND OPINION ON REMAND

This matter comes before the Commission on an order from the Appellate Court, Fourth District, Workers' Compensation Commission Division wherein the Court confirmed in part, and reversed in part, the decision of the Commission dated August 19, 2016 and remanded the matter with instructions.

Procedural History

This matter proceeded to hearing before Arbitrator McCarthy. On March 1, 2013, Arbitrator McCarthy issued his decision awarding benefits of 15% loss of use of the person as a whole pursuant to Section 8(d)2 of the Act finding Petitioner suffered from Coal Workers' Pneumoconiosis (CWP) and Chronic Obstructive Pulmonary Disease (COPD) due to an occupational exposure as a result of Petitioner's employment duties of a coal worker/miner.

Petitioner filed a timely review, and on May 2, 2014, the Illinois Workers' Compensation Commission (the Commission) affirmed and adopted the arbitrator's decision in its entirety. Petitioner subsequently appealed the matter to the Circuit Court of Macoupin County (14 MR 50). The appeal was dismissed by agreement of the parties.

On September 5, 2014, Petitioner timely filed Petitions pursuant to Sections 19(h) and 8(a) of the Act. On May 5, 2016, a hearing was conducted before Commissioner Basurto. On August 19, 2016, the Commission issued its decision granting Petitioner's Section 19(h) Petition and

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finding "Petitioner's permanent disability has materially increased to the extent that he is now permanently disabled to the extent of 85% of the person as a whole under §8(d)2 of the Act." *Commission Decision* (08/19/16), p. 19.

Respondent timely appealed to the Circuit Court of Macoupin County which entered its order on July 10, 2017 confirming the Decision of the Commission.

Respondent timely appealed to the Appellate Court, Fourth District, Workers' Compensation Commission Division. On June 14, 2018, the Court by Rule 23 Order affirmed in part, and reversed in part, the circuit court's order confirming the Decision of the Commission. Specifically, the Court held "the claimant demonstrated a material increase in his disability. We, however, vacate the court's judgment confirming the Commission's decision that the claimant was disabled to the extent of 85% of a person as a whole, and remand the matter with directions for the Commission to make a finding of whether the 85% award is inclusive of the original 15% award." *Monterey Coal Company v. Illinois Workers' Compensation Commission*, 2018 IL App (4th) 170574WC-U, ¶ 42.

On January 15, 2019, the Appellate Court issued its mandate to the Circuit Court of Macoupin County. On August 28, 2019, the parties entered an agreed order instructing the Macoupin County Clerk's Office to transmit the entire record to the Commission. Thereafter, the Commission thusly received the record.

Findings of Fact

The Commission affirms and adopts the Statement of Facts, bullet points 1 through 25, pages 1 through 19 as set forth by the Commission in its decision of August 19, 2016 and incorporates such facts herein.

Conclusion of Law

The Commission affirms and adopts its finding that Petitioner sustained a material increase in his disability as affirmed by the Court in its Rule 23 Order of June 14, 2018. As directed by the Court, in reviewing its prior decision as well as the evidence, the Commission finds Petitioner's disability increased to the extent of an additional 85% loss of use of the person as a whole pursuant to Section 8(d)2 of the Act. As such, Petitioner is disabled to the extent of 100% loss of use of the person as a whole inclusive of the prior award of 15% loss use of the person as a whole pursuant to Section 8(d)2 of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner sustained a material increase in his disability pursuant to Section 19(h) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $567.70 per week for a period of 425 weeks, as provided in §8(d)2 of the Act, for the reason that Petitioner sustained a material increase in his disability of 85% loss use of the person as a whole.

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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.

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 6 2020

L. Elizabeth Coppoletti

Stephen Mathis

Marc Parker

LEC

D: 6/23/2020

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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 Penalties/Fees	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

PAUL BREWSTER,

Petitioner,

vs. NO: 18 WC 21407

CITY OF CHICAGO,

Respondent.

20IWCC0369

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 imposition of penalties and fees 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

In *McMahan v. Industrial Commission*, 183 Ill. 2d 499, 515, 702 N.E.2d 545 (1998), the Supreme Court of Illinois explained the compensation authorized by §19(l) is in the nature of a late fee:

> The statute applies whenever the employer or its carrier simply fails, neglects, or refuses to make payment or unreasonably delays payment "without good and just cause." If the payment is late, for whatever reason, and the employer or its carrier cannot show an adequate justification for the delay, an award of the statutorily specified additional compensation is mandatory.

In contrast to Section 19(l), Section 19(k) provides for substantial penalties, imposition of which are discretionary rather than mandatory, and "is intended to address situations where there is not

only a delay, but the delay is deliberate or the result of bad faith or improper purpose. This is apparent in the statute's use of the terms 'vexatious,' 'intentional' and 'merely frivolous.'" *McMahan*, 183 Ill. 2d at 515. Section 16 of the Act provides for an award of attorney fees when an award of additional compensation under 19(k) is appropriate. *820 ILCS 305/16* (West 2012).

The rationale for the Act's penalties provisions is well known. The Act "provides an income stream to an injured worker, who is typically left without income while he is disabled. (Citation omitted.) The penalty sections attempt to prevent bad faith and unreasonable withholding of compensation benefits from employees. (*Board of Education v. Industrial Com.* (1982), 93 Ill. 2d 1, 442 N.E.2d 861.)" *Ford Motor Co. v. Industrial Commission*, 140 Ill. App. 3d 401, 405, 488 N.E.2d 1296 (1986). It is equally clear, however, those sections are "not intended to inhibit contests of liability or appeals by employers who honestly believe an employee not entitled to compensation; they are intended to promote the prompt payment of compensation where due and to deter those occasional employers or insurance carriers who might withhold payment from other than legitimate motives. A failure to pay because of a good faith belief that no payment is due will not warrant a penalty." *Avon Products v. Industrial Commission*, 82 Ill. 2d 297, 412 N.E.2d 468 (1980).

Concluding Respondent's failure to pay Temporary Total Disability benefits for the period June 27, 2018 through August 7, 2018 was not only unreasonable but also vexatious, the Arbitrator ordered Respondent to pay §19(l) penalties as well as §19(k) penalties and §16 fees. On Review, Respondent argues penalties and fees are not warranted. In so doing, Respondent first offers its interpretations of the language of §19(k) and the holding in *McMahan*, claiming "When asking for penalties, the burden is on the petitioner. He has not established that the respondent was unreasonable or vexatious," then asserts it reasonably relied on Dr. Colman's June 19, 2018 full duty release in refusing to pay additional Temporary Total Disability benefits.

Prior to addressing the merits, the Commission feels it necessary to correct Respondent's misperception of the burden of proof on this issue. A claimant does not bear the burden of proving the respondent's conduct was unreasonable; rather, long-standing precedent establishes that when penalties are sought, the burden is on the respondent to justify a delay in payment of benefits. See *City of Chicago v. Industrial Commission*, 63 Ill. 2d 99, 104, 345 N.E.2d 477 (1976) ("[H]e who delays payment bears the burden of excusing the delay."). As such, the issue the Commission must resolve is whether Respondent proved its failure to pay Temporary Total Disability benefits was objectively reasonable under the circumstances. *Ford Motor Co.*, 140 Ill. App. 3d at 405.

Respondent's payment log demonstrates it paid no benefits after June 22, 2018. RX2. Although not precisely articulated, the Commission understands Respondent's rationale for not re-initiating Temporary Total Disability benefits is based upon the significant change in work capacity between Dr. Colman's June 19, 2018 full duty release and the June 27, 2018 work status note, wherein multiple restrictions were imposed.

Petitioner confirmed Dr. Colman released him to return full duty to his job as a truck driver in June 2018. T. 16. Petitioner phoned the personnel department to discuss that release. Petitioner testified he explained the work slip indicated no restrictions, but because he was on

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multiple medications which precluded him from driving, he requested an accommodated assignment which Respondent denied given the full duty release authored by Dr. Colman. T. 23. Petitioner subsequently contacted the case manager who advised Petitioner should contact Dr. Coleman and clarify the restrictions. T. 24. The Commission observes, though, the June 27, 2018 note did not merely address driving restrictions due to narcotic pain medications; instead, Dr. Colman also imposed significant physical restrictions (light work lifting 20 pounds maximum with frequent lifting/carrying up to 10 pounds – PX2) without the benefit of a physical examination.

The Commission finds Respondent's skepticism about the June 27, 2018 restrictions and refusal to immediately reinstitute payment of Temporary Total Disability benefits was objectively reasonable under those circumstances. However, the Commission further finds Respondent's theory that Petitioner was sabotaging his return to work was negated when the valid FCE of July 27, 2018 confirmed Petitioner physical restrictions which prohibit him from returning to his pre-injury position.

The Commission concludes Respondent's failure to reinitiate benefits following the valid FCE warrants the imposition of penalties under §19(l), but we do not believe it meets the heightened standard required for §19(k) penalties or §16 attorney fees. The Commission finds Respondent's decision to rely on a full duty release from the treating physician was not made in bad faith nor was it vexatious.

The unpaid Temporary Total Disability benefits began accruing on June 27, 2018. As of the September 17, 2018 hearing date, the delay in payment of benefits was 83 days. The Commission orders Respondent to pay §19(l) penalties in the amount of $2,490.00 ($30 x 83 = $2,490.00).

The Commission vacates the award of §19(k) penalties and §16 fees.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 29, 2018, as modified above, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $919.55 per week for a period of 161 5/7 weeks, representing June 26, 2015 through June 19, 2018 and June 27, 2018 through August 7, 2018, that being the period of temporary total incapacity for work under §8(b) of the Act. Respondent shall have credit for $143,587.41 for TTD benefits paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $735.37 per week for a period of 175 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the 35% loss of use of the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner §19(l) penalties in the amount of $2,490.00.

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IT IS FURTHER ORDERED BY THE COMMISSION that the awards of §19(k) penalties and §16 fees are hereby vacated.

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

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

Under Section 19(f)(2), no "county, city, town, township, incorporated village, school district, body politic, or municipal corporation" shall be required to file a bond. As such, Respondent is exempt from the bonding requirement. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUN 2 6 2020

L. Elizabeth Coppoletti

Stephen Mathis

D. Douglas McCarthy

LEC/mck

O: 5/6/2020

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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BREWSTER, PAUL
Employee/Petitioner

Case# **18WC021407**

CITY OF CHICAGO
Employer/Respondent

20IWCC0369

On 11/29/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.47% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2208 CAPRON & AVGERINOS PC
DANIEL F CAPRON
55 W MONROE ST SUITE 900
CHICAGO, IL 60603

0010 CITY OF CHICAGO CORP COUNSEL
DANIEL KALLIO
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Paul Brewster
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **18** WC **21407**

Consolidated cases: _____

20 IWCC0369

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Kurt Carlson**, Arbitrator of the Commission, in the city of **Chicago**, on **September 17, 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 **June 25, 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 $**71,724.38**; the average weekly wage was $**1,379.32**.

On the date of accident, Petitioner was **67** years of age, ***single*** with **no** dependent children.

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

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

Respondent shall be given a credit of $**143,587.41** for TTD.

ORDER

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $919.55/week for 161 5/7 weeks, commencing June 26, 2015 through June 19, 2018, and June 27, 2018 through August 7, 2018, as provided in Section 8(b) of the Act.

Permanent Partial Disability: Person as a whole

Respondent shall pay Petitioner permanent partial disability benefits of $735.37/week for 175 weeks, because the injuries sustained caused the 35% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

Penalties

Respondent shall pay to Petitioner penalties of $**827.59**, as provided in Section 16 of the Act; $**4,137.96**, as provided in Section 19(k) of the Act; and $**1,260.00**, as provided in Section 19(l) of the Act.

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

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

Signature of Arbitrator

11-29-18
Date

NOV 29 2018

ILLINOIS WORKERS' COMPENSATION COMMISSION

Paul Brewster,	)	
	)	
Petitioner,	)	
	)	
v.	)	**No. 18 WC 21407**
	)	
City of Chicago,	)	
	)	**20IWCC0369**
Respondent.	)	

ATTACHMENT TO ARBITRATOR'S DECISION

I. Findings of Fact.

Petitioner is a truck driver by trade and a member of the Teamsters union. He worked for Respondent from 1995 until 2001, and again from 2007 until 2015. His job required him to operate a variety of vehicles such as tractor-trailers, snow plows and vans. He would also be required to occasionally lift items weighing from 35 to 45 lbs.

On June 25, 2015, Petitioner was operating a dump truck for Respondent's Department of Transportation. His foot slipped while exiting the truck, causing him to twist and wrench his lower back. He was seen that day at MercyWorks Clinic, where he was diagnosed with a contusion to his left rib cage and lower back. (PX 1, p. 2) Petitioner's injury was treated conservatively over the next several weeks, primarily with rest, physical therapy and medication. (PX 1, p. 2-7) When his back pain failed to abate, the physicians at MercyWorks obtained an MRI on October 8, 2015 which revealed degenerative changes and compression of the S1 nerve root. (PX 1, p. 7) Petitioner was thereupon referred to Dr. David Cheng at Midwest Orthopedics at Rush.

On October 22, 2015, Dr. Cheng examined Petitioner and continued his regimen of conservative treatment. (PX 2, p. 91-92) On December 29, 2015, Dr. Cheng administered an S1 epidural steroid injection. (PX 2, p. 85) A second injection was administered on April 29, 2016. (PX 2, p. 81) On May 25, 2016, Dr. Cheng noted that Petitioner had experienced only temporary relief from the injections, so a surgical consult with Dr. Matthew Colman was recommended. (PX 2, p. 79)

On June 28, 2016, Petitioner was examined by Dr. Colman who recommended an L5-S1 microdiscectomy. (PX 2, p. 77) On August 4, 2016, Respondent's adjuster notified Dr. Colman that Petitioner was being scheduled for an IME. (PX 2, p. 71) This exam took place on January 30, 2017 with Dr. Michael

Kornblatt, who was unaware of Dr. Colman's treatment recommendation but who felt that an updated MRI should be obtained. (RX 1) On October 21, 2017, Respondent provided Dr. Colman with authorization to schedule Petitioner for surgery. (PX 2, p. 67) On January 24, 2018, Petitioner underwent an L5-S1 laminectomy. (PX 2, p. 34)

Petitioner underwent a course of post-operative physical therapy, after which he returned to Dr. Colman on June 19, 2018 and was released to return to full duty. (PX 2, p. 21) Petitioner testified that he did not attempt to return to work, owing to the fact that he was still taking narcotic medication for his injury. Dr. Colman's chart note from Petitioner's visit of June 19, 2018 reflects that Petitioner was taking Hydrocodone, Gabapentin and Flexeril. (PX 2, p. 5)

Petitioner returned to Dr. Colman on June 27, 2018 and was given a slip for light duty. (PX 2, p. 20) Petitioner testified that Respondent's medical management nurse was provided with a copy of this slip. On July 10, 2018, Petitioner returned to Dr. Colman who recommended an FCE due to Petitioner's "inability to work full duties safely." (PX 2, p. 3)

On July 27, 2018, Petitioner underwent an FCE at Athletico. This test revealed that Petitioner had put forth an acceptable effort but that he was only able to perform 52.63% of the demands of his regular job as a truck driver. Petitioner's job description had been provided to Athletico by Respondent. (PX 3, p. 1)

On August 7, 2018, Dr. Colman provided Petitioner with a slip restricting him 20 lbs lifting, limited bending and walking, and no driving. (PX 4) Petitioner testified that he provided a copy of this slip to Respondent's nurse, that he faxed a copy to Respondent's adjuster and that he spoke with both his general foreman and Respondent's personnel office. At no time since June 27, 2018 has Respondent provided Petitioner with work with Dr. Colman's restrictions.

II. Conclusions of Law.

In support of the Arbitrator's decision on whether Petitioner's condition of ill-being is causally connected to his work accident, the Arbitrator concludes as follows:

Petitioner denied any prior problems with his lower back and there is no evidence to the contrary. He sought treatment immediately following the accident of June 25, 2015 and, excepting only when Respondent was seeking to schedule an IME, there have been no gaps in treatment since that time. Petitioner denied sustaining any accidents or injuries involving his lower back since the accident at work. There is no evidence to the contrary. Respondent's examining doctor, Dr. Kornblatt, felt that Petitioner's accident had aggravated a pre-existing degenerative condition. (RX 2, p. 3)

Based on the foregoing the Arbitrator concludes that Petitioner's current condition of ill-being relative to his lower back is causally connected to his accident of June 25, 2015.

In support of the Arbitrator's decision on the period of temporary total disability, the Arbitrator concludes as follows:

The parties agree that Petitioner was temporarily totally disabled for the period from June 26, 2015 through June 19, 2018. At issue is the period from June 27, 2018 through August 7, 2018. That was the period during which Dr. Colman had reconsidered his full duty release, re-imposed restrictions on Petitioner and subsequently ratified the findings of the FCE reflecting that Petitioner was unable to perform all the duties of a truck driver. The only medical evidence of Petitioner's condition during the six week period in question is that of Dr. Colman.

Based on the foregoing, Petitioner is entitled to have and receive TTD benefits for the 161 5/7 week period from June 26, 2015 through June 19, 2018; and from June 27, 2018 through August 7, 2018.

In support of the Arbitrator's decision on whether penalties should be imposed upon Respondent, the Arbitrator concludes as follows:

Petitioner testified that he provided Respondent's representatives with the medical documentation reflecting that he was unable to return to his regular job as a truck driver. Respondent did not rebut this testimony, nor did they provide any medical evidence reflecting Petitioner's ability to work as a truck driver for the six week period from June 27, 2018 through August 7, 2018. In fact, Respondent provided no basis whatsoever for non-payment of benefits.

The Arbitrator can only conclude that Respondent's refusal to pay TTD benefits was unreasonably delayed within the meaning of Section 19(l), but also vexatious within the meaning of Section 19(k) of the Act.

Based on the foregoing, the Arbitrator concludes that Petitioner is entitled to receive the sum of $1,260.00 in Section 19(l) penalties, that being $30.00 per day for the 42 day period of unpaid TTD. The Arbitrator further concludes that Petitioner is entitled to receive the sum of $4,137.96 in Section 19(k) penalties, that being 50% of the unpaid TTD. Finally, the Arbitrator concludes that Respondent shall pay to Petitioner's attorney the sum of $827.59 pursuant to Section 16 of the Act, that being 20% of the Section 19(k) penalties.

In support of the Arbitrator's decision relating to the nature and extent of Petitioner's injuries, the Arbitrator concludes as follows:

With regard to subsection (i) of Section 8.1b(b), the Arbitrator notes that no permanent partial disability impairment rating was submitted into evidence. Therefore, the Arbitrator gives no weight to this factor.

With regard to subsection (ii) of Section 8.1b(b), the Arbitrator notes that Petitioner was employed as a truck driver at the time of the accident and that he is not able to return to work in that capacity as a result of his injury. Petitioner has permanent restrictions and has undergone an FCE which reveals that he is able to perform only slightly more than half of the duties of his regular job. Therefore, the Arbitrator gives significant weight to this factor.

With regard to subsection (iii) of Section 8.1b(b), the Arbitrator notes that Petitioner was 67 years old at the time of the accident. Because this is at or near normal retirement age, the Arbitrator gives some weight to this factor.

With regard to subsection (iv) of Section 8.1b(b), the Arbitrator notes that because Petitioner's restrictions preclude his return to his regular job as a truck driver, he will experience a significant adverse impact on his future earning capacity. Therefore, the Arbitrator gives significant weight to this factor.

With regard to subsection (v) of Section 8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that Petitioner has ongoing complaints of lower back pain and reduced core strength which have adversely impacted his ability to perform activities of daily living such as tying his shoes, mowing his lawn, doing his laundry and vacuuming his house. Petitioner testified that he has not been able to engage in sexual activity since his accident. The Arbitrator observed Petitioner while he was testifying and finds him to be a credible witness.

Based on the foregoing, the Arbitrator concludes that Petitioner has sustained a 35% loss of the person as a whole pursuant to Section 8(d)2 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JERRY DONOVAN,

Petitioner,

vs. NO: 18 WC 38025

PALMER HOUSE HILTON,

Respondent.

20IWCC0370

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, notice, causation, temporary disability, medical benefits, 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 specifically finds Petitioner was credible and testified in a straightforward manner. We observe Respondent's own evidence, that being the call log demonstrating a 13-minute phone call from the hotel to Petitioner at 4:02 p.m., corroborates Petitioner's testimony that Ms. Jones phoned him back the afternoon of November 19. We further find Petitioner's testimony as to the events of November 21 to be credible. While Ms. Jones denied that Petitioner told her about a work accident when he came to HR with his daughter in November, and instead they just shot the breeze and talked about the holidays, the Commission finds Jones' testimony is suspect given Petitioner has not been to work since going to the hotel, with his daughter in tow, to report the accident on November 21. 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 25, 2019 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $1,221.34 per week for a period of 14 weeks, representing November 20, 2018 through February 25, 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.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay the reasonable, necessary and causally related medical expenses contained in Petitioner's Exhibit 1, pursuant to §8(a) and subject to §8.2 of the Act. Respondent is entitled to a credit under §8(j) of the Act for any related medical expenses that have been paid 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 Responent shall provide and pay for the right shoulder surgery prescribed by Dr. Nicholson.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $19,900.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUN 2 6 2020

L. Elizabeth Coppoletti

LEC/mck

O: 6/17/2020

Stephen Mathis

43

D. Douglas McCarthy

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

DONOVAN, JERRY
Employee/Petitioner

Case# **18WC038025**

20IWCC0370

PALMER HOUSE HILTON
Employer/Respondent

On 4/25/2019, 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 2.40% 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:

1357 RATHBUN CSERVENYAK & KOZOL
LUIS MAGANA
3260 EXECUTIVE DR
JOLIET, IL 60431

1139 NOBLE & ASSOCIATES
DENNIS J NOBLE
387 SHUMAN BLVD SUITE 210
NAPERVILLE, IL 60563

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

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

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

JERRY DONOVAN
Employee/Petitioner

v.

PALMER HOUSE HILTON
Employer/Respondent

Case # **18** WC **38025**

Consolidated cases: _____

20IWCC0370

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Cellini**, Arbitrator of the Commission, in the city of **Chicago**, on **February 21, 2019 and February 25, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

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

20IWCC0370

FINDINGS

On the date of accident, **November 15, 2018**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**94,796.52**; the average weekly wage was $**1,832.01**.

On the date of accident, Petitioner was **60** years of age, ***single*** with **2** dependent children.

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

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

Respondent is entitled to a credit for any awarded medical expenses that were paid by Respondent pursuant to Section 8(j) of the Act.

ORDER

The Arbitrator finds that the Petitioner sustained accidental injuries arising out of and in the course of his employment with Respondent on November 15, 2018. The Arbitrator further finds that the Petitioner provided timely notice of this accident within 45 days pursuant to Section 6(c) of the Act.

The Arbitrator finds that the Petitioner's right shoulder injury is causally related to the November 15, 2018 accident.

Respondent shall pay Petitioner temporary total disability benefits of **$1,221.34 per week** for **14 weeks**, commencing **November 20, 2018 through February 25, 2019**, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical expenses contained in Petitioner's Exhibit 1, as provided in Sections 8(a) and 8.2 of the Act.

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

Respondent shall authorize the right shoulder rotator cuff repair surgery prescribed by Dr. Nicholson pursuant to Sections 8(a) and 8.2 of the Act.

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

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

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

Signature of Arbitrator

April 23, 2019
Date

APR 25 2019

STATEMENT OF FACTS

This matter was initially heard on 2/21/19, when testimony was taken and exhibits were admitted into evidence. The matter was bifurcated for purposes of determining the need for additional witnesses based on the testimony elicited at the initial hearing. The hearing was continued on 2/25/19, at which point the parties indicated no further witnesses would be presented, but one additional exhibit, Rx6, was admitted by stipulation of the parties, and proofs were closed.

Petitioner testified he has been employed by Respondent as a full-time union painter, a member of Local 147, since 1/26/04. The job involves plastering, patching, painting and putting up vinyl wallpaper on walls throughout the hotel. Petitioner indicated the vinyl wallpaper is glued, heated and smoothed. He works with two other painters and a plasterer, noting he sometimes performs plastering himself even though it is not his specific job. Petitioner lives with his sister and two children.

On 11/15/18 around 10:30/11:00 a.m., Petitioner testified that while he was vertically smoothing down seams of vinyl on a wall with a taper's knife at about shoulder height, his right shoulder popped and he developed shoulder pain. He testified he took it easy after that and continued to try to work through it for the next couple of hours by trying to stretch it out. He initially thought he strained it or pulled a muscle but testified he now cannot abduct his right arm to his side, and while he can elevate overhead, this causes pain.

Petitioner didn't report the incident to Respondent on the day it occurred, testifying he felt it was something he could work through, like he'd done with prior neck strains. He didn't feel he needed to seek treatment that evening because it "didn't hurt that much." He took a hot bath and over-the-counter pain medications. When he went to work the next day, 11/16/18, he had right shoulder problems and pain. He finished his shift at 3 p.m. and again didn't report the injury to Respondent, hoping it would improve over the weekend (11/17 and 11/18/18). However, he testified he got worse over the weekend, though he acknowledged he still didn't seek treatment.

The following Monday, 11/19/18, Petitioner testified he called off work at 4:41 a.m. to the boiler room at 312-726-7500, speaking to whomever was there at the time. He indicated this was the proper place to contact when calling off work. He testified he didn't report the injury to this person because he was just calling off work and it

wasn't a supervisor. His supervisors are Justin Jameson and Eric Tschudy. Petitioner testified he called Jameson on his cell phone (773-312-6207) around 7 a.m. or 8 a.m. on 11/19/18, leaving a message indicating that he needed to talk to him. He also texted him at the same number around 8:49 a.m., again indicating he needed to talk to him. He testified that Jameson texted him back indicating he was with his wife and out of the office that day and he would get back to Petitioner.

Later that day, around 10 a.m., Petitioner testified he called Respondent's Human Resources department and asked to speak to Michelle Jones, the labor relations person. He was told she couldn't talk to him then and she would get back to him. Petitioner testified that Ms. Jones called him back at 4:02 p.m. and at that time he told her he was injured and how it occurred. He wasn't sure if he described his shoulder symptoms. He indicated she told him he needed to complete a report and checked to see if he could do it by email before informing him that he had to do it in person. Petitioner testified he didn't go that day because he had a child at home and could not leave.

Petitioner testified he again called off work the next day, Tuesday, 11/20/18, and went to see Dr. Nicholson at Midwest Orthopedics, where he reported the accident and his symptoms. The records reflect Dr. Nicholson noted a history of known *left* shoulder arthritis. Petitioner reported he was at work on 11/15/18 and felt his right shoulder give out while working: "He had immediate pain and discomfort but slogged his way through the rest of the day. On Friday, he did his best to make his way through work and over the weekend, he had worsening pain and discomfort in the right shoulder with weakness. He reported the injury to the workers' compensation but is here on regular insurance today." X-rays reflected no osteoarthritis or fracture. Exam noted full range of motion but external rotation lag with his arm at his side and abducted 90 degrees with profound weakness. Noting concern for the integrity of the posterior rotator cuff, Dr. Nicholson prescribed an MRI, noting if it was intact, he would recommend therapy and pain management. An 11/20/18 note indicates Petitioner should be off work from 11/15/18 to 11/21/18. (Px2; Rx4).

Petitioner testified that he completed an accident report at Respondent's security office on 11/21/18 with a security guard, Tommy. He believed he indicated he was having shoulder problems and didn't yet know he had a tear at that point. He indicated he hurt himself lifting vinyl, clarifying this was smoothing it and pushing it back against the wall. He testified he didn't complete the report himself and, that his 10-year old daughter was with him and did most of it: "at least the legible part."

The accident report (Rx5) indicates Petitioner was injured on 11/15/18 at 10:30 a.m.: "Injured shoulder lifting vinyl in Room 17-148." This was reported to Tommy Hardin on 11/21/18 at 2 p.m., and Petitioner testified that Hardin completed this page. On the page to be completed by employee, it states that on 11/15/18: "Was putting back vinyl and my muscle in my shoulder twitch, and it got worse." This page, signed by Petitioner, indicates he reported this to HR on 11/19/18 at 8:30 a.m. (Rx5). Petitioner testified that on page 2 of the report, where it asked how the accident happened, he started writing himself at the beginning but believed his daughter then completed this section for him.

Petitioner underwent a right shoulder MRI on 11/21/18. The report notes a history of right shoulder pain since 1/2008 and "work related injury." The impression was: 1) full thickness tear of the distal supra and infraspinatus tendons, 2) mild fatty atrophy of the infraspinatus and teres minor tendons with mild muscular strain, 3) severe tendinosis of the distal subscapularis tendon, 4) split-thickness tear of the long head of the biceps tendon, noting the intraarticular long head of the biceps was not visualized and could also be torn, 5) moderate to severe AC joint osteoarthritis and 6) mild glenohumeral osteoarthritis. After reviewing the MRI, Dr. Nicholson recommended a right rotator cuff repair and indicated Petitioner should remain off work. (Px2).

Petitioner acknowledged he had previously treated with Dr. Nicholson for his left shoulder and that a left total shoulder arthroplasty had been recommended. He hasn't filed a workers' compensation claim for this as Dr. Nicholson told him it wasn't something that would be covered by workers' compensation. He allowed Petitioner to keep working with regard to the left shoulder. Petitioner testified he has talked to Mr. Jameson about his left shoulder, initially in February 2018, letting Jameson know he was looking into whether it involved workers' compensation, and that Dr. Nicholson indicated it was not related to repetitive activities and Petitioner could take care of it after he retired.

Petitioner testified he had no prior right shoulder treatment or problems, and that his right shoulder never previously prevented him from working.

Prior to the currently alleged accident date, on 12/21/17, Dr. Nicholson noted Petitioner was a patient of Dr. DellaValle and reported progressive pain and loss of function in the left shoulder. Petitioner was not sure if he ever injured it. He believed he had undergone an injection 10 years prior and that he took anti-inflammatories from time to time. Following x-rays, Dr. Nicholson diagnosed advanced left shoulder arthritis. An MRI was recommended to analyze the soft tissues of the left shoulder. He did not otherwise believe any conservative treatment would help Petitioner. On 2/21/18, Petitioner underwent a left shoulder MRI which showed severe osteoarthritis at the glenohumeral and AC joints. There were no high-grade tears, but there was tendinosis and partial thickness supraspinatus tear with moderate joint effusion. (Rx4). On 8/22/18, Dr. Nicholson indicated Petitioner was well-known to him and had advanced left shoulder osteoarthritis. He was having difficulty sleeping and indicated he could not take time off work. MRI films indicated that the rotator cuff was intact, but he had complete loss of joint space with bone-on-bone contact. The left shoulder was injected. (Rx4). Petitioner visited Dr. Nicholson on 11/14/18, the day before the alleged accident date, again for the left shoulder, and he reported the injection gave him no relief at all except for a couple of days. Dr. Nicholson recorded: "He is trying to figure out his retirement timing and thinks he is going to be able to retire by the end of the year. He would like to get something done with his left shoulder sometime in January or February, which would be a total shoulder replacement." Dr. Nicholson noted that MRI showed an intact rotator cuff, but Petitioner reported constant pain "especially as a professional painter." (Rx4).

Petitioner saw Dr. Ahmed, who appears to be his primary provider, on 12/3/18. It states he was there for a follow up and had arthritis pain of the right shoulder and suffered from anxiety. The assessment notes left shoulder pain. (Rx6). The Arbitrator notes that the prior reports of Dr. Ahmed from 5/21/18 and 9/6/18 all note diagnoses including left shoulder pain with nothing indicated regarding the right shoulder. On 12/5/18, Dr. Nicholson indicated Petitioner should remain off work pending recommended surgery for repair of a right rotator cuff tear. (Px2).

Petitioner submitted an exhibit containing his cell phone records, including calls and texts/instant messages. It lists Petitioner's phone number as 708-690-6697. He indicates that two 11/19/18 texts at 8:49 a.m. and 8:50 a.m. to 773-312-6207 were to Justin Jameson. (Px3). The following calls are listed:

11/19/18	4:41 a.m.	312-726-7500	2 minutes	(outgoing call)
11/19/18	8:33 a.m.	"justin boss"	1 minute	(outgoing call)
11/19/18	10:24 a.m.	312-726-7500	6 minutes	(outgoing call)
11/19/18	4:02 p.m.	312-726-7500	13 minutes	(incoming call)
11/20/18	4:31 a.m.	312-726-7500	2 minutes	(outgoing call)
11/21/18	4:32 a.m.	312-726-7500	2 minutes	(outgoing call)
11/21/18	10:50 a.m.	312-726-7500	4 minutes	(incoming call)

Next to the entry for "justin boss" is a handwritten phone number: 773-312-6207. (Px3). It is not clear why this entry does not show the number in print.

Petitioner testified that an 11/19/18 phone call to 312-833-3424 was to his union BA Dennis Roach, noting he is supposed to call all injuries in to his union counsel as soon as possible. It appears this was at 7:14 a.m.., but the Arbitrator notes this entry and many others were blacked out in the copy submitted into evidence. Petitioner did not know whose number 877-632-6637 was, nor did he know who the incoming call on 11/19 at 7:29 a.m. from 708-236-2701 was from. He called the BA Roach again at 8:10 a.m., which was a 22-minute call, and Petitioner testified they discussed the accident. He couldn't recall if he spoke to Roach directly on the initial call or not, but testified Roach advised him to complete an accident report with Respondent.

Once Respondent determined he was making a workers' compensation claim, Petitioner indicated he needed the carrier's contact information to provide to Dr. Nicholson's office. He testified he called Human Resources for this on 11/29 and 11/30/18 but didn't get a call back, so he then called his attorney. He ultimately had someone else get the information for him, but that Dr. Nicholson indicated the carrier's contact person never returned their call.

Petitioner testified he continues to have right shoulder pain when he lifts or moves his right arm the wrong way and when he sleeps and eats. He again indicated he had none of these symptoms prior to the alleged accident date. He testified understands he has a tear in the right shoulder and cannot work, so he intends to get surgery as soon as he can. He was waiting until after his retirement to undergo left shoulder surgery. He indicated he had planned to retire as soon as possible until he injured the right shoulder. The day before the accident he was told that he could retire by 12/31/18 but now was unable to do so, which is why he just wanted to work through the injury.

On cross-examination, Petitioner reiterated that he was smoothing out the wall vinyl when he was injured. He testified the first time he reported his 11/15/18 injury to the Respondent was when he spoke to Ms. Jones when she called him back on 11/19/18 at 4:02 p.m. On further cross, Petitioner testified he called Jameson at 773-312-6207 at 8:33 a.m., after which they exchanged texts. (Rx3). He believed that was the only text exchange between he and Jameson that day and he did not believe that Jameson called him back that day. He recalled the 12/4/18 text messaging with Jameson as well (Rx3). After texting with Jameson on 11/19/18, Petitioner testified he tried to contact HR at 10:24 a.m. that same day, indicating he initially connected with the operator, then to the receptionist in HR, asking her to have Ms. Jones call him back and that it was very important. It was his understanding that Ms. Jones worked in labor relations. He wasn't sure if he ever told Jameson he had been hurt at work, testifying he had already reported it to Ms. Jones and she told him what he needed to do at that point, so he didn't need to discuss it with Jameson. He testified that he has had many talks with Jones over the years, including personal things, and that "we were friends." He estimated he would see and talk to her a couple of times per month, sometimes more.

Petitioner testified the 3:27 p.m. call to 312-421-0046 was to his union council, which is different from BA Roach. He testified he left a message with Joe Rhinehart, to whom he is supposed to report all accidents to regardless of his local, and who Roach also told him to call. They ended up getting in touch with each other about a week later, and Petitioner testified "he was on vacation for the record."

Petitioner testified he had not had a prior work accident with Respondent over 14 years of employment and that he did not know the "normal" accident reporting protocol for the Palmer House, didn't recall being advised of how to do it and had no knowledge of any postings at the hotel regarding how to report a work accident. He

testified that they had monthly meetings, but they were not really "safety" meetings, though they will "cram a few" safety meetings in.

He reiterated that he advised Ms. Jones about how he injured his shoulder and she advised him he had to go to security to complete an accident report. He testified that he also knows "Jennifer" in the HR department, and that after he reported the accident to security he was taken to HR where he spoke to Michelle and she advised him that Jennifer was the person who handles workers compensation for Respondent. He provided Dr. Nicholson's initial 11/20/18 medical report to Jennifer at that time.

With regard to Dr. Nicholson's 11/20/18 report indicating Petitioner said he reported the injury to workers' compensation, but he was there using his regular health insurance, Petitioner testified he didn't recall saying this. He testified he contacted Nicholson's office on Monday morning, 11/19/18, and the 11/20/18 visit was the first appointment available to him.

Petitioner acknowledged he had been trying to figure out his retirement timing in planning his left shoulder treatment and was going to have the surgery performed in January after his December 2018 retirement. He emotionally testified that he now cannot retire as planned because he has a compensation claim pending while being off work, indicating "that's the rule" from his pension fund that a worker has to be working to be able to retire.

Petitioner was cross-examined regarding the accident report (Rx5) and its indication that Petitioner reported the accident to 8:30 a.m. on 11/19/18 and that this was a mistake and his timing may have been off. He went to the Respondent's security desk, on Ms. Jones advice, with his daughter in the afternoon after undergoing his MRI and was sent to the security office on the 5th floor. He then went to HR but indicated he wasn't certain whether security took him there.

Petitioner testified he did not recall requesting disability through his union on 11/28/18. He testified that an 11/28/19 document titled "Chicago Painters and Decorators Welfare Fund" in the records of Dr. Nicholson was regarding his left shoulder and a box checked indicates the injury or sickness was not due to the employment. On page 2 of the document, a question asks if the patient had ever had the same or similar condition, and it is checked "yes", and asked when this was, it states: "Long time." (Px2; Rx4). Petitioner testified he could read it, but not sure what it is. He vaguely remembered filling it out but testified that this was completed for his welfare fund, not his pension, and that he was not applying for disability but was clarifying that his left shoulder was not work related. It had nothing to do with the right shoulder. He otherwise couldn't have his prior left shoulder treatment billed through his PPO plan. It had nothing to do with the right shoulder.

Petitioner agreed the report states, as to how the accident occurred, "muscle in my shoulder twitched", and that he didn't say it popped in this document. The twitch was in the top outer portion of the shoulder. He testified a twitch and a pop was the same thing in his mind in that something moved in his shoulder and he developed pain.

Petitioner agreed he's had one prior workers' compensation claim from 1989 with a different employer for an ankle injury and that he was taken away in an ambulance He also acknowledged a 1997 claim with National Decorating where he fell 2.5 floors and caught his legs on cables and an ambulance again took him away.

Petitioner has had no right shoulder injuries since the accident date and hasn't sought treatment with anyone else besides Dr. Nicholson for the right shoulder.

Petitioner testified he is not receiving any benefits from his union and hasn't applied. He has received no workers' compensation benefits to date. Petitioner agreed that Ms. Jones was the only Respondent representative that he actually discussed the accident with. He hasn't returned to work since being taken off work and had not seen Jameson since until the hearing date. Petitioner testified he replied to Jameson's text (Rx3) indicating he hadn't heard from Petitioner or HR and asked how he was doing.

Rx2 is a "Watchdog Report" of the Respondent that appears to indicate the Petitioner called the Boiler room on 11/19/18, but it does not indicate a time. There is a second entry indicate receipt of a call from Petitioner's phone on 11/19/18 with no indication of who received it. Both calls indicate a duration of one minute. (Rx2).

Rx3 is a page reflecting text messages between Petitioner and Justin Jameson. The first exchange is not dated and shows Jameson contacted Petitioner stating: "Heard your message, I hope you are ok. I am out today and tomorrow as well. With Zina right now, call you when I free up"; and Petitioner responded: "K thank you." The second exchange is dated 12/4, and Jameson states: "Hey haven't heard from you of HR, just wanted to check in and see how you doing." Petitioner responded: "I'm in pain thanks the run-around to see the doctor! I'm a big boy I'll be fine thank you! Just not what I needed. Too close to retiring!", and "I'll let you know more when I know more. Thank you." (Rx3).

Justin Jameson was called to testify by Respondent. He has worked as Respondent's assistant director of property operations for 7 years and handles the day to day operations of tradesmen, preventative maintenance rooms and public space. He testified that they have pre-shift meetings at 7 a.m. to discuss what is happening in the hotel that day and which areas are being used. He testified that any safety and security sheets that come from the Safety and Security Director, Keith McCray. They also have monthly safety topics that vary, from blood borne pathogens to vehicle safety to emergency hotel procedures. They also discuss work accidents, such as slip and falls, how to correctly lift and carry and day to day tradesman things, including painters. He is familiar with the Petitioner and testified he regularly attends the meetings.

When a worker reports an injury, they are directed to security to report it. At orientation, all employees are provided a handbook on injury reporting procedures. There are also postings explaining how to report, and who to contact, i.e. a supervisor or security office on the dock. If they go to security first, they would then notify Jameson as the supervisor. He is Petitioner's direct supervisor.

Mr. Jameson testified he did text the Petitioner on 11/19/18 after receiving his voice mail. Petitioner indicated he would be off work and needed to speak to him. He testified it wasn't until 11/21/18 when he was advised Petitioner was coming in to complete an accident report that he knew Petitioner was claiming a work accident. He identified Rx3 as accurate text exchanges with Petitioner on 12/4/18, noting his texts are in green and Petitioners' are in gray. Petitioner does not mention a work accident in them.

On cross examination, Mr. Jameson testified Petitioner had been performing his regular job duties prior to 11/15/18. As to the Petitioner's left shoulder, Mr. Jameson testified "we may have discussed it", but he had no knowledge of Petitioner missing work due to the left shoulder.

He testified that either he or his boss, Eric, signs off on all tradesmen accident reports as department manager/supervisor. He testified that he had never seen Petitioner's accident report, Rx5, prior to the hearing date. He agreed it is dated 11/21/18 at 2:00 p.m. and was signed by Tommy Hardin, who also is authorized to sign these reports. He testified he was familiar with Hardin's signature. before. Petitioner's accident report is blank where the Department Manager or supervisor would sign. He acknowledged it is not the Petitioner's job to provide the report to his supervisor, it would come to him or Eric from either security or Human Resources.

Mr. Jameson indicated he had no knowledge of the accident report when he texted with Petitioner on 12/4/18. That is why he sent the text noted in Rx3. Petitioner was not working at that time.

Human Resources did tell Mr. Jameson on 11/22/18 that Petitioner was injured and was coming in to complete the accident report. He received a call from Jennifer Hildebrand in HR that day, and she explained Petitioner had completed an accident report and was claiming a work injury. Jameson testified he did not ask to see the report and never discussed Petitioner's injury with Ms. Jones, who he indicated handles disputes with union worker issues, including things such as accidents, while Ms. Hildebrand specifically handles workers' compensation matters. Mr. Jameson testified that pre-shift meetings are not specifically for safety issues, but safety issues do come up in them.

On redirect, Mr. Jameson testified that Respondent's protocol is that if someone is injured at work, they should contact a supervisor or go to security. To his knowledge, Petitioner went to security on 11/21/18, but he wasn't aware of it until 11/22/18. Ms. Jones would likely send an injured worker directly to security. If a work accident is reported to Ms. Jones, she would direct it to Ms. Hildebrand.

Michelle Jones testified that she has worked as Respondent's Director of Labor Relations for about 3 years, which involves handling discipline, being a liaison between workers and unions, and also hearing complaints and concerns from employees. She testified her job does not involve workers' compensation matters. If a worker calls in such case, she would refer them to Jennifer Hildebrand. She interacts with employees often, all day long, and is familiar with the Petitioner. She testified she talks to the Petitioner on average a couple times per month, indicating they would make small talk and discuss life. They have discussed disputes among co-employees and his concerns with the hotel. They did not discuss workers compensation or injuries at the hotel.

Ms. Jones testified that she first became aware that Petitioner was claiming a work injury when she was copied on an email from the Director of Security indicating he had completed an accident report. She was not aware what day he was injured or any specifics about how he was injured, and she never discussed his injuries. She hasn't discussed a work-related injury with Petitioner since 11/21/18. Ms. Jones testified that if someone came to her indicating they were hurt at work, she would refer them to security or to Hildebrand, depending on the situation. She testified that she and Hildebrand worked in the same office until January 2019. Again, she indicated that she was never contacted by Petitioner about a work injury, and if she had she would have mentioned it to Hildebrand.

On cross, Ms. Jones agreed that Respondent's facility phone number is 312-726-7500. Outgoing numbers from the Respondent facility are in a variety of different numbers. She testified that she spoke to the Petitioner when he came in with his daughter and they "shot the breeze" but did not recall the exact date. She testified he did not mention a work accident to her. She had never seen the accident report prior to the hearing date. She testified that it was common for Mr. Hardin in security to provide accident reports to HR, and that these would normally go to Jennifer Hildebrand. She testified that she is in many hotel areas at various times during her shifts but more often than not is in her office. She is often in meetings.

CONCLUSIONS OF LAW

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

The Arbitrator finds that the Petitioner sustained accidental injuries arising out of and in the course of his employment on 11/15/18.

The evidence in this case unquestionably involves some factual discrepancies. The Respondent reasonably challenged the compensability of the Petitioner's claim, but the Arbitrator finds that the greater weight of the evidence supports the claimant.

The initial question involves notice based on the Respondent's dispute of same. The Arbitrator finds that the Petitioner provided timely notice of the accident to Respondent pursuant to Section 6(c) of the Act. The Act requires that notice be provided to the Respondent within 45 days of the alleged accident date. Here, the Petitioner completed an accident report with the Respondent on 11/21/18, well within 45 days. The Arbitrator finds that the Petitioner provided timely notice of the accident.

While the Petitioner's notice was statutorily timely, it also was not provided on the date of the accident or the next day, Friday, 11/16/18. The Petitioner alleges he provided notice to Michelle Jones on 11/19/18. He also worked on 11/16/18, the day after the alleged incident.

Much of the discrepancy in this case involves when the Petitioner reported the alleged accident and to whom. He alleges that he initially left a message for his supervisor, Justin Jameson, on 11/19/18, but acknowledged that he didn't specify that he had injured himself at work in that message, or in his reply to Jameson's text response that day. He indicated he wanted to talk with someone directly. He testified he then called Ms. Jones that same morning but had to leave a message. He testified that she called him back that afternoon and he told her what had occurred and asked what he needed to do to report his accident and was told he had to come in and make a report with security, which he did on 11/21/18. The testimony of Ms. Jones was somewhat jarring in the face of the Petitioner's testimony, in that she denied speaking to Petitioner at all on 11/19/18 about a work accident.

While the Petitioner would appear to have more incentive to testify in support of his case than Ms. Jones, as she does not have a direct interest in the outcome of the case, what the Arbitrator cannot get past is the fact that the Petitioner received an incoming call from the Respondent at 4:02 p.m. that lasted 13 minutes, and the Respondent has provided no explanation of whom that call came from. This clearly fits with the Petitioner's version of events. The Respondent provided evidence of the phone call with the boiler room but did not provide any documentary evidence regarding any other phone calls. The Arbitrator believes this is a key factor in the accident determination in this case.

There are arguably inconsistent histories in the medical records in terms of whether the Petitioner was "lifting" vinyl versus his testimony regarding smoothing the vinyl, but the Arbitrator does not believe this is a discrepancy that is fatal to Petitioner's case. The histories are close enough in the Arbitrator's view that a minor inconsistency may have been recorded.

Another factor the Arbitrator finds relevant is that the Petitioner's pre-accident medical records and his testimony support that he was looking forward to retiring in December 2018 and was planning to have left shoulder surgery after that. His unrebutted testimony was that he cannot accrue time towards his retirement while off work for workers' compensation. This would seem to create a strong disincentive for him to lie about an accident and extend the timing of his retirement, and thus the timing of left shoulder surgery.

The Respondent points out that the accident report of 11/21/18 indicates the accident occurred at 10:30 a.m. on page one, and at 11:30 a.m. on page two. The Arbitrator does not find this to be a significant contradiction given

that the report was prepared the same day. The Respondent correctly points out that Petitioner testified that the night of the accident date he did not seek treatment because it "just didn't hurt that much, I guess." Again, it is not unreasonable, in the Arbitrator's view, for the Petitioner's pain to have increased after that day. The Arbitrator must acknowledge that the Petitioner then waited an additional four days before seeking treatment. However, his explanation was reasonable in that he hoped he would improve over the weekend, and when he didn't he called Dr. Nicholson's office Monday morning and was not able to get an appointment until Tuesday. He also indicated he did not feel it was an emergency situation and that he was going to see his orthopedic surgeon as soon as he could.

While Petitioner did not report his injury to supervisor Jameson, he indicated that after attempting to contact Jameson on 11/19/18, he had already provided notice to Respondent later that day.

Again, overall, the Respondent had a reasonable basis to question the Petitioner's claim in this case, and the Arbitrator notes that while listening to the testimony at hearing the question of compensability remained open in the Arbitrator's mind, but after reviewing the entirety of the evidence in the record, the Arbitrator finds that the preponderance of the evidence supports that the Petitioner sustained accidental injury to the right shoulder which arose out of and in the course of his employment with Respondent on 11/15/18.

WITH RESPECT TO ISSUE (F), IS THE PETITIONER'S PRESENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

The evidence submitted at hearing supports a causal connection between Petitioner's right shoulder injury and his 11/15/18 work accident. His unrebutted testimony is that he had been working full unrestricted duty prior to the accident date. He further stated that he had no right shoulder problems and had never treated for his right upper extremity in the past. Respondent's witness, supervisor Justin Jameson, testified that Petitioner was carrying out all of his job duties prior to his report of accident. Petitioner did indicate he had a left shoulder problem but that it was not work related and did not keep him from carrying out his job duties. Dr. Nicholson's 11/21/18 note indicates that Petitioner had a "work related injury." Petitioner treated with Dr. Nicholson prior to the work accident for his left shoulder condition, and there is nothing the Arbitrator noted in those records which reflect prior right shoulder complaints. Given the Arbitrator's findings regarding accident, a chain of events analysis supports a causal relationship as well. Respondent did not present any medical evidence disputing a causal relationship. The Arbitrator finds that the greater weight of the evidence supports the finding that the Petitioner's right shoulder condition is causally related to his 11/15/18 work accident.

WITH RESPECT TO ISSUE (J), WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY AND HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner submitted his claimed causally related medical expenses into evidence as Petitioner's Exhibit 1. The billing included is from Midwest Orthopaedics at Rush/Dr. Nicholson totaling $2,597.00. Of this amount, Blue Cross/Blue Shield paid and/or received write offs of $2,535.51, leaving a balance of $61.49, which appears to be indicated to be the Petitioner's responsibility.

The Arbitrator finds that the Respondent is liable for this bill pursuant to Section 8(a) as well as Section 8.2, the Medical Fee Schedule. The Respondent's liability is limited to the Fee Schedule, as is the providers entitlement to payment. If the $61.49 balance is based on billing in excess of the fee schedule, neither Petitioner nor Respondent are liable for this amount pursuant to Section 8.2. The parties stipulated that Respondent may have

paid some of the awarded medical expenses per Px1 via group health coverage through Blue Cross/Blue Shield, and if so the Respondent is entitled to credit for such payments, so long as Respondent holds Petitioner harmless pursuant to Section 8(j) of the Act.

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

Given the Arbitrator's findings above regarding accident and causation, and given the findings in Petitioner's right shoulder MRI, the Arbitrator finds that the Petitioner is entitled to the right rotator cuff repair surgery prescribed by Dr. Nicholson pursuant to Section 8(a) of the Act. Again, no medical evidence as presented challenging the reasonableness and necessity of the recommended treatment. Based the greater weight of the evidence, the Arbitrator finds that the Respondent is liable for the prospective medical treatment prescribed by Dr. Nicholson, and Respondent shall authorize same.

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:

Given the Arbitrator's findings above regarding accident and causation, the Arbitrator further finds that the Petitioner is entitled to TTD benefits from 11/20/18 through 2/25/19, the last hearing date. After treating with Dr. Nicholson on 11/20/18 and undergoing a right shoulder MRI, Petitioner was restricted from work. Dr. Nicholson indicated that Petitioner shoulder be off work from 11/15/18 to 11/21/18. However, this is a post-dated note. Dr. Nicholson then indicated that Petitioner should remain off work pending authorization of surgery. Based on the greater weight of the evidence, the Arbitrator finds that Respondent is liable for TTD benefits from 11/20/18 through 2/21/19.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WINNEBAGO

☐ 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 Credit	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

AARON McDONALD,

Petitioner,

vs. NO: 14 WC 20253

OLD DOMINION FREIGHT LINE, INC.,

Respondent.

20IWCC0371

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causation, medical expenses, temporary 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 vacates the credit to Respondent for $11,620.56 in non-occupational indemnity benefits and $11,843.78 in medical expenses paid through its group plan. Section 8(j) of the Act allows for credit for benefits paid where compensation is awarded. Since no compensation has been awarded, the credit is inapplicable. The Commission finds such amounts were paid by Respondent.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 16, 2018, as modified above, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's claim for benefits is denied.

IT IS FURTHER ORDERED BY THE COMMISSION that the credit of $11,620.56 in non-occupational indemnity benefits and $11,843.78 in medical expenses is hereby vacated.

The bond requirement in Section 19(f)(2) is applicable only when "the Commission shall have entered an award for the payment of money." *820 ILCS 305/19(f)(2)*. Based upon the denial of compensation herein, no bond is set by the Commission. The party commencing the

20IWCC0371

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 6 2020

L. Elizabeth Coppoletti

Stephen Mathis

D. Douglas McCarthy

LEC/mck

O: 6/17//2020

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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

McDONALD, AARON
Employee/Petitioner

Case# **14WC020253**

OLD DOMINION FREIGHT LINE INC
Employer/Respondent

20IWCC0371

On 7/16/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.10% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2489 BLACK & JONES
JASON ESMOND
308 W STATE ST SUITE 300
ROCKFORD, IL 61101

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

STATE OF ILLINOIS)
)SS.
COUNTY OF WINNEBAGO)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

AARON MCDONALD
Employee/Petitioner

Case # 14 WC 20253

v.

Consolidated cases:

OLD DOMINION FREIGHT LINE, INC.
Employer/Respondent

20IWCC0371

An *Application for Adjustment 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 Doherty, Arbitrator of the Commission, in the city of Rockford, on May 16, 2018. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were Petitioner's earnings?

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

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

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

K. ☒ What temporary benefits are in dispute?

☐ TPD ☒ Maintenance ☒ TTD

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

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

N. ☒ Is Respondent due any credit?

O. ☐ _____

FINDINGS

On the date of accident, December 20, 2013, Respondent was operating under and subject to the provisions of the Act.

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

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

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

In the year preceding the injury, Petitioner earned $50,024.00; the average weekly wage was $962.00.

On the date of accident, Petitioner was 31 years of age, married, with 0 children under 18.

Respondent shall be given a credit of $0.00 for TTD, $0.00 for TPD, $0.00 for maintenance, and $11,620.56 for non-occupational indemnity benefits, and $11,843.78 in other benefits, specifically medical bills paid through its group medical plan, for a total credit of $23,464.34. ARB EX 1

ORDER

The Arbitrator finds that Petitioner did not experience a compensable acute or repetitive accidental injury causally related to his employment with Respondent on the alleged date of December 20, 2013 or on any date.

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

Carolyn M. Casey

Signature of Arbitrator

7/12/18

Date

JUL 16 2018

FINDINGS OF FACT

Petitioner testified that he began working for Old Dominion Freight as a driver in September 2012. He testified that his work duties involved loading freight, delivering freight, and also loading tires. He reported that he spent a great deal of his time at Titan Tire, a client of Old Dominion Freight, loading tires. He testified that he would load tires for a few hours each day or up to the full day. He testified that some of the tires were very large and were loaded with a forklift. He testified that other tires, which weighed between 800 to 1,000 pounds, would be rolled into the trailer. He also testified that he would also handle smaller tires weighing up to 64 pounds. He testified that he would have to load the tires to the ceiling of the trailers. Petitioner's written job description at PX 1 describes the necessary physical ability to drive a truck as well as the ability to secure freight, frequently enter and exit the cab of the truck and frequent pushing and pulling of freight weighing up to 500 pounds on a dolly. PX 1. PX 1 does not specifically mention throwing tires. It does designate frequent bending, twisting, climbing, squatting, crouching and balancing to handle, position, and secure freight. PX 1.

Petitioner testified that the biggest load would be 600 tires weighing approximately 64 pounds each. He testified that a few loads had 1,000 to 1,300 tires, but that they were smaller tires. He testified he would fill more than one trailer per day. He testified that he could fill up 6-8 trailers per day. Petitioner testified that the tires would be loaded onto pallets and that he would push a pallet into the trailer and unload the tires while inside of the trailer. Petitioner testified that he generally loaded a few hundred tires per day but that the total varied. Petitioner testified that he would load the tires by himself. However, he testified that the large tires would be brought in with a forklift. He testified that he did not lift anything over his head greater than 80-90 pounds. He testified that he performed the tire throwing activity between September of 2012 and December 20, 2013.

Petitioner testified that he had pain in his low back starting in March or April of 2013. He testified he was only able to stand for 15 minutes due to SI joint pain and that he would have pain at 6-7/10 that he described as a burning sensation. He testified that his pain at that time was limited to his low back and that it had no radicular component. He testified that the workers at Titan Tire provided him with a seat to sit on consisting of an oil drum. Petitioner testified that he would take periodic rest breaks while throwing tires by sitting on the oil drum.

On direct examination, Petitioner was initially unable to recall the first time he sought treatment. He testified that he recalled going to see his primary care provider to obtain muscle relaxers. Petitioner testified that he saw Dr. Dean at UIC on March 20, 2013 and confirmed that he reported having back pain for 20 years. He confirmed that he had back pain since he was 10-11 years old. However, he testified that the pain he experienced while working for Old Dominion Freight was greater than his prior back pain. On cross-examination, Petitioner confirmed a prior history of low back pain and treatment since the age of 11.

Petitioner testified that he stopped working on December 20, 2013 and took a regularly scheduled vacation. Petitioner that the radicular pain and symptoms began when he got into the back seat of a car to take his father back to a nursing home. The Arbitrator notes that Petitioner originally alleged an accident date of December 24, 2013, on his Application for Adjustment of Claim filed in June 2014. ARB EX 2, RX 5. Petitioner amended the accident date to December 20, 2013 on the date of trial, May 16, 2018. Petitioner testified at trial that he was not actually working on December 24, 2013. Respondent's Exhibit 6 also confirms that Petitioner did not work on December 24, 2013. (Rx. 6)

Petitioner was questioned on cross-examination regarding his work activities on December 20, 2013, the amended accident date. He testified that he did not notice anything unusual on that date while working. He

could not recall whether he threw any tires on that date or how many tires he threw. He testified he could not recall how many tires he threw in December of 2013 generally or how much the tires weighed.

On cross-examination Petitioner also volunteered that the tire throwing work slowed down significantly during the summer of 2013 at which point he would simply perform driving. He testified that the tire throwing subsequently picked up later in 2013. On re-direct examination, Petitioner testified that he would perform tire lifting and stacking approximately 3-4 days per week prior to December 20, 2013. He testified that during the summer of 2013 he did not perform any lifting – only driving.

Petitioner could not recall specifically whether he sought treatment in December 2013 or January 2014. Upon questioning from his attorney, petitioner confirmed that he sought treatment with a chiropractor in early January of 2014.

Petitioner testified that he called work on January 6, 2014 and reported to them that he could not work due to back pain. He testified that he likely called in the morning. He testified that he probably spoke with Steve Keene or Bill Russo. He could not recall who he specifically spoke with. He testified that he reported "having back pain." He did not specifically testify that he reported that his pain was work related. On cross-examination, Petitioner confirmed he did not specifically report his low back condition as being work-related. He reiterated his testimony that he could not recall who he spoke with on January 6, 2014.

Petitioner testified as to his subsequent treatment. He acknowledged seeing his chiropractor in January of 2014. He testified about his treatment at UIC on January 6, 2014 when he was given work restrictions. He testified about his treatment at Roscoe Physical Therapy and acknowledged that he reported an initial history on January 8, 2014 of roughhousing with his brother or dog. However, petitioner denied that this is what caused his symptoms.

Petitioner was asked by his attorney why he never reported his low back condition as being work related. Petitioner's goal, he testified, was to place his treatment through his group health insurance and obtain disability benefits. Petitioner testified that he wanted to get his back fixed and get back to work.

Petitioner testified to subsequently undergoing treatment in the form of ongoing physical therapy. He confirmed that he reported to his primary care provider, Dr. Dean, on February 10, 2014 that he picked up his 90 pound dog and felt back pain. He testified to undergoing an MRI on February 28, 2014 and confirmed he was subsequently referred to Rockford Spine Center.

He was asked why he specifically denied that his incident was work related when being seen at Rockford Spine Center initially on March 4, 2018. Petitioner testified that he did not report it as work related as he did not think his back condition was career ending.

He confirmed he underwent surgery with Dr. Roh on March 26, 2014, which helped with his radicular pain. However, he reported that following surgery he had the same back pain that he was experiencing in March of 2013 after surgery.

Petitioner also testified that his providers at Rockford Spine Center including Dr. Walker indicated that he likely needed to find a new job, but acknowledged that he did have a full duty release. Petitioner testified that he met with Bill Russo after he underwent surgery. He testified that he was told he would not have been able to return back to full duty work and therefore did not return to work for Old Dominion Freight. He testified that the respondent never provided him with a straight answer as to whether or not he could return to full duty work pursuant to same. Petitioner could not specifically recall when he attempted to return back to work for the respondent, but testified it may have been in June of 2014.

Petitioner confirmed that he underwent an FCE thereafter on October 29, 2014. He testified that he started a new job following his FCE. He testified that he now worked in information technology. Petitioner testified that he started a new job on October 30, 2014. He reported that he works as the head of the managed services department. He testified that his job is relatively sedentary. Petitioner admitted that he is currently earning the same or more than he previously earned while working for Respondent.

Petitioner alleged that he continued to undergo some ongoing treatment including with Dr. Walker. He testified that he received an injection in January of 2015 that did not really help. He also testified that he underwent chiropractic treatment with Chris Scott Wellness between April of 2015 and March of 2016 and that it occasionally helps. Petitioner also testified to receiving treatment with Dr. Braaksma with OrthoIllinois. He testified that Dr. Braaksma recommended petitioner continue working within his restrictions. He testified he was undergoing chiropractic care with Cevene. He also reported that he was treating with a new primary care provider, Dr. Gurtizen.

Regarding his current condition, Petitioner testified that he could likely perform any activity, but that the following day he would be in pain. He testified that he can mow his yard and clean his basement. He testified that he has gotten back into golfing because, per his testimony, if his back is going to hurt all the time he might as well continue golfing.

He testified his low back pain is the same as it was 8 months prior to the onset of his radicular symptoms but that the radicular symptoms have resolved. He testified that sitting for too long increases his pain. He testified to 3-4/10 pain while sitting. He testified his back injury limits him from playing with his 3-year-old daughter. He acknowledged that he was able to perform his current work duties on a full duty basis. Petitioner testified that he does play softball and golf despite resulting back pain.

Records from UIC at Rockford document that Petitioner treated prior to the December 24, 2013 disputed accident date for low back pain. Petitioner was first seen on March 20, 2013 by APN Carole Eatock. The history indicates, "The patient presents with job consists of throwing tires. The location is the lower back, the left lower back, and the right lower back and the tail bone. The duration is 20 years. ..." PX 3, RX 3. Petitioner complained that he had low back pain ongoing since age 11. He reported that he had been treating with a chiropractor. He claimed he went to a chiropractor for the first time at age 11 and he had been there six to seven times over the past two weeks. He admitted a history of low back pain, but denied any injury or trauma and denied any leg pain/radiation. He reported that he was training for a triathlon. (Px. 3, Rx. 3) On cross examination, petitioner confirmed a prior history of low back treatment since the age of 11. He confirmed that he would not disagree with any medical records that documented as of March 20, 2013 that he had seen a chiropractor 6-7 times over the last 2 weeks.

On August 3, 2013 he was seen at Gunderson chiropractic. He filled out an intake form on which he indicated an onset of pain 2 weeks earlier with an unknown cause. He reported he had a similar condition in the past. (Px. 4) On cross examination, Petitioner confirmed he had seen a chiropractor named Dr. Gunderson on August 3, 2013 and indicated on that form that he had an onset of low back pain for the last 2 weeks.

Following the alleged accident date amended at trial to be 12/20/13 he was seen on January 6, 2014 complaining of acute back pain. He reported a pain in his lower back radiating into both of his legs. He reported an onset of December 24, 2013. He reported that he was seeing a chiropractor and felt that it helped a little. Notably absent from this record was any reporting by Petitioner that he allegedly injured himself as a result of his work duties for Respondent. (Px. 3, Rx. 3) The record notes that "Pt may have injured his back a few days to a few hours before his pain started." PX 3, RX 3.

A physical examination showed no significant abnormalities except some tenderness to palpation in the L2 to L4 region. X-rays were ordered. Petitioner was referred to Roscoe PT. (Px. 3, Rx. 3)

Records from Roscoe PT document treatment starting on January 8, 2014. Petitioner completed a health questionnaire form. He indicated that his problems began December 24, 2013. Petitioner was asked if his problem related to a specific injury and he stated it was possibly the result of roughhousing the weekend before. According to the initial evaluation report, the therapist states that petitioner had increased pain in his low back radiating to his bilateral lower extremities around Christmas. Petitioner reported that this may have been due to roughhousing with his brother or possibly with the dog. (Px. 7 p. 230, Rx. 2)

On cross-examination, Petitioner was asked about his initial visit to Roscoe. Petitioner testified that he told the physical therapy provider that he was not sure what caused his pain but that it may have been due to roughhousing with his brother or dog the weekend of December 24, 2013. He also confirmed that he filled out an intake form indicating same.

Petitioner underwent a course of therapy from January 8, 2014 to March 20, 2014. On January 28, 2014, Petitioner reported that the radicular pain had resolved "for the most part" and that he was still in PT. PX 3, p. 42. Dr. Dean wrote a note keeping Petitioner off work dated 1/24/14 stating "Aaron is a patient currently under my care with an acute lumbar radiculopathy. He has been of work since his Christmas vacation ended." Petitioner was to be reevaluated on 2/10/14 to see if he could return to work on 2/11/14.

Petitioner continued in PT at Roscoe. On February 11, 2014, petitioner reported a flare-up of pain after lifting an 80 pound dog (which is consistent with his reporting to Dr. Dean on February 10, 2014 as noted below). (Px. 7, Rx. 2)

He was subsequently seen at UIC on February 10, 2014 by Dr. Dean. Dr. Dean noted that Petitioner had lumbar back pain with radiculopathy. He reportedly was in physical therapy and making good progress. He reportedly had a slight setback the prior Thursday when he picked up his 90+ pound dog to take him to the vet. A physical examination showed positive straight leg raising, particularly on the left. He was diagnosed with acute left lumbar radiculopathy and sent back to physical therapy. (Px. 3, Rx. 3) Petitioner admitted on cross-examination that he had a flare-up of his pain while picking up a dog to take it to the vet. Petitioner was kept off work for another 2 weeks.

Petitioner was next seen at UIC on February 21, 2014. He complained of back pain with radiculopathy. He reportedly was in physical therapy and a seeing a chiropractor and was doing better with intermittent persistent numbness and tingling with prolonged sitting. Petitioner was concerned that he had not had an MRI. Petitioner was given a release to return to work as of March 3, 2014 without restrictions unless the symptoms worsened or regressed. (Px. 3, Rx. 3)

The records from the Rockford Spine Center document that Petitioner called on February 25, 2014 with complaints of back and leg pain/numbness since Christmas. It was recommended that he have an MRI prior to an initial office visit. (Px. 5, p. 148, Rx. 7) An MRI was then performed on February 28, 2014 at Summit Radiology. The MRI showed a massive left paracentral and left posterolateral disc herniation with caudal extrusion at L4-L5. This impinged the left-sided traversing nerve roots. (Px. 5, Rx. 7)

Petitioner was first seen at Rockford Spine Center on March 4, 2014. Petitioner completed registration and insurance information forms. He was asked whether his injury was the result of an accident and he said no. He was asked if his injury happened on the job and whether he reported the accident to his employer and he said no. He asked if an attorney was involved and he said no. He was asked if this was the result of a car accident or whether another person was responsible for his accident and he said no. (Px. 5. P. 105, Rx. 7) The notes

further indicate that Petitioner reported the leg pain "since Christmas." P. 118. On cross-examination Petitioner was asked about the intake form. He confirmed that he denied his condition was the result of any injury at work on the intake form.

Petitioner was evaluated by Dr. Michael Roh of Rockford Spine Center on March 4, 2014. He completed a history and physical form. He complained of back pain along with leg pain and leg numbness. He claimed that he had the problem for 2-3 months. He claimed it got worse February 27, 2014. In response to the question of what started the problem petitioner said he was not sure. He admitted that he already had treatment from his primary care physician, Dr. Leslie Dean, and also from a chiropractor, Jeremy Gunderson. Dr. Roh's initial chart note indicated that petitioner denied having any accident or injury. He complained of back pain and left leg pain and numbness. He denied any lawsuit or workers' compensation claim. (Px. 5, Rx. 7) On cross-examination, Petitioner testified that he was seen by Dr. Roh on March 4, 2014 and specifically denied that he knew what caused the onset of his low back.

A physical examination showed neurologic abnormalities and positive straight leg raising. The MRI was abnormal. Dr. Roh diagnosed a left L5 radiculopathy secondary to a massive L4-L5 central and left paracentral herniated disc. He recommended petitioner have surgery. Petitioner agreed to undergo surgery. (Px. 5, Rx. 7)

Petitioner returned to UIC and was seen by Dr. Dean on March 6, 2014. He noted that petitioner had persistent back pain, had seen a spine surgeon and had an MRI. The MRI showed a herniated disc. Petitioner was diagnosed with acute left lumbar radiculopathy. Surgery was planned. (Px. 3, Rx. 3) Surgery was performed on March 26, 2014. Dr. Roh performed a left-sided L4-L5 microlumbar discectomy. During the surgery, he found a large disc herniation. He found that the nerve root was quite swollen and erythematous as a result of the severe compression. He removed multiple large extruded herniated disc fragments. He found a large annular defect. (Px. 5, Rx. 7)

Petitioner was next seen on April 11, 2014 by Dr. Dean. He was status postsurgery. He reported that he was significantly improved. His back pain was completely resolved. He still had some numbness and tingling into his left calf. PX 3, P. 58 Continued therapy was recommended. (Px. 3, Rx. 3). Petitioner returned for therapy at Roscoe PT on April 14, 2014 and continued in therapy through May 30, 2014. (Px. 7, Rx. 2)

After surgery, Dr. Roh saw petitioner in follow up on May 8, 2014. He reported that his symptoms of leg pain were 80% better. He continued to complain of low back pain. Physical therapy was recommended. (Px. 5, Rx. 7). On May 22, 2014, Petitioner saw Dr. Dean who noted that Petitioner could return to work on May 27, 2014. PX 3, p. 62.

Petitioner filed his Application for Adjustment of Claim thereafter on June 3, 2014. (Rx. 5)

Petitioner was then seen by Dr. Marie Walker on June 24, 2014. Petitioner complained of "a several year history of intermittent low back pain that became worse after a recent microdiscectomy at L4-5 for disk herniation and sciatica. The sciatica was resolved after the surgery, but the chronic back pan that he has had intermittently for many years came back." He reported that he was pitching for two and a half hours and that aggravated his symptoms along with other movements and with prolonged sitting. He reported his pain was at a level of 5-6/10. Physical examination was fairly negative. Dr. Walker diagnosed petitioner with mechanical low back pain that was primarily muscular, but could be in part SI joint mediated. Petitioner was recommended to stretch and do exercises. An SI injection was to be considered. (Px. 5, Rx. 7) On cross-examination, Petitioner confirmed that he reported a history of chronic back pain for many years to Dr. Walker. On the intake questionnaire dated 6/14/13, Petitioner reported that he had the axial back pain since "about 1 year before surgery til now."

On June 24, 25 and 26, 2014, Petitioner called Rockford Spine Center to discuss any physical restrictions. He was advised that the medical provider had no restrictions for him as of that date. The records also note that Petitioner was told he should find a less demanding job but that Dr. Roh had released Petitioner without restrictions. PX 5. P. 111. He called again on June 27, 2014 to request that Dr. Walker dictate a note stating he is unable to work at current job intensity and needs to find a different job that is less labor intensive. Dr. Walker responded that although prior mention was made by Dr. Walker regarding an FCE, Petitioner could not have an FCE because "not WC." PX 5, p. 110. Dr Walker then advised that she "agree pt may not tolerate current job requirements/activities needs to find different job but no perm restrictions and therefore will not qualify for disability." PX 5, p. 110 .

Petitioner was seen by Dr. Dean on July 3, 2014. He was claiming recurrent SI joint pain. Petitioner reported that he was having pain with prolonged standing. He denied any shooting pain or numbness down his legs. He reported that he was released to return to work at the end of May but that his current employer was neither taking him back nor firing him. Petitioner requested an evaluation for any work restrictions and a functional capacity evaluation was recommended. (Px. 3, Rx. 3) Petitioner also reported that he could do almost anything but had pain the next day.

On September 17, 2014, he was seen at Gunderson Chiropractic with complaints of neck pain, which is not a condition petitioner had as a result of the disputed work accident. He was also complaining of mid-back pain. There were no complaints of lumbar pain. He had ongoing similar complaints on September 20, 2014. He received treatment at C7 and T8. (Px. 4)

On October 29, 2014 he underwent an FCE. The FCE was done at Orthopedic Rehab Specialists of Rockford. PX 8. The FCE was valid and Petitioner demonstrated the ability to meet the material handling demands for a heavy demand vocation. PX 8.

The history documented in the FCE was as follows: "This client, Aaron McDonald, arrived for functional capacity evaluation for ongoing bilateral low back and SI pain. He states he had been working for Old Dominion Freight Line for 8-10 months prior to his actual onset of his pain which was on 12-24-13. He states that he was rolling down a hill with some family members at his home, he then went to get into his car and felt pain." PX 8, p. 257. The FCE does not contain a history of throwing tires at work. The history does indicate that Petitioner reported "he was having stiffness in his back and pain in his back and difficulty standing all the way vertical after sitting for a period of time for several weeks prior to this actual onset of his injury." PX 8, p. 258.

On cross-examination, Petitioner testified that he did provide the above history to the therapist. He was asked whether he told the physical therapy provider that he was "rolling down a hill with some family members at his home" when he went to get into his car and felt pain. He testified that was not entirely accurate, but reiterated his testimony from direct examination that he did initially feel radicular symptoms while helping a family member into a car.

On re-direct examination, Petitioner was asked about the history reported to the FCE therapist. He testified that he reported to the FCE therapist that he thought the onset of his radicular symptoms could have been related to playing with a dog or playing with his brother or getting into a car, but that these events occurred on separate days. He reiterated his testimony that his radicular symptoms started on December 24, 2013.

He was not seen again at Gunderson Chiropractic until January 24, 2015 with complaints of upper back pain that he alleged started on January 23, 2015. He was given cervical and thoracic manipulation. (Px. 4)

On June 5. 2015, Dr. Rho prepared a physical capabilities questionnaire in connection with Petitioner's claim for disability benefits. Dr. Rho indicated petitioner was able to return to full duty work effective June 13, 2014 at the very heavy physical demand level. (Px. 5, Rx. 7) On October 5, 2015, he was seen again at Gunderson chiropractic with complaints of cervical and thoracic pain. He did not have any complaints of lumbar pain. (Px. 4) Petitioner testified that he has continued to undergo intermittent treatment for his low back. (Px. 9, 10, 11, 12) Of significance, he was seen at Cevene Care Clinic on June 1, 2016. He reported that he had a herniated disc in 2014. He did not report that it was work related. (Px. 11)

Petitioner was examined by Dr. Jesse Butler at Respondent's request on June 24, 2015, or well after he had filed his Application. He was asked to provide a history. Petitioner admitted to Dr. Butler that while he would have some back pain at times from work, he did not have any radicular issues until December 2013 when, while getting in the back seat of a car to take a family member to a rehab facility, he felt a shock in the lower back and left leg. Petitioner confirmed this occurred around December 24, 2013. (Rx. 1)

Based on this admission to Dr. Butler, Dr. Butler concluded that petitioner did not experience any accident as a result of his work duties. He also noted that petitioner's diagnosis and symptoms were not related to any kind of repetitive stress work duties. He noted that while petitioner may have had some intermittent low back pain with some of his work duties involving loading tires, none of that back pain ever resulted in any radicular complaints or medical treatment. He concluded petitioner could return to full duty work and that he did not require any ongoing restrictions. He noted that petitioner had already returned to work as an information technology specialist. (Rx. 1)

Petitioner was questioned at trial about his IME. He admitted he underwent the exam after he had retained an attorney and filed his Application. He admitted that Dr. Butler asked him how his pain started. He admitted that he reported to Dr. Butler that he had chronic low back pain. He admitted that he reported to Dr. Butler that he had an onset of radicular pain while getting into the back seat of a car to take a family member to a rehab facility, and that this occurred on December 24, 2013.

Dr. Butler's deposition, took place on June 5, 2017. RX 1. On direct examination, Dr. Butler testified consistent with his narrative report. Dr. Butler testified that petitioner's disc herniation at L4-5 was not caused by either an acute incident or due to repetitive stress associated with petitioner's work duties that involved throwing tires. On cross examination, Dr. Butler acknowledged that over time petitioner's work duties for the respondent could have led to thinning of the annular fibers and that weakening of these fibers can ultimately result in a disk herniation. However, Dr. Butler testified that it was speculative to conclude that Petitioner's work duties caused Petitioner's low back condition.

Dr. Butler testified that petitioner simply did not provide a history of experiencing an onset of symptoms while at work, but rather while assisting a family member into a car. Dr. Butler testified that this history provided to him by the petitioner led him to conclude that petitioner's onset of symptoms was directly associated with the acute incident described by the petitioner of assisting a family member into an automobile on 12/14/13. He testified that Petitioner provided a history of radicular symptoms that started after an activity that was not at work. RX 1.

Petitioner underwent an examination with Dr. Jeffrey Coe, on December 8, 2015. (Px. 13) Petitioner reported that he had worked for the respondent for one and a half years as a truck driver. Petitioner reported that he began to experience pain in his low back in March of 2013 while throwing tires. (Px. 13) Petitioner was treated with pain management and chiropractic treatment in the summer of 2013 for primarily low back pain. P. 13. Petitioner advised him that his low back condition worsened in the summer and fall of 2013 with work activities of hand loading and unloading the trailers and moving tires from the back of the trailer. He advised Dr. Coe that in December 2013, he unloaded a lot of tires over a 2 to 3 day period. P. 14. Petitioner advised that his

pain had been localized to his back up to December 2013 and then his pain began to radiate down both legs. P. 15. Petitioner also advised of his prior chiropractic treatment for his low back pain since his teenage years but stated that the pain was different and did not radiate down his legs until December 2013 when he threw tires. P. 24.

In his opinion, Petitioner's work for Respondent, loading and throwing tires throughout his day, was causative of Petitioner's lower back condition. He testified to his opinion that the work activities for Respondent, that is the loading and unloading tires from the truck, was a factor in the breakdown of his lumbar spine with acute herniation of the L4-5 intervertebral disc, the left lumbar radiculopathy, and the postoperative multifactorial lower back pain. PX 13, p. 30. Dr. Coe also recommended Petitioner limit lifting to the medium physical demand level with avoidance of repetitive bending or twisting. (Px. 13). He concluded that petitioner's treatment to date was reasonable, necessary, and causally related to the work accident. He felt that petitioner required ongoing pain management treatment.

On cross-exam, Dr. Coe acknowledged that his opinion on Petitioner's work duties playing a factor in his condition was contingent on Petitioner reporting an accurate history of his work duties. P. 37-38, 56. He acknowledged that if the history of injury was inaccurate then his opinions concerning causal connection would be based on incomplete or inaccurate information. P. 39.

Dr. Coe did not know when petitioner specifically started working for the respondent, but testified it was around September of 2012. He did not know how many days petitioner worked or how many hours per day petitioner worked. He did not know how often petitioner worked between March and December of 2013. He did not know petitioner's specific daily work duties. He did not know how much time petitioner spent driving, loading and unloading trucks or throwing tires. P. 41-42.

He stated that petitioner initially reported that his back was injured in March of 2013. He acknowledged reviewing a note from March 20, 2013 of a nurse practitioner. He confirmed petitioner complained of back pain and that petitioner reported a history of 20 years of back pain. He confirmed petitioner reported he was training for a triathlon and that he had been seeing a chiropractor since age 11. Dr. Coe acknowledged that the initial March 20, 2013 record failed to document any complaints of radicular symptoms down the legs and that petitioner was only complaining of left-sided low back tenderness and general low back pain. P. 43-44. He also testified that he reviewed a Dr. Gunderson note from August 13, 2013. He could not recall whether he reviewed petitioner's intake form, but acknowledged that petitioner was not reporting any radicular symptoms as of August of 2013. P. 46-47.

He then testified that petitioner had no treatment between August 2013 and January 2014. P. 47. He acknowledged that there was no history of throwing tires in the January 6, 2014 medical records. P. 48. He further testified that the Roscoe Pt records from January 8, 2013 indicate Petitioner's report that his symptoms were caused after roughhousing with either his brother or his dog. P. 50. He acknowledged that petitioner reported his pain increased around Christmas with radiating pain. There was no mention of work duties in this PT intake record. P. 51. Dr. Coe testified that petitioner did not report this roughhousing incident to him at the time he took petitioner's history, but that he did question petitioner subsequently about it and petitioner provided an explanation. Dr. Coe did not provide any testimony as to what Petitioner's "explanation" was.

Dr. Coe also acknowledged that petitioner reported some aggravating incident on February 10, 2014 to Dr. Dean when he picked up his 90 pound dog at home. He acknowledged this was a significant weight and that if someone had to lift this kind of weight for work that would place him in the heavy physical demand category. P. 53. .

Dr. Coe was also questioned about the Rockford Spine Center/Dr. Roh records. Dr. Coe acknowledged that he reviewed petitioner's intake form and that petitioner did not indicate that his pain was the result of any kind of work injury. P. 54. He confirmed that the records of Dr. Walker, the physiatrist petitioner eventually treated with at Rockford Spine Center, document that petitioner had a several year history of back pain. He also acknowledged that petitioner reported pitching for 2-1/2 hours to Dr. Walker with a subsequent worsening in back pain. Dr. Coe assumed this meant petitioner was throwing a baseball. He did not know the extent to which petitioner participated in playing baseball. P. 60.

He confirmed petitioner's FCE placed him in the heavy physical demand level despite the fact that Dr. Coe indicated petitioner could only return to work in the medium-heavy physical demand level. He confirmed petitioner underwent pain management and had ongoing back pain similar to the chronic pain he had prior to his alleged work accident. He confirmed that petitioner's radicular pain had resolved. Dr. Coe acknowledged it was possible petitioner had merely returned to baseline and had ongoing myofascial pain, similar to what he had before the alleged accident. P. 64.

Lastly, Dr. Coe testified that people with a chronic history of low back pain can have a further breakdown as a result of their degenerative condition resulting in a disc herniation. He confirmed this breakdown can occur idiopathically. He confirmed a breakdown can occur as a result of roughhousing with another person or a dog. He confirmed a breakdown can occur as a result of training for a triathlon or other exercise. He confirmed a breakdown can occur as a result of lifting a 90 pound dog. P. 70. He confirmed that a breakdown can occur as a result of bending abnormally, such as what petitioner reported to Dr. Butler.

CONCLUSIONS OF LAW

The above findings of fact are incorporated into the following conclusions of law.

In support of the Arbitrator's decision relating to (C) Accident, (F) Causation, (E) Notice (J) Medical Services, (K) Temporary Benefits, (K) Maintenance Benefits, (N) Respondent's Credit and (J) Nature and Extent, the Arbitrator makes the following conclusions of law:

Based on the above and the record in its entirety, the Arbitrator finds that Petitioner did not sustain an acute trauma or a repetitive trauma type injury arising out of and in the course of his employment by Respondent and manifesting on December 20, 2013 or on any other date. In so finding, the Arbitrator notes the substantial and persuasive number of medical records/histories that clearly attribute Petitioner's axial and radicular complaints to non-work related events. The Arbitrator places greater weight on these histories and, in this matter, the opinion of Dr. Butler over the testimony of Petitioner and the opinion of Dr. Coe. This finding applies equally to Petitioner's axial back pain and to his radicular pain. Despite the logical connection which can be drawn between throwing tires and back pain, the record is devoid of sufficient evidence in this matter to prove either an acute trauma or repetitive activity sufficient to result in cumulative trauma related to Petitioner's employment. Further, there is no sufficient credible evidence to show a causal connection between Petitioner's employment and his axial back pain symptoms or disc herniation.

The Arbitrator initially notes that Petitioner's original date of accident alleged was December 24, 2013, which is the date mentioned in most of his medical records as the date of initial radicular pain. Petitioner was not at work on December 24, 2013 but rather off for a holiday break. The amended date of 12/20/13 was his last day worked for Respondent. Petitioner testified that his axial low back pain symptoms began in March 2013 and that he sought treatment on March 20, 2013. The record of March 20, 2013 history indicates, "The patient presents with job consists of throwing tires. The location is the lower back, the left lower back, and the right

lower back and the tail bone. The duration is 20 years. ..." PX 3, RX 3. Petitioner complained that he had low back pain ongoing since age 11. He reported that he had been treating with a chiropractor. He claimed he went to a chiropractor for the first time at age 11 and he had been there six to seven times over the past two weeks. He admitted a history of low back pain, but denied any injury or trauma. He reported that he was training for a triathlon. (Px. 3, Rx. 3) On cross examination, petitioner confirmed a prior history of low back treatment since the age of 11. He confirmed that he would not disagree with any medical records that documented as of March 20, 2013 that he had seen a chiropractor 6-7 times over the prior 2 weeks. Petitioner was seen on one occasion thereafter for low back pain on August 3, 2013 at Gunderson chiropractic. He filled out an intake form on which he indicated an onset of pain 2 weeks earlier with an unknown cause. The Arbitrator specifically notes that Petitioner's two medical visits in March and August 2013 do not provide sufficient support for a finding of a work related aggravation or repetitive trauma type injury given the lack of work activity described and the extent of his long-standing low back treatment.

Moreover, Petitioner's medical records after December 2013 through 2014 contain numerous references to non-work related causes for his radicular pain and disc herniation. Those include helping his father into the back seat of a car, horseplay with family members over the holiday at home and lifting a 90 pound dog. Petitioner also explicitly denied a work relation on all of the medical history intake forms as noted above. Dr. Coe agreed that the non-work related causes proffered by Petitioner could further breakdown a chronic history of low back pain and degeneration and result in disc herniation. The Arbitrator further notes that the work history on which Dr. Coe primarily based his opinion does not comport with the evidence at trial thus negating the credibility of his opinion. The Arbitrator finds no credible support in the record to support Petitioner's assertion that his work duties for Respondent, which to some extent involved lifting and stacking tires, gradually wore down his low back resulting in the need for surgery. Petitioner admitted that his work duties varied and that in the summer and fall of 2013 he only performed his driving duties and did not throw tires.

Based on the foregoing, the Arbitrator finds that Petitioner did not sustain a work related aggravation or repetitive trauma type injury or that his work duties for the Respondent caused or contributed to his low back condition based on a preponderance of the credible evidence at trial. Benefits under the Act are denied.

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

James Emm,

Petitioner,

20IWCC0372

vs. NO: 18 WC 007281

Grasser's Plumbing and Heating,

Respondent.

DECISION AND OPINION ON REVIEW

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

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

20IWCC0372

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: JUN 2 6 2020

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MEP/ypv
049

Maria Elena Portela
Maria E. Portela

Kathryn A. Doerries
Kathryn A. Doerries

Thomas J. Tyrrell
Thomas J. Tyrrell

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

EMM, JAMES
Employee/Petitioner

Case# **18WC007281**

GRASSER'S PLUMBING AND HEATING
Employer/Respondent

20IWCC0372

On 8/20/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.84% 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:

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

2593 GANAN & SHAPIRO PC
TIMOTHY C STEIL
411 HAMILTON BLVD SUITE 1006
PEORIA, IL 61602

20 IWCC0372

STATE OF ILLINOIS)
)SS.
COUNTY OF LA SALLE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

James Emm
Employee/Petitioner

Case # **18** WC **7281**

v.

Grassers Plumbing and Heating
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 **Anthony C. Erbacci**, Arbitrator of the Commission, in the city of **Ottawa**, on **July 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. [ ] 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, **Februrary 22, 2014**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**72,662.72**; the average weekly wage was $**1,397.36**.

On the date of accident, Petitioner was **38** years of age, ***married*** with **2** dependent children.

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

ORDER

Petitioner failed to prove his current elbow condition is causally related to the February 22, 2014 work accident. Thus, Petitioner's instant claim for compensation is denied.

No benefits are awarded herein.

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

August 12, 2019
Date

AUG 20 2019

FACTS:

The Parties stipulated that the instant 19(b) trial was limited to Petitioner's disputed left cubital tunnel condition and ancillary issues related to that condition. Petitioner alleges injuries to other body parts as a result of the same accident. However, per agreement of the Parties, Petitioner's other alleged conditions as a result of this same accident were not addressed at trial and will not be addressed in this Arbitration Decision.

Petitioner testified he was employed by Respondent as a service technician on his accident date of February 22, 2014. Petitioner testified he had no problems with his left elbow before February 22, 2014.

Petitioner testified he was called to a house without heat and went to the house to provide service. Petitioner testified he returned to his truck when he stepped down and slipped on ice while holding onto his toolbox. Petitioner testified he fell on his left shoulder and upper arm and felt immediate pain. Petitioner testified he did not land on his left elbow. He also testified he did not have any specific elbow pain at the time of the accident.

Petitioner testified he did not seek treatment immediately. Rather, Petitioner sought treatment a few weeks later with upper arm pain and a little bit of pain into his neck.

Petitioner testified he did not receive specific elbow treatment until 2017. Petitioner testified he did not have elbow pain until approximately the middle of 2017 when he started having tingling into his pinky and ring finger. Prior to the cubital tunnel symptoms, Petitioner testified he previously had two left shoulder surgeries with the first on July 27, 2015 performed by Dr. Perona and the second surgery on April 19, 2016 performed by Dr. Verma. Petitioner testified he was released from care by Dr. Verma in 2016.

Petitioner testified Dr. Fernandez performed an ulnar nerve decompression in August 2017. Petitioner testified he did not receive relief after this procedure. Petitioner testified Dr. Fernandez recommended a second operation. Petitioner testified he would like to proceed with that surgery. Petitioner testified he has had no new injury since the accident in 2014.

Petitioner testified he is still employed with Respondent in a new position as a parts ordering person. Petitioner has worked in that position since February or March of 2018.

The medical records admitted into the record demonstrate that on June 28, 2017, Petitioner was seen by Dr. Fernandez with complaints of numbness and tingling in the left hand and arm into the ring and small fingers with radiation from the medial elbow. Petitioner recently had an EMG test which confirmed ulnar nerve entrapment. Petitioner reported he had sustained an injury after a fall on ice in February 2014 and underwent a series of shoulder surgeries but has had continued problems with the left elbow. Petitioner reported he had significant increase in his symptoms about three to six months prior. On exam, Petitioner had positive Tinel and elbow flexion test. The diagnosis was left elbow cubital tunnel syndrome. Dr. Fernandez indicated that he believed there was a causal relationship between Petitioner's current left arm condition of cubital tunnel syndrome and it being work-related. He indicated this was either directly or indirectly related to Petitioner's work activities

and/or the prior surgeries he had for the left shoulder. Conservative and surgical treatment options were discussed.

On August 28, 2017, Dr. Fernandez performed a left elbow ulnar nerve release with in situ cubital tunnel release. (Px-1).

Dr. Fernandez's post-operative medical records document Petitioner continued to have subjective complaints after his cubital tunnel release. (Px-1). On November 8, 2017, Petitioner was seen by Dr. Fernandez and there was discussion of proceeding with a left elbow subcutaneous ulnar nerve transposition.

On December 26, 2019, Dr. Fernandez prepared a causation letter. (Px-2). Dr. Fernandez indicated Petitioner's condition and the need for treatment was still related to the injury Petitioner sustained after a fall in February 2014. Dr. Fernandez indicated Petitioner had shoulder surgery and then developed these conditions as a result of that. (Px-2)

On May 9, 2019, Dr. Fernandez prepared an IME addendum. (Px-2) Dr. Fernandez indicated after Petitioner's injury of October 22, 2014, Petitioner developed symptoms and complaints of pain with numbness and tingling along the hand and arm with subsequent diagnosis of left elbow ulnar neuropathy that was seen objectively on May 9, 2017. Dr. Fernandez commented Petitioner had no complaints or treatment for similar problems before that injury. Petitioner reported to Dr. Fernandez that the symptoms occurred after the accident and intensified after the shoulder surgeries as well. Dr. Fernandez recommended a revision surgery with the ulnar nerve release and subcutaneous transposition. Dr. Fernandez attempted to explain his opinion by stating that the Petitioner's shoulder surgery may have had a contributory effect to the cubital tunnel condition in the sense that it required immobilization of the elbow. Dr. Fernandez also opined that injury across the arm with impact to the elbow and/or hyper flexion or extension injury across the elbow can also cause or contribute to the condition of ulnar neuropathy or cubital tunnel syndrome making it work-related. Dr. Fernandez indicated Petitioner did not have any other significant risk factors nor did he have a history pointing to the development of cubital tunnel until the work injury.

At Respondent's request, Petitioner underwent an examination by Dr. Vender on January 22, 2018. (Rx-2). Petitioner reported to Dr. Vender he noticed pain in his elbow and numbness and tingling in the ulnar aspect of his hand in approximately January or February of 2017. Petitioner reported he underwent a surgical release of the ulnar nerve in August 2017 and initially he was doing well but stated that the numbness and tingling persisted to some degree. Dr. Vender diagnosed Petitioner with status post ulnar nerve decompression of the left elbow. Findings on new EMG studies taken that day, were consistent with the prior diagnosis of mild ulnar neuropathy. Dr. Vender opined it was not uncommon to have residual findings on EMG after surgical treatment for neuropathy such as cubital tunnel syndrome or ulnar neuropathy at the elbow.

Dr. Vender reviewed Petitioner's medical records and noted that there was no indication in the records of trauma to the elbow that would be considered contributory to ulnar neuropathy. (Rx-2). Dr. Vender opined trauma to the shoulder itself would not lead to the development of an ulnar neuropathy. Dr. Vender stated the repeat EMG studies did not demonstrate any significant findings and he would not recommend further surgery on the ulnar nerve. Dr. Vender also did not believe Petitioner required any additional physical therapy or work conditioning. Dr. Vender opined Petitioner

did not require any work or activity restrictions with regard to the elbow and he indicated that the Petitioner had reached maximum medical improvement.

CONCLUSIONS:

In Support of the Arbitrator's Decision relating to (F.), Is Petitioner's current condition of ill-being causally related to the injury, (J.), Were the medical services that were provided to Petitioner reasonable and necessary and Has Respondent paid all appropriate charges for all reasonable and necessary medical services, and (K.), Is Petitioner entitled to any prospective medical care, the Arbitrator finds and concludes as follows:

Based on the evidence presented at trial, the Arbitrator finds Petitioner failed to prove his left cubital tunnel condition has a causal relationship to the work accident.

Per Petitioner's own admission, his symptoms did not develop until the middle of 2017 which is more than three years after the accident. The development of these symptoms and the diagnosis of cubital tunnel condition is too remote from the accident to be credibly considered related to the accident.

Dr. Fernandez' opinions on causation are unpersuasive. Dr. Fernandez did not address or discuss as any point the significant temporal gap between the accident and the onset of symptoms. Dr. Fernandez only generically described Petitioner providing a history of symptoms after the shoulder surgeries.

Initially, Dr. Fernandez opined that Petitioner's condition was related to his work activities and/or to the prior left shoulder surgeries. No evidence was presented at trial that Petitioner had informed Dr. Fernandez of his job activities or that Dr. Fernandez knew anything about Petitioner's employment duties. Regardless, Petitioner did not allege repetitive trauma injury on his Application for Adjustment of Claim and the Arbitrator elects to give that opinion no weight. Furthermore, Dr. Fernandez did not initially explain how or why the cubital tunnel condition was related to the prior left shoulder surgeries.

Dr. Fernandez opined in his report of May 9, 2019, that the cubital tunnel condition was causally related either from post-surgery immobilization after the shoulder surgeries or on the basis that an injury across the arm with impact to the elbow and/or hyper flexion or extension injury across the elbow can also cause or contribute to cubital tunnel syndrome. Neither of these opinions are supported by the record. There was no evidence in the record as to how long Petitioner's left shoulder was immobilized after either surgery. There are also no records in evidence that Petitioner had cubital tunnel symptoms contemporaneously with or immediately after his left shoulder was immobilized. What is known is that Petitioner was released from care by Dr. Verma in 2016 and did not develop cubital symptoms until the middle of 2017. No evidence was presented that Petitioner's left arm was immobilized in 2017 or at the time he noticed his cubital tunnel symptoms. In light of the significant gap in the onset of cubital tunnel symptoms, it is difficult to relate the cubital tunnel condition to the immobilization after surgery on a temporal basis. Additionally, Petitioner admitted at

trial he did not strike his elbow which would rebut Dr. Fernandez' alternative rational that this a work-related injury.

While the Arbitrator notes the opinions of Dr. Fernandez, as well as his credentials, the Arbitrator finds the opinions of Dr. Vender more persuasive and supported by the record in the instant matter. Dr. Vender opined that trauma to the shoulder would not cause the cubital tunnel syndrome. He also noted that the updated EMG study, which was never addressed by Dr. Fernandez, did not demonstrate any significant findings which would require surgery. Dr. Vender placed Petitioner at maximum medical improvement at the time of his examination of the Petitioner on January 22, 2018, and he opined Petitioner could return to work without restrictions related to the elbow.

Based upon the foregoing, and having considered the totality of the credible evidence adduced at hearing, the Arbitrator finds that Petitioner failed to prove his cubital tunnel condition has a causal relationship to the February 22, 2014, accident. Thus, the Arbitrator finds that the treatment Petitioner received for the cubital tunnel condition is not related to the accident and therefore Petitioner's request for payment of medical bills for cubital tunnel treatment is denied. Petitioner's request for authorization of the cubital tunnel surgery is also denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Kimberly Brawthen,

Petitioner,

20IWCC0373

vs.

NO: 17 WC 000517

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 5, 2018 is hereby affirmed and adopted.

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

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

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

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

o051920
MEP/ypv
049

Maria E. Portela

Thomas J. Tyrrell

Kathryn A. Doerries

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

BRAWTHEN, KIMBERLY
Employee/Petitioner

Case# **17WC000517**

20IWCC0373

PARSEC INC
Employer/Respondent

On 7/5/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0290 KARCHMAR & STONE
ADAM KARCHMAR
111 W WASHINGTON ST SUITE 1030
CHICAGO, IL 60602

0481 MACIOROWSKI SACKMANN & ULRICH
ROBERT T NEWMAN
105 W ADAMS ST SUITE 2200
CHICAGO, IL 60603

STATE OF ILLINOIS)
)SS.
COUNTY OF WILL)

20IWCC0373

- [ ] 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)

Kimberly Brawthen
Employee/Petitioner

v.

Parsec, Inc.
Employer/Respondent

Case # **17** WC **517**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Anthony C. Erbacci**, Arbitrator of the Commission, in the city of **New Lenox**, on **June 8, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [ ] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [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, **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 $**32,836.44**; the average weekly wage was $**631.47**.

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

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

Respondent shall be given a credit of $**4,570.64** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**4,570.64**.

ORDER

Respondent shall authorize and pay the reasonable and necessary expenses associated with the left shoulder surgery prescribed for the Petitioner by Dr. Fuentes, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay for the reasonable and necessary medical services provided to the Petitioner by Physicians Immediate Care, as provided in Sections 8(a) and 8.2 of the Act.

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

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

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

Arbitrator Anthony C. Erbacci

July 2, 2018
Date

FACTS:

The Petitioner sustained an undisputed accidental injury which arose out of and in the course of her employment on December 9, 2016. The Petitioner testified that she was standing in the doorway of her spotter truck when it was struck by another truck and she was jarred several times with her left arm striking the door frame, her left upper thigh hitting the door latch, and her right arm and right hip hitting the door frame on the opposite side. The Petitioner testified that she noticed pain in both of her arms and thighs as well as bruising on her left arm and shoulder. The Petitioner was taken into the office and then to an immediate care center where she followed up a couple of times. The Petitioner testified that she had no problems with her left arm or shoulder prior to her work injury.

The Petitioner was then seen by her primary care physician, Dr. Rogers, who ordered an MRI and then diagnosed a left shoulder SLAP tear. Dr. Rogers referred the Petitioner for a surgical consult and she then saw Dr. Fuentes who prescribed arthroscopic surgery for the Petitioner.

On February 6, 2017, the Petitioner was examined by Dr. Daniel Troy at the request of the Respondent. Dr. Troy opined that the Petitioner sustained a left shoulder contusion/strain which was resolved. Dr. Troy further opined that the Petitioner was at maximum medical improvement and, except for a couple more physical therapy visits, was not in need of any further medical treatment.

The Petitioner was then examined by Dr. Guido Marra at the request of her attorney. Dr. Marra opined that the Petitioner did have a labral tear which was caused by her work accident. Dr. Marra further opined that the surgical repair of the Petitioner's labrum as prescribed for her by Dr. Fuentes was appropriate and causally related to the accident.

The Petitioner testified that she currently continues to have difficulty using her left arm and that the conservative treatment she received has not really helped her condition. The Petitioner acknowledged that she did return to her regular full time work on February 24, 2017, and she testified that she has "some good days" and "some bad days" with regard to the condition of her left arm and shoulder. The Petitioner testified that Dr. Fuents continues to prescribe surgery for her left shoulder and she testified that she wanta to undergo the surgery prescribed for her by Dr. Fuentes.

CONCLUSIONS:

In Support of the Arbitrator's Decision relating to (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 and concludes as follows:

Petitioner testified she had never experienced any problems with her left shoulder before the accident and the medical records support her testimony. Immediately after the accident, Petitioner complained of pain to her supervisor and continued to complain of the same pain and limited range of motion to her subsequent medical providers. These providers include Physicians Immediate Care, her primary care physician, Dr. Teresa Rogers, her physical therapists at Momentum Physical Therapy, her orthopedic surgeon, Dr. Henry Fuentes, and her examining physician, Dr. Guido Marra. Only Dr. Troy, the Respondent's examining physician, noted a normal physical exam.

Both Dr. Mara and Dr. Fuentes agree that the Petitioner has a torn left shoulder labrum, and they both attribute Petitioner's complaints of pain and limited range of motion to the torn left shoulder labrum.

At Petitioner's first exam with Dr. Fuentes' on February 20, 2017, Dr. Fuentes agreed with the MRI findings and then performed a physical examination. Petitioner reported tenderness over the left anterior glenohumeral joint and anterior rotator cuff joint, had a positive O'Brien's test, a positive Speed test, a positive shoulder apprehension sign, and a positive relocation test. Dr. Fuentes attributed Petitioner's left shoulder issues to the Petitioner's work accident and recommended surgery.

Dr. Marra examined the Petitoiner on April 18, 2017, and found Petitioner had a positive Neer test, positive painful arc, a positive O'Brien's test, positive apprehension test, and a positive dynamic labral sheer test. Dr. Marra also reviewed the MRI scan and medical records, and he also opined that the Petitioner's labral tear is related to the Petitioner's work accident. Dr. Marra agrees with Dr. Fuentes that the Petitioner is a candidate for surgery to repair the torn labrum.

Dr. Troy, however, believes Petitioner's complaints of pain are from a labral sprain which he found to have been resolved at the time of his examination of the Petitioner on February 6, 2017. The Arbitrator notes that Dr. Troy based his opinion on his normal physical examination of the Petitioner which included normal range of motion and absence of any strength deficiencies. The Petitioner's medical records demonstrate, however, that the Petitioner continued to have complaints of left shoulder soreness and difficulty with using her left arm to perform certain tasks, both before and after Dr. Troy examined her. The Arbitrator also notes that Dr. Troy's examination findings are inconsistent with the physical examinations performed by Physicians Immediate Care, Dr. Rogers, Dr. Fuentes, Dr. Marra, and Momentum Physical Therapy, all of whom noted the Petitioner's left shoulder problems and complaints.

Based upon the foregoing, the Arbitrator finds the opinions of Dr. Fuentes and Dr. Marra to be more credible, reliable, and persuasive than the opinions of Dr. Troy.

Based upon the foregoing, and having considered the totality of the credible evidence adduced at hearing, the Arbitrator finds that the Petitioner's current condition of ill-being is causally related to the work injury of December 9, 2016. The Arbitrator further finds that the left shoulder surgery prescribed for the Petitioner by Dr. Fuentes is reasonable and necessary medical treatment which is causally related to the Petitioner's December 9, 2016 work injury.

In Support of the Arbitrator's Decision relating to (J.), Were the medical services that were provided to Petitioner reasonable and necessary/Has Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds and concludes as follows:

The petitioner offered the bill of Physicians Immediate Care into the record. The Arbitrator finds that the services rendered to the Petitioner by Physicians Immediate Care were reasonable and necessary medical treatment which is causally related to the Petitioner's December 9, 2016 work injury. Respondent is, therefore, responsible for payment of those expenses subject to the medical fee schedule.